NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 10:30 – 13:15 on Wednesday 4 July 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
TB180/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence	**Chair**	**10**	**10.30**
TB181/18 (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**		
TB182/18 (D)	**Minutes of the Meeting held on 6 June 2018** To **approve** the minutes of the Board of Directors	**Chair**		
TB183/18 (D)	**Matters Arising Action Log** To **review** the Action Log and receive relevant updates	**Chair**		
TB184/18 (P)	**Patient/Staff Story: Experience of Being Admitted to Hospital when you have a Learning Disability** To **receive** the presentation and **discuss** learning from the above	**Michelle Kitson**	**15**	**10.40**
STRATEGIC CONTEXT				
TB185/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**10**	**10.55**
TB186/18 (D)	**Acute Sustainability Programme Progress Report** To **receive** the report and discuss implications for the Trust	**DoS**	**15**	**11.05**
QUALITY & SAFETY				
TB187/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of QSC**	**5**	**11.20**

Ref No.	Agenda Item	Lead	Duration	Time
TB188/18 (D)	**Quality Improvement Plan Progress Update (In response to CQC Report –March 2018)** To **receive** the monthly report	**DoN**	**15**	**11.25**
TB189/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**IMD**	**10**	**11.40**
TB190/18 (D)	**Monthly Safer Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**10**	**11.50**
PERFORMANCE				
TB191/18 (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**	**10**	**12.00**
TB192/18 (D)	**Integrated Performance Report** To **receive** assurance from the current position in relation to national performance targets and integrated governance	**DoF**	**15**	**12.10**
TB193/18 (P)	**Director of Finance Report** To **receive** the current financial position at Month 2 and progress on the Cost Improvement Programme / Internal Sustainability and to approve the following	**DoF**	**10**	**12.25**
GOVERNANCE / WELL LED				
TB194/18 (D)	**Risk Management:** • **Board Assurance Framework** • **Risk Register** To **receive** the quarterly BAF report and the monthly report on the Risk Register	**Execs/ CoSec**	**10**	**12.35**
TB195/18 (V)	**Items for Approval / Ratification:** • **Ratification** of decision taken under Emergency Powers by Chair and CEO to **approve** an application to the Secretary of State for Health & Social Care for an Uncommitted Revenue Support Loan • **Ratification of** decision taken by Quality and Safety Committee on 25 June 2018 to approve the Quality Accounts	**DoF** **CoSec**	**10**	**12.45**
TB196/18 (V)	**Questions from Members of the Public**	**Public**	**10**	**12.55**

Ref No.	Agenda Item	Lead	Duration	Time
CONCLUDING BUSINESS				
TB197/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	**5**	**13.05**
TB198/18 (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**	**5**	**13.10**
TB199/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**		
TB200/18 (V)	**Date and time of next meetings:** **Public Board:** *Wednesday 5 September 2018, 11.30am* Seminar Room, Clinical Education Centre, Southport District General Hospital **AGM:** *Wednesday 5 September 2018, 14.30pm* Lecture Theatre, Clinical Education Centre, Southport District General Hospital	**Chair**		**13.15** **CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Richard Fraser

NHS
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NHS Trust

Register of Interests Declared by the Board of Directors 2018/19 AS AT 28 June 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	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
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**
CHRISTIAN, Mr Steven	Acting Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**28 June 2018**
CLARKE, Mr Ged	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**		**Kinsella Clarke Chartered Accountants. A number of Trust's Medical Consultants**	**1 May 2016**

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									are clients.	
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**	**2 August 2017** **Updated 14 March 2018 & 4 May 2018**

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									Care	
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**
PATTEN, Mrs Therese	Director of Strategy	**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**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**Owner: providing practice & GMC work**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**		**Nil**	**9 April 2018**

NHS
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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 6 June 2018

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 4 July 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
David Bricknell, Non-Executive Director
Ged Clarke, Non-Executive Director
Juliette Cosgrove, Director of Nursing, Midwifery & Therapies
Pauline Gibson, NED Designate *
Julie Gorry, Non-Executive Director
Jugnu Mahajan, Interim Medical Director
Silas Nicholls, Chief Executive
Therese Patten, Chief Operating Officer
Steve Shanahan, Director of Finance

In Attendance

Caroline Griffiths, NHSI Improvement Director
Laura Hilton, Acting Director of Human Resources
Samantha Scholes, Interim PA to the Company Secretary

Apologies:

Audley Charles, Interim Company Secretary
Jane Royds, Associate Director of HR *
Gurpreet Singh, Non-Executive Director

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB132/18	**Chairman's Welcome and Note of Apologies**	
	Mr Fraser as Chair opened the meeting by welcoming the Board members. He welcomed Ms Cosgrove as Director of Nursing to her first Trust Board meeting. Apologies were received from Mr Charles, Mrs Royds and Mr Singh.	

	The Chair welcomed Ms Hilton, attending the Board in Mrs Royds' absence and noted that Mr Shanahan was acting as Company Secretary in Mr Charles' absence.	
TB133/18	**Declaration of Directors' Interests Concerning Agenda Items**	
	The Chair asked if there were any interests that conflicted with items on the agenda and that any changes or additions to the Register of Interests declared by the Board of Directors should be submitted to the Interim Company Secretary. Ms Cosgrove's Declaration of Interests was added to the Register.	
TB134/18	**Minutes of the Meeting Held On 2 May 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 2 May 2018. **RESOLVED:** The Board **approved** the minutes as an accurate record.	
TB135/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn:	
	June 2017 Cultural Review: on-going process not concluded.	**ADHR**
	TB185/17 Standard Operating Procedure for the Administration of Meetings: to be brought to the July Board	**CoSec**
	TB061/18 Report – Security in Pharmacy: Security had been reviewed and a report would be brought to the next Audit Committee by Mandy Power.	**GC**
	TB067/18 IM&T Strategy: for July Board	**DoF**
	TB085/18 Monthly Mortality Report: to go to MOG in July	**IMD**
	TB087/18 Monthly Safe Staffing Report: Continuing discrepancy; a decision on the best set of data to use would be made and presented to the Workforce Committee with escalation to Board if necessary.	**DoN**
	TB095/18 Board Development Programme and Frequency of Board meetings: Clarification was being sought from NHS Improvement (NHSI).	**Chair**
	TB113/18 Monthly Mortality Report: duties and responsibilities	

	were re-circulated on 4 June 2018.	
STRATEGIC CONTEXT		
TB136/18	**Chief Executive's Report**	
	Mr Nicholls presented the report. Juliette Cosgrove was welcomed to the team as Director of Nursing, Midwifery and Therapies. Therese Patten was moving to a new role, Director of Strategy, from 11 June. Ms Patten's responsibilities as Chief Operating Officer would move to Steve Christian who joined the Trust from NHS Improvement on secondment for three months, whilst the post was recruited to. The resignation of the Executive Medical Director had been accepted and Dr Jugnu Mahajan would continue as the Interim Medical Director whilst the post was being recruited. **'Super Week' on the fourth week of May** Super Week embeds operational changes to benefit patients. 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: 1. Stopping 12-hour waits in A&E 2. Ending the practice of giving patients care in corridors 3. Improving performance against the national standard to treat, transfer or admit 95% of patients attending A&E within four hours Despite the 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 of the year • No 12-hour waits had been recorded since April. Operational grip and control in site management and wards continued to drive a safe and calm approach to managing our urgent care pathways • A decreasing number of patients were treated on the A&E corridor and for a shorter time Those achievements had 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 would begin in A&E on 14 June which would 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
Mr Nicholls was very pleased to hear that staff and partners were thinking 'out of the box' at a clinical leaders' workshop in June about how we could best meet the needs of patients in the future.

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

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

MP supports Dementia Action Week
Southport has one of the oldest populations in the UK, so the Trust 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 developed with the help of our Patient Experience Group, and member Terry Durrance in particular.
The booklet would be available to patients leaving hospital and Southport MP Damien Moore came along to support the launch event.

The Board agreed that the Trust would do all it could, to support a dementia friendly environment.

May was a month of celebrations including:
• Dr May Ng, Consultant Paediatrician and Paediatric Endocrinologist, was elected to Diabetes UK Council of Healthcare Professionals
• We learned that 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
• The catering team at Ormskirk hospital retained their five-star

	rating in food hygiene following an inspection by the local environmental health team. The Board congratulated everyone on their hard work and achievements. **RESOLVED:** The Board **received** the Report	
QUALITY & SAFETY		
TB137/18	**Patient Story: Meg Langley (Medical & Surgical Therapy Team Leader): 'Older People's Day'**	
	The Chair welcomed Ms Langley who organised the recent '*Older People's Day'* held at the Clinical Education Centre on 5 October 2017, which was an opportunity for older people and their families to learn about the support and services available to the community and celebrate their achievements. For people aged 65+, one in three were likely to experience a fall, some of which could be prevented by accessing support, including physiotherapy. It was noted that increasingly older people also presented with multiple problems. The event was a massive success with great feedback. People who had not been patients of the Trust attended as well as those who had and saw the opportunities and specialist support to be of significant benefit, with their perception of the Hospital being more positive than anticipated. Feedback from providers was that the next event could be larger and there were currently 45 services expressing a desire to be involved in it. The Board congratulated Ms Langley for developing an idea into reality, it being a success which could be repeated, possibly in Ormskirk as well as Southport. Ms Cosgrove added that the use of Twitter by Ms Langley to increase the profile of the organisation was both positive and beneficial. The Chair and Mr Nicholls echoed the congratulations of the Board and looked forward to the next event. **RESOLVED:** The Board **received** the presentation	

TB138/18	**Quality & Safety Committee - Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Birrell, on Mrs Gorry's behalf as Chair of this Committee, presented the report. The 2017/18 Quality Accounts were not yet completed so it was proposed that they should need to be signed off at the Quality & Safety Committee (QSC) meeting in June. Ms Cosgrove acknowledged that the process for that should have begun much earlier and had implementation on an on-going basis using a process which had already commenced for 2018/19. Following the training of a critical mass of Consultants, it was anticipated that Structure Judgement Reviews would commence in July. **RESOLVED:** The Board **received** the update	
TB139/18	**Quality Improvement Plan Progress Update**	
	Mrs Cosgrove presented the report. This report updated the Board on progress made to date in the delivery of actions related to the CQC recommendations following receipt of the CQC Inspection report of March 2018. Of the 97 actions in the improvement plan, there were • 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 was decided that the plan would be delivered through discreet single actions or larger Improvement Projects, the Blue, Red, Amber and Green (BRAG) rating tool had also been reviewed and updated to include a **Blue** category of 'Delivered and Sustained'. Monitoring would occur through realistic milestones and mock CQC inspections. Of the 97 improvement actions, 96 were currently rated amber (on track to deliver) and one was blue (delivered and sustained) based on current review and progress.	

	Mrs Gorry noted that prior to the December 2017 inspection, there was a Board and Senior Managers session relating to 'Well-Led' to make provision for Board Development, alongside duties and responsibilities plus demonstrable evidence of what was being done. The momentum needed to be sustained and possibly a follow-up session considered. **RESOLVED:** The Board **received** the report	
TB140/18	**Freedom to Speak Up Annual Report**	
	Mrs Cosgrove presented the report. The purpose of the report was to update the Board on concerns raised to the Freedom to Speak Up (FTSU) Guardian, to confirm actions completed to date against the National Guardian Office's (NGO) recommendations and confirm actions planned for the coming year. Key points for information: Following the NGO review in September 2017 the Trust had an established action plan which had been approved by both the Trust Board and NHSI. The Trust saw the review and current action plan as a key priority and key achievements of this action plan included 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 the consultant workforce had 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. The guide set 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 was arranging time through a board development session to complete this self-assessment tool by August 2018.	**CoSec**

	The appointment of the FTSU Guardian managed by both the Trust and the FTSU Team was discussed alongside the necessity for a Senior Independent Director (SID). It was agreed that unless a significant need arose the role of a SID would not be necessary. Clarification was requested in relation to FTSU concerns raised and if the outcomes were considered 'closed' when the response or action had been fed back to the complainant (if the person was known). **RESOLVED** The Board **received** the report	**DoN**
TB141/18	**End of Life Strategy**	
	Dr Groves, Consultant, Palliative Medicine, presented the report. An End of Life Strategy Steering Group, which met monthly, resulted from the publication of the End of Life Care Strategy and drew together all those interested in, or responsible for, End of Life Care. This fed into the Trust's Quality & Safety Committee and West Lancashire, Southport & Formby Supportive & Palliative Care & End of Life Integrated Clinical Network, which was a subgroup of the Cheshire & Merseyside Palliative and End of Life Care Clinical Network Group. The Trust had participated in all National End of Life Programmes for Acute Trusts and was currently one of ten Trusts selected to take part in the national 'Building on the Best' (BotB) Programme. Dr Groves presented the Palliative & End of Life Strategy which identified that 40% of patients requiring specialist palliative care services were seen by the Team. Another 40% were not and received in-patient hospital care when they could have been more appropriately cared for in a non-hospital environment. Nationally, 1% of the population died each year, with 56% of those deaths in hospital with 60-70% people expressing a preference to die at home. The BotB programme utilised four work streams: • Cross boundary communication • Share decision making • Outpatients • Pain and symptom management The Chair asked why the Modified Relief (MR) Opioid	

	Administration Audit was noted to which Dr Groves responded that continuing pain management was vitally important, however it was acknowledged that that did not always occur in a timely manner due to staffing issues. He further asked if people refused palliative care on the basis that clinicians would then not to treat them to recover but focus instead on alleviating symptoms and pain. Dr Groves replied that that was definitely not the case. Some groups of people chose not to access palliative care as it didn't fit with their beliefs and had a strong network of support, which was their choice to be respected. It was noted that End of Life training was an essential skill for some staff and some staff were more comfortable than others at addressing End of Life. Doctors in particular could view a patient's death as a failure and may have avoided the issue in trying to treat them. It was recognised that the whole team caring for a patient should work together to recognise the indicators and initiate the conversation between themselves wherever possible. Dr Groves concluded the presentation by stating that End of Life Care was everybody's business and there was only one chance to get it right for each individual and family. **RESOLVED** The Board **approved** the strategy.	
TB142/18	**Monthly Mortality Report**	
	Dr Mahajan presented the report. **Summary Hospital-level Mortality Indicator (SHMI)** had been higher than anticipated with the latest available reportable period for SHMI, (rolling 12 month period reported quarterly) was for 1st October 2016 to 30th September 2017 for which the Trust was reported to be at a ratio of 117.39:100.(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. **Disease-Specific Mortality** – December 2017 The jump in the number of Lower Respiratory Tract Infection (LRTI) and bronchitis deaths was 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 had resulted in the reduction of reported	

	Pneumonia deaths from September 2017. The seasonal rise in figures for respiratory related deaths was therefore being seen in an increase to both LRTI and bronchitis ratios. **Stroke** Stroke had 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 took into account specific indicators of poor stroke outcome (for example stroke severity). Septicaemia, Urinary Tract Infection and Acute Kidney Injury had all seen a reduction. **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 was recognised that that was particularly high for the month of March, it was believed that was reflective of the national picture. That would be subject to further scrutiny as more information became available. A Monthly Dashboard Highlights – March 2018 now included a radar graph which showed a clear correlation between the effects of staffing on deaths, for instance. Dr Mahajan agreed to provide the graph in landscape, clearer format for the next report. **RESOLVED:** The Board **received** the report	**IMD**
TB143/18	**Workforce Committee (WFC): Alert, Advise and Assure (AAA) Report**	
	Mrs Gibson, as Chair of the Committee, presented the report. **Sickness absence policy**: The policy remained under dispute and Mrs Royds and staff side were meeting as soon as possible to seek resolution. **Central Training Budget:** the reduced allocation resulted in reliance on funds being awarded by Health Education North West (HENW). If those were not forthcoming, then Continuous Personal Development (CPD), for nurses for example, was at risk. That was being added to the nursing risk register. There were some strategic decisions to be made on the allocation in light of the mandatory	

	training requirements. **Visibility of CBU training risks:** there was no a forum where those were visible across the organisation for strategic decision making. **Operational/Management Board**: Linked to above there was no operational forum for cross-trust debate/decision making on the people agenda which impacted the items brought to WFC with too many operational issues brought for discussion. Mrs Gibson would run a session to define the behaviours at WFC as a High Performing Team. **Personal Development Review (PDR):** Despite best efforts the PDR completion % was reducing. CBUs were actively focussed in their meetings on raising this with support from HR. A request was made for encouragement/challenge to take accountability to improve that in all areas (especially Corporate). **Safe Staffing** – the Committee could not provide assurance on safe staffing however it could provide assurance on fill rates. There was a piece of work underway to review the reporting so that what is received was meaningful. The Committee recorded its congratulations to the success of the following: • E-learning: way ahead of expectation. • Navajo Chartermark: the Trust had been awarded the LGBTIQ Chartermark Certificate –thanks to everyone who had worked so hard to make it possible. **RESOLVED:** The Board **received** the report	
TB144/18	**Monthly Safe Staffing Report**	
	Mrs Cosgrove presented the report. The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of 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
Nonregistered	375.60	340.48
Total	1234.18	1095.16

To comply with best practice the report would change for July Board to encompass fill rates etc. The Trust remained below the 90% target standard, due to vacancies and short-term sickness. That had been a static position for some time, so doing something else must be considered, including:

Recruitment of Band 4 Assistant Practitioners, which was not a short-term solution.
A drive to reduce sickness
Daily meetings with Head of Nursing and Matrons to view the week's rosters and data.

Ms Cosgrove agreed that working alongside the Cheshire & Merseyside recruitment teams for creative options could be fruitful.

Mr Birrell noted that vacancies remained static for a number of months. Evidently recruitment was possible but retaining staff had proved repeatedly difficult. The question was what the Trust does differently to resolve this.

Ms Cosgrove concurred that that was an on-going challenge. There was a Workforce plan and initiatives however, that was insufficient. Ms Patten added that staff found sudden requests to work on different wards or sites stressful and unsettling and the early morning huddle Ms Cosgrove had initiated was reducing the volume of non-informed reactive decisions earlier in the day.

It was further noted that with less additional capacity open, staffing needs were reduced and beds should not be opened if there were insufficient staff.

Mrs Gorry highlighted the work of volunteers and the impact those could have in never falling short of basic patient care and looked forward to Ms Cosgrove's forthcoming review of volunteers and the

	Volunteer Manager's post. **RESOLVED:** The Board **received** the report.	
PERFORMANCE		
TB145/18	**Finance, Performance & Investment Committee (FP&I): Alert, Advise and Assure (AAA) Report**	
	Mr Birrell, as Chair of the Committee, presented the report. At the end of April 2018, the Trust had a deficit of £2.6m against a deficit plan of £2.9m. That position was in line with the figures outlined in the 2018/19 Annual Plan which was discussed at the Board in May A review of the Trust's IT services suggested that further investment was needed to deliver the Trust's ambitious IT Plan. Consideration was being given to ways in which that could be achieved but it should be noted that the option of outsourcing had been discounted because it was a comparatively expensive solution. Further refinement had been undertaken of the Service Line Reporting/ Patient Level Costing System but the work remained subject to validation. It was anticipated that by the end of July a version would be available which could be used as an integral part of reviews with CBUs and specialties. **RESOLVED:** The Board **received** the report.	
TB146/18	**Emergency Care Performance Report including 4-Hour Access Patient Flow**	
	Ms Patten presented the report. **4-Hour Access Patient Flow** **Month** | **%** March 2018 | 79.2 April 2018 | 83.8 May 2018 | 88.7 The Super Week on the fourth week in May had been a success up to the Thursday of that week and the system was starting to show resilience. The weekend following was good. On Monday 28 May between 17:30 and 19:30, the department received 5 ambulances and 28 patients which it handled well, again showing signs of improvement.	

	Ms Patten shared an updated dashboard. The previous two weeks had been challenging due to school holidays impacting on staff availability. Safety was maintained however the wait to be seen was longer than anticipated. **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 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. Rapid Improvement Event – turnaround times improving **12 hour Breaches** One event occurred over Easter Sunday – Easter Monday; previously it had been incorrectly reported there had been no breaches in April. **Actions to Improve** The reset of the Programme for Improvement now included Jan Ross as Programme Improvement Director and was gradually coming to fruition with a significant improvement in performance evident in April. Throughout May further work continued, 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. Ms Patten shared an updated dashboard. The previous two weeks had been challenging due to school holidays impacting on medical staff's availability and therefore performance. Safety was maintained, however, the *wait to be seen* was longer than anticipated. The percentage of patients with a Decision to Admit (DTA) within 3 hr .15 mins was on an increasing trend, except in the last two weeks and average time to DTA had reduced to 220 minutes. The percentage of patients admitted directly to base wards was on a reducing trend with only 20% of patients admitted directly i.e. the use of right admitted pathways.	

	Although the total number of corridor patients had reduced slightly, the average time spent by corridor patients was on a decreasing trend. Patients on average spend 1.5 hours less on corridors than in April. The Interim Discharge Lounge was delayed in opening due to an Estates issue and it was anticipated this would open from 24 June 2018. Ms Patten agreed to look into 'First Responders' and Special Constables undertaking some paramedic activity locally. It was not known if those were working in collaboration with North West Ambulance Service (NWAS) It was agreed that the report should be in the Quality section of the Board. **RESOLVED:** The Board **received** the report	**DoS** **CoSec**
TB147/18	**Integrated Performance Report (IPR)**	
	Mr Shanahan presented the report. **Diagnostic Waits** Two locum radiologists were appointed to assist with capacity problems. **Stroke 90% ward stay** The figure of 165 admissions in April and the graph relating to performance of 60% to be checked. **Transient Ischaemic Attack** The statement of no clinical impact to be checked. **Income & Expenditure** Mr Birrell objected to the RAG status being Green, when the Trust was in deficit whilst accepting that was on a month on month status. **RESOLVED** The Board **received** the report	**DoF** **DoF**
TB148/18	**Director of Finance Report**	
	Mr Shanahan presented the report.	

	Current financial position at Month 1 • The Trust's planned deficit was £2.88m in month 1; the actual deficit was £2.62m, £254k less than planned. • Income had delivered Plan although assistance from 2017/18 • Expenditure was under Plan despite CIP underachievement. • Agency spend was below April's Plan but unless major reductions in medical staff occurred it was unlikely the NHSI target for the year would be achieved. Ms Patten requested a weekly report on CBUs, to track issues on a live basis instead of retrospectively monthly. **RESOLVED:** The Board **received** the report	
GOVERNANCE/WELL LED		
TB149/18	**Risk Management**	
	Ms Cosgrove presented the report. Since the last meeting 2nd May 2018, no new risks were added to the Risk Register. Two risks have been downgraded to high on the Risk Register: • 1664: Inability to provide out-patient review appointments in the required timescales; this risk had been reduced to high due to controls that had reduced waiting lists: external support sourced: risk stratification completed/ weekly telephone calls with NHSI/ NHSE continue. • 1815: If the ability to egress out of A&E was compromised, then the department would become 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 had been reduced to high due to the introduction of an additional building – (modular building - Clinical Decision Unit CDU). • There remained 3 risks rated as extreme. Mr Nicholls observed that it was good to see a reduction in risks, indicating a returning to business as usual. **RESOLVED** The Board **received** the reports	
TB150/18	**Items for Approval/Ratification**	

	Uncommitted Revenue Support Loan The Board ratified the decision taken under Emergency Powers by the Chair and Chief Executive that the application be submitted to the Secretary of State for Health & Social Care. **RESOLVED**: The Board **ratified the decision** **End of Year Documents:** • Annual Report • Annual Governance Statement • Annual Accounts **RESOLVED:** The Board ratified the decision taken by the Audit Committee at its meeting on 23 May 2018 to approve the end of year documents and which decision was approved by the Board via the Chair, Chief Executive and two Non-Executive Directors, taken under delegated powers from the Board on 24 May 2018	
TB151/18	**Questions From Members of the Public**	
	Mr Ryan asked if the Trust would like its activities, such as the Older Person's Day listed in a local church's diary. The Trust welcomed the involvement of the whole community. Mr Johnson asked if the new proposed coloured uniforms had been agreed, to which Ms Cosgrove responded that that was still being discussed.	
CONCLUDING BUSINESS		
TB152/18	**Any Other Business**	
	1. The Chair advised the Board and members of the Public that NHS Improvement had approved the recruitment of a permanent, exclusive Chair for the Trust and recruitment would take place in due course. 2. The Chair reminded members of the Public, that the new Public Board time was 11:30 – 2pm.	
TB153/18	**Items for the Risk Register/Changes to the BAF**	
	There were no items or changes.	
TB154/18	**Message from the Board**	
	There was no message from the Board.	
TB155/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 4 July 2018, 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 4 July 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
JUN 2017	**Cultural Review**	**ADHR June 2018**	Board members to be apprised of the review's findings and implications	On-going process - not concluded	**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**.	Next new Contract meeting has been arranged for 1 August 2018	**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 is identified.	**AMBER**
JUN 2018	**TB146/18 Emergency Care Performance Report including 4-Hour Access Patient Flow**	**DoS July 2018**	Ms Patten agreed to look into 'First Responders' and Special Constables potentially undertaking some paramedic activity locally.	Contact made with Robert Hussey, Community Resuscitation Manager to investigate	**GREEN**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 4 July 2018

BRAG Status Key

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

COMPLETED ACTIONS

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
JUN 2018	TB140/18 Freedom to Speak Up (FTSU)	CoSec August 2018	FTSU self-assessment tool to be completed by the Board by August 2018	FTSU Self-assessment Workshop scheduled for after July Board	BLUE
JUN 2018	TB142/18 Monthly Mortality Report	IMD July 2018	The radar graph to be provided in landscape with a readable format for the next report.	Updated in current report	BLUE

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

4 July 2018

Agenda Item	**TB185/18**	**Report Title**	**Chief Executive's Report**
Executive Lead	Silas Nicholls, CEO		
Lead Officer	Silas Nicholls, CEO		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information		☐ To Note ☐ To Receive

Executive Summary

- Finance - This financial year, the Trust expects to be in the red by £35.8m
- Summer improvements planned for A&E
- BAME staff network launched
- Freedom to Speak Up
- CQC notes progress in paediatrics and sexual health
- Exercise Golden Eagle

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

This financial year, the Trust expects to be in the red by £35.8m.

To reduce this figure, a Cost Improvement Programme (CIP) target of £7m has been agreed. This is 3.5% of our total spend for 2018/19 and will reduce the planned deficit to £28.8m.

No CIP schemes will be agreed that risk the safety of patients or the quality of services we provide. However, that doesn't mean we won't have to make some tough decisions and look at how we can do things differently.

We need to maximise the efficiency of our services and ensure that we get the best out of every pound.

The Trust also needs to develop new ways of working so we get the best out of our theatres, outpatients and diagnostic services. Having CIP schemes:

- Helps free up money to re-invest in new developments
- Gives confidence to our regulators so we get the freedom to concentrate on running our own services and looking after patients
- Supports putting our finances on a more stable footing so we don't see the month-on-month worsening of our financial position which happened in the past

There is now an increased focus on all types of spend, including agency and temporary staff. We are reviewing all contracts and prices to ensure we are getting the best value for money.

The Trust will also encourage staff to give their suggestions on where we can improve – as well as where it makes sense to grow and develop services.

May's financial performance. The Trust achieved its planned deficit for May of £2.8m. Favourable income and variance on pay cancelled out larger than expected spend on non-pay items.

Summer improvements planned for A&E

The successive year-on-year rise in A&E attendances continued through May. The Trust saw 230 more patients compared to 2017, which is a 5.1% increase. Performance against the national standard to treat, transfer or admit 95% of patients within four hour was recorded at 88.7% for the month.

The timeliness of signing off the handover of patients from ambulance service remains a challenge. This is in part due to the generally older, frailer nature of the local population.

Improvements to Southport hospital A&E over the summer, and due for completion by September, will see four dedicated cubicles for ambulance patients, and triage and reception moved to the front door of the department. A much-needed additional clinical assessment space will support more timely handovers.

BAME staff network launched

The first network meeting for black, Asian and minority ethnic (BAME) staff was held this month attended by Director of Strategy Therese Patten and interim Medical Director Jugnu Mahajan.

Equality and Diversity lead Karen Chazen supported setting up the group. She is also exploring the establishment of a group for disabled staff. These could be staff with a hidden disability, mental health issues or who are registered disabled

The Trust will also shortly begin collecting information on the workforce in relation to disability as it already does for ethnicity.

Freedom to Speak Up

A recommendation of the National Guardian's Office review last year into culture at the Trust was staff should receive regular mandatory training on speaking up. Two new courses – one for staff and an additional course for managers – are now part of the Trust's mandatory training catalogue.

CQC notes progress in paediatrics and sexual health

We were pleased to welcome inspectors from the Care Quality Commission in June on what will become regular relationship visits. Their focus was on children and young people's services.

The Paediatric team and Sexual Health Service made a presentation highlighting their priorities, achievements to date and risks and challenges. The inspectors noted the excellent progress since their last inspection in 2016.

Staff also had the opportunity to give their views at drop-in sessions.

Exercise Golden Eagle

Staff from across the Trust took part in Exercise Golden Eagle on June 5, a mass casualty exercise involving NHS organisations across Cheshire and Merseyside. The Trust received virtual patients from the exercise controllers to test our systems and responsiveness. Wards and teams provided live information to make our participation in the exercise as realistic as possible.

Congratulations this month to …

- **Spinal Unit Action Group** (SUAG) whose work at the North West Regional Spinal Injuries Centre at Southport hospital was recognised with a Queen's Award for Voluntary Service for supporting spinal cord injured people and their families

- **G ward at Ormskirk hospital** who received the Placement Experience of the Year 2018 award from Edge Hill University Faculty of Health and Social Care. Members of

the team, who work across wards G (gynaecology/urology), H (orthopaedic) and F (day surgery), were nominated by student Emma Cashen

- **Critical Care clinical educator Mel Pinnington** for organising Trek the Globe, a fun well-being project that has captured the imaginations of more than 120 staff. They compete as teams to clock up physical activity which moves them virtually across the globe

- **Medical, Surgical and Frailty Therapy team** at Southport hospital who raised more than £400 for Alzheimer's Society by hosting a #CupcakeDay

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- **Dr May Ng** who has been invited to speak at the House of Commons on 19th July to the All-Party Parliamentary Group on Diabetes. As well as being Associate Medical Director Specialist Services, May is a Consultant Paediatrician and Paediatric Endocrinologist

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 July 2018

Agenda Item	**TB186/18**	**Report Title**	**Acute Sustainability Programme Progress Report**
Executive Lead	Therese Patten		
Lead Officer	Therese Patten		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure X For Information		☐ To Note X To Receive

Executive Summary

The Trust Board supports the principle that our hospital needs to change, and therefore we have embarked on a programme of work to transform the services provided at Southport and Ormskirk. With system partners and clinical colleagues we are working to develop a range of scenarios to describe how hospital care might look in future. A Service Change Proposal will be developed and shared in the summer. Where change is significant due public engagement and consultation will follow.

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*
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 X Annual Business Plan Priority X Best Practice X Service Change

Impact *(is there an impact arising from the report on any of the following?)*	
X Compliance X Engagement and Communication X Equality X Finance	X Legal X Quality & Safety X Risk 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)*

Further updates will be brought to Trust Board as the work progresses.

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

ACUTE SUSTAINABILITY PROGRAMME
PROGRESS REPORT JULY 18

1 Executive Summary

The Trust Board supports the principle that our hospital needs to change, and therefore we have embarked on a programme of work to transform the services provided at Southport and Ormskirk. With system partners and clinical colleagues we are working to develop a range of scenarios to describe how hospital care might look in future. The thinking is being shaped by what is best and safest for patients. There is no blueprint for change and clinical colleagues are working through a methodology that has a strong clinical evidence base and demonstrates a positive benefit for patients.

2 Introduction

Southport and Ormskirk Hospital NHS Trust provides acute and community services for a population of c. 258,000, and has a turnover of £165m with approximately 3,242 staff. The Trust operates two sites which causes a number of operational challenges. The financial deficit for 17/18 was £34m and the Trust has recently been rated as Requires Improvement by the CQC. The Trust's RTT performance is good, however the Trust is challenged in meeting a number of other statutory targets including with A&E and cancer.
Despite its relatively small size the Trust offers a range of services including:

- Urgent and emergency care for adults and children – including an A&E, acute medicine, emergency surgery and critical care. Currently the adult and paediatric A&E facilities are on different sites
- A full range of women's and children's services including obstetrics, gynaecology, paediatrics and neonatology
- Elective (planned) care and surgery, including some complex and cancer surgery

3 The Sustainability Challenge

The current configuration of services across the Trust's two acute sites is not efficient. Previous work, such as the Southport and Ormskirk Hospital NHS Trust Clinical and Financial Sustainability Review (November 2015) has suggested that the current service configuration of services is not clinically or financially sustainable.

Clinically we struggle providing services across two sites, and in some specialities services are fragile being provided by very small teams. In addition, the scale of the financial challenge is such that without changes that go beyond the traditional Cost Improvement Plans, the health economy will not achieve financial sustainability. The sustainability challenge is compounded by difficulties recruiting, impacting the quality of care and the expenditure on agency staff.

4 Cheshire and Merseyside Health Care Partnership

The Cheshire and Merseyside Health and Care Partnership (C&M HCP) has been established to deliver the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside. The Partnership is made up of nine local authorities, 12 clinical commissioning groups and 19 NHS providers and is supported by core senior leadership team.

It has been agreed that the main focus for change and delivery will be through the development of 'Place-Based Care', that is where all care, direct and indirect, NHS and non-NHS, for a defined population will be integrated and managed through a single accountable

approach. In Cheshire and Merseyside the placed-based communities are currently aligned to the nine council boundaries of Knowsley, Sefton, Liverpool, Halton, St Helens, Warrington, Cheshire East, Cheshire West and Chester, and Wirral.

5 The Acute Sustainability Programme

The C&M HCP has established a work programme called the Acute Sustainability Programme to develop implementable plans for a sustainable (clinical, finance, workforce) acute health system across Cheshire and Merseyside. The Programme has five key work streams:

1. Urgent and emergency care services
2. Women's and children's services
3. Elective care services
4. Acute sustainability of East Cheshire NHS Trust (Cheshire East Place) and
5. Acute sustainability of Southport and Ormskirk (S&O) NHS Trust (Sefton Place)

The Southport and Ormskirk Acute Sustainability Programme has been established to deliver on work stream five. This programme of change will ensure that future health service provision across Southport, Formby and West Lancashire is financially and clinically sustainable, and meets the needs of the local population for years to come.

The first phase of the Acute Services redesign is the development of a service change proposal for Southport and Ormskirk hospitals. This work is led by Silas Nicholls (CEO) and supported by a Clinical Leaders Group (CLG). The CLG has clinical membership from across the health and social care system and provides clinical oversight and assurance for the acute sustainability work. In addition, the Trust has support of two Clinical Senates: the Northern England Clinical Senate as a critical friend, and the Yorkshire and Humber Clinical Senate as a clinical assurance partner.

6 The Clinical Senate Report

In December 2017 the Northern England Clinical Senate was commissioned to provide independent advice to the Trust and its partners on clinically sustainable options for the future (Appendix 1). At the time Care for You, the Trust clinical development programme was in the initial stages of considering speciality level service reviews in the following areas:

- Emergency Department and Acute Medicine
- Frail Elderly
- Emergency Surgery
- Women and Children's

The Senate team met many staff from the Trust and the wider system and produced a report providing advice and challenge to help the Trust progress the work of developing more detailed, workable clinical scenarios. The report also gives a view on the likely ability of these individual models to mutually support each other and present a coherent and clinically sustainable plan for the future of hospital and related community services in Southport and Ormskirk.

7 Programme Scope

The initial focus of the Southport and Ormskirk Acute Sustainability programme is to produce a Service Change Proposal which builds on the work of the Northern England Clinical Senate. It links with the care pathways re-design work stream to create the evidence base

for clinically-supported service scenarios. The Service Change Proposal has two components:

1. A Case for Change highlighting the key issues driving the need for redesign and reconfiguration
2. A number of high level clinical scenarios including a 'do-nothing' option, which describe the potential opportunities to deliver sustainable care in future

Early headlines from the Case for Change include:

- Workforce challenges (numbers and skills) exacerbated by the current service configuration
- A CQC rating of requires improvement
- Weaknesses in community and primary care service provision leading to issues with flow
- Obstetric service costs rising, with a falling number of births
- Significant frail patient population who aren't always cared for in those most appropriate or efficient way
- Market share for elective services shrinking with significant efficiency challenges
- Financially do nothing is not an option
- Current estate is not fit for purpose for the future

The focus of the clinical scenarios will be to provide community-based, integrated care, instead of organisation-based care. This means removing the artificial barriers between health and social care, shifting the balance to early intervention, and moving care closer to home to improve the independence and wellbeing of the population.

8 Conclusion

The Trust is embarked on a clinically-led service change programme. The work is led by clinicians from across the system and is critically supported and assured by two Clinical Senates. A Case for Change is being developed and a number of clinical scenarios which are likely to suggest the consolidation of services on a single site. A Service Change Proposal will be developed and shared at a later date. Where change is significant, it will be subject to appropriate public engagement and consultation.

9 Recommendations

Trust Board is asked to note the progress made with the Acute Sustainability Programme.

Northern England Clinical Senate

Northern England Clinical Senate advice to the Southport and Ormskirk Hospital NHS Trust

Report of Prof Andrew Cant – Chair, Northern England Clinical Senate

December 2017

Contents

Report:

Appendices:

1. Chair's introduction

In September 2017, the Northern England Clinical Senate was approached by the Clinical Leadership Group of Southport and Ormskirk Hospital NHS Trust (with the support of its local clinical commissioning groups) who sought independent clinical advice and support as part of the development of their Care For You programme.

Having listened to their description of the challenges they faced it seemed the Clinical Senate could best provide this support by acting as a "Critical Friend", identifying clinical experts across the range of areas covered by the Care For You programme who could provide advice and challenge to each of the specialty and service level models being developed, so as to help create more detailed, workable options. More importantly, we could then also give a view on the likely ability of these individual models to mutually support each other and present a coherent and clinically sustainable plan for the future of hospital and related community services in Southport and Ormskirk.

This report summarises our initial findings following a series of discussions held with local clinicians and other health professionals both within Southport and Ormskirk Hospital NHS Trust and from some of the other providers and commissioners that they work with.

I would like to sincerely thank the staff that met with us during the first week in December 2017 during our visit. In each case, and without exception, the Senate Team found dedicated hardworking staff that are passionate about providing a high quality service for patients, often in difficult circumstances and despite a long period of organisational uncertainty.

Many elements for a clinically sustainable future for health services across Southport and Formby, South Sefton and Ormskirk already exist within these teams. However, the lack of consistent leadership at executive level and the challenges of maintaining services in an unbalanced configuration across two hospitals which together serve a population barely large enough for one hospital presents considerable challenges. The current arrangements are not sustainable and simply trying to maintain the status quo will not work.

It is incumbent on the incoming leadership of the Trust, the local commissioning organisations, the responsible Sustainability and Transformation Partnerships and the regional offices of the national regulatory bodies to come together to enable these plans to be fully developed in a way that is congruent with proposed changes in Cheshire, Merseyside and West Lancashire.

I hope that the findings, together with recommendations for next step changes, as well as the analysis of potential options for reconfiguration will contribute to the start of a route-map for what could be an exciting future for Southport and Ormskirk through the Care For You programme.

Prof Andrew J. Cant
Chair – Northern England Clinical Senate

2. Summary of main findings

The Clinical Senate Team met a wide range of clinicians and other health professionals during the week of our visit and heard a frank, candid and honest assessment of the challenges faced by their specialties/services and the organisation as a whole. A summary of these challenges are outlined in section 3.

After consideration of these challenges and in the view of the Clinical Senate Team, the route-map to long-term clinical sustainability should take place in three phases of distinct but mutually supportive work:

- Phase 1 – Implementing changes that can be taken without the need to re-configure services. These changes should begin immediately to improve operational performance and improve clinical sustainability. In many instances Southport and Ormskirk will be able to implement them internally whilst there are other that require more networked solutions (or new/clearer service level agreements established) with neighbouring acute providers. There are also some changes that will require a whole-system place-based approach across primary, community and acute providers with aligned CCG commissioning and social care engagement. These proposed changes are outlined in section 4.
- Phase 2 – Reconfiguring services across the current Southport and Ormskirk sites. Once the recommended changes in Phase 1 have taken place, a second phase of transformation will be needed. Phase 2 includes the service challenges that can only be solved by reconfiguring services across the two current hospital sites. The current configuration is inefficient, unsustainable and potentially dangerous but each potential future option has implications for the level of service Southport and Ormskirk can sustain. These changes can only be introduced within the wider STP(s) context as there will undoubtedly be changes to patient flows that will have a consequence for neighbouring providers. Planning for Phase 2 can run concurrently with the implementation of Phase 1 but a further analysis of activity and population flows and travel and transport implications (with local authority input) is needed before a definitive view on the preferred option can be given. Our initial thoughts however are outlined in section 5.
- Phase 3 – Even if Phase 1 and Phase 2 of these changes are implemented successfully, maintaining a clinically sustainable organisation across the current Southport and Ormskirk sites will be difficult for a population of 230,000 as it is hard to sustain viable services for one district hospital for such a size of population, let alone two. This risk may be mitigated if the local NHS is successful in commissioning and building a new hospital situated between Southport and Ormskirk during this time. Should this not be achievable however the STP(s) should consider establishing “chain” arrangements between the two current sites and other larger providers in Cheshire and

Merseyside and Lancashire. Maintaining the physical capacity in these sites but bringing the workforce into larger networks (offering a wider range of experiences and potential rotation for staff) may give the best chance for long-term clinical sustainability into the future. Further comment on these considerations is given in section 6.

Having outlined a three phase approach to achieving clinical sustainability, it is also important to remember the well-used adage "*culture eats strategy for breakfast*". The lack of consistent executive leadership in recent years has clearly led to uncertainty within the clinical teams of Southport and Ormskirk and a lack of confidence in the delivery of any new clinical models. Whilst outside of the scope of this work, it will clearly impact on the delivery of the recommendations contained within this report and as such needs to be addressed as a matter of urgency by the Trust Board, STP(s) and national regulators.

A line also needs to be drawn under the past by all organisations across the wider health economy and a new relationship created across commissioners and providers that will support the introduction of the new care models that is centred around patients and not individual organisational needs.

Finally, despite highlighting a series of service and organisational challenges, there is much to be positive about within Southport and Ormskirk Hospital NHS Trust. The Clinical Senate Team were very impressed by the cadre of young clinical leaders within the trust, each with a vision for their own service areas and how to improve care for patients, although it is telling that none are considering apply for the substantive Medical Director post. It is this body of clinicians, leading their teams in the transformation process, that can deliver an exciting new model of care should the Trust leadership give them the confidence to do so. With such clinical leaders in place there is hope for the future and a foundation to build on.

3. Service and organisational challenges

The following observations regarding the specialty / service areas covered by the review are based on the documentation provided to the Senate and the discussions held with the local clinical teams. In some instances further information was requested to ascertain the scale of certain issues or cover gaps that have arisen due to lack of appropriate representation in some of the sessions.

3.1 Emergency Department and Acute Medicine

The Senate Team members met with a clinical team who they found to be working very hard in difficult circumstances. The main issues outlined to the Senate Team were as follows:

- The disjointed flow of patients though Southport Hospital constitutes the biggest challenge facing the ED and Acute Medical Services. The Senate Team heard that the 4 hour wait standard is achieved for only about 60% of patients, with 40-50 medical admissions a day. The AMU has only 22 beds, and the six ambulatory care spaces are almost always converted to bed spaces
- The practice of all patients including GP admissions coming through the ED adds to the strain in the department which clearly does not have the physical capacity to cope with the number of patients. Whilst medical support may come from in-hospital teams, it is not clear that the number of nurses is increased to cope with the excess number of patients. It is essential that some immediate change is instituted to help alleviate the flow issue
- To alleviate this disjointed and inadequate flow of patients, efforts are made to improve the discharge process for acute patients (a significant issue also for the Frail Elderly pathway which impinges greatly on the issue for the ED - see below).
- There is a belief with those working in the ED and Acute Medicine that there are sufficient beds within the Trust to meet the needs of the local populations, but that these beds are not in the correct place
- That whilst the Trust has an impressive approach to the retention and developing of Middle Grade ED staff, this is a diminishing and fragile resource
- The lack of stroke staff is leading to middle grade staff delivering thrombolysis in the ED which is not in keeping with national standards and is taking middle grade staff away from other acute work in ED.

3.2 Frail Elderly

The Senate Team members met with staff from primary community and secondary care who were clearly passionate about the development of a high quality service that worked seamlessly across the sectors and organisation for the benefit of patients. Unfortunately in the clinical discussion there was no representation from GPs from West Lancashire CCG or their main community provider so there are gaps in our assessment related to patients from this area.

- The Trust serves a significantly older population than in most of the country.
- Approximately 20% of the population are over 65 and have higher than average rates of non-elective admission and length of stay in hospital. Over half of the people over age 70 admitted as emergencies have been assessed as frail (as part of the frail elderly action plan in November 2017) which is approximately 15 % of all emergency admissions (based on 2013 – 14 data).
- Whilst there is a Frail Elderly Short stay unit (FESSU) in Southport hospital it is always at capacity and often people needing longer term care are brought here. The unit used to have a space for assessment and therapy as part of the ward but this is no longer available (with patients taken for therapy sessions from the ward to the rehabilitation suite at Southport Hospital).
- There has been a fracturing of provision along the Frail Elderly pathway following the re-procurement of community services (which also had an impact on organisational relationships at executive level that hindered the development and implementation of the pathway).
- There is a lack of step-up and step-down capacity available to GPs trying to avoid admitting Frail Elderly patients to hospital, or ensure prompt discharge.
- Significant parts of the current pathway are reliant on individuals who are working over and above their job plans on good-will to provide the current service whilst trying to develop the future models of care. The number of geriatricians would appear to be very low considering the demography of the local population.
- The efforts so far to improve care for the frail elderly have been impaired by the lack of financial commitment to the plans and trials (for example a long term plan is required for the discharge to assess beds that are currently only funded until March 2018). There has not been a coordinated approach to commissioning and this has led to significant variation in the services available to the whole population. The panel heard anecdotally that variation in services directly impacts the length of stay in hospital for people from West Lancashire CCG but data was not available to quantify this during the visit.
- That whilst the current Palliative Care service is working really well, the lone consultant largely responsible for it is approaching retirement and there is currently no succession plan in place.

3.3 Emergency Surgery

The Senate Team Emergency Surgery members only met one Consultant Surgeon but were able to spend more time with a Consultant Anaesthetist. There was evidence of some good and committed practice. However, there is a pressing need to change practice to bring it rapidly up-to-date to meet modern ways of working.

Whilst the Terms of Reference asked the Clinical Senate to consider emergency surgery and the deteriorating patient, elective surgery was also considered as it became clear that the issues between the two (and into the in-scope acute medical service) are interdependent.

- There appears to be significant variation in surgical practice with some working models supported by single consultant, and variation in practice across the team (both internally and with the wider Trust)
- The current pathway for acute surgical admissions is ineffective and the lack of “hot clinics” appears to result in needless admissions and whilst there are plans to address this, the definite implementation date was unclear
- Out-dated practice (e.g. admitting the day before a surgical procedure or in-patient investigation that could be done as an out-patient, and the under-provision of day case surgery) is significantly impacting on bed availability and patient flow.
- Approximately one third of surgical beds are boarded by medical patients, and surgical wards are used for bed escalation when there are surges in admissions. There appears to be reluctance by the surgical teams to utilise the theatre capacity on the Ormskirk site for elective surgery, particularly for increased day case activity.
- The lack of a GI Bleed service/rota and lack of 24/7 availability of specialist interventional endoscopic skills combined with no access to Interventional Radiology is of concern.
- The current anaesthetic on-call arrangements (two consultants on call with the first on call covering both sites supported by one middle grade resident on each site) are operating effectively presently but are vulnerable in the medium term

3.4 Women and Children's

3.4.1 Paediatric services

The Senate Team found a paediatric unit that was well organized and welcoming, with staff that are rightly proud of the service they deliver. The consultants who contributed to the session were engaged, motivated and keen to deliver as high a quality service as possible, and appeared to be largely succeeding in doing so. Whilst the unit did not to seem very busy with inpatients during the visit (despite it being winter) the activity figures shared with the Senate Team in relation to child attendances at ED (circa 27,000 a year) indicate sufficient patient numbers to justify the service and the 15% attendance-to-admission conversion rate close to what would normally be expected.

The challenges facing the paediatric service were found to be:

- Staffing levels are insufficient to meet the Royal College of Paediatrics and Child Health standard for acute paediatric care that require a consultant presence in the hospital at "busy" times (evenings & weekends) and the 7 day services standard (relating to consultant review within 14 hours for all admitted patients). We understand that there often is consultant on-site presence during busiest working times, but that the commitment to be so is not reflected in their job plans. A further two consultants (at least) would need to be recruited to bring the total up to 10 to make this possible while maintaining the other services of the hospital.
- There is a dwindling pool of non-training grade doctors which makes replacement challenging when this grade of doctor moves on or retires
- There is no on-site surgical opinion available with all children & young people requiring surgical input transferring to Alder Hey
- There is inequity in the commissioning of the children's community nursing service for patients using the Southport and Ormskirk Hospital NHS Trust paediatric service leading to different levels of care for patients using the same unit based on their registered GP. The children's community nursing service is only commissioned by two of three main CCGs – children living in areas covered by the other CCG cannot be discharged early for outpatient parenteral antibiotics or receive community nursing support (which are particularly important for neuro-disabled children). The children's epilepsy specialist nursing service is also commissioned by two of three CCGs – children living in areas covered by the other CCG do not receive specialist epilepsy nurse input (e.g. school / nursery liaison & training)

3.4.2 Maternity and Neonatal services

The Senate Team again found a well organised and committed team offering high-quality care in a warm environment. The challenges included:

- The unit sees a very small number of births annually. Although the large drop in recent birth numbers was explained by an artificially high number the previous year due to changes in maternity provision in neighbouring providers, the total number of births (2,273 according to NHS Digital Maternity Statistics 2016-17) is still considered relatively low.
- During the Senate session in Ormskirk, the transfer rate of women to ITU was given as 4 a year. Whilst this may be slightly higher than expected for a unit of this size, this was explained by an appropriately low risk threshold when considering transfer options. The service does not currently have on-site access to Emergency Surgery,
- ITU or a 24 hour blood bank (which is considered a high risk as recently identified in the recent review of the Liverpool Women's Hospital). An adequate "make do" work-around has been established where high risk patients such as those with identified placenta accrete are transferred to other units. For major postpartum haemorrhage some blood is kept on site and the lab technician will then come across to the Ormskirk side to deal with blood request. However this is not a long term solution.
- The service faces some staffing issues i.e. there is currently locum cover for consultant paediatric sessions and cover is needed for the junior rota (with the current short term solution being the use of locum consultant covering the registrar shifts at night not sustainable). The temporary arrangements that have been put in place are perfectly reasonable in the circumstances (and are typical of those put in place by many others in similar situations), but they are not sustainable (in even the medium term) and mean that the unit remains vulnerable to recurrent and / or staffing crises as a result of either further staff attrition and / or sudden absences due to sickness.
- The lack of A&E and resident surgeon on the same site is a problem
- The small number of admission of babies <34 weeks makes the maintenance of skills difficult

3.5 Organisational challenges

As well as these specialty / service area level challenges, each clinical team outlined critical over-arching issues that are contributing to significant difficulties within their areas. These relate to a lack of consistent leadership at executive level within the Trust. Clinical teams believe this has three main consequences:

1. Known issues that compromise services are left unchallenged and allowed to continue whilst ideas for improvement coming from the clinical teams are not taken up
2. That vital relationships and influence with other providers and commissioning bodies has been lost leading to a fracturing of the local health system which ultimately end up as operational issues for the Trust (e.g. inability to meet the 4 Hour A&E standard or discharge patients effectively)
3. That the Trust is left on the fringes of STP discussions in both Cheshire and Merseyside and North Lancashire which, given the geographical positioning of the two sites on the edges of these areas, is even more important so as not to become an afterthought or not appropriately considered as a viable option in wider transformation proposals

Furthermore, the local CCGs are not aligning commissioning plans with each other nor understanding the impact of one decision on the overall effectiveness of the wider health economy. In addition that short-term financial planning by both commissioners and the Trust is exacerbating the current operational difficulties and driving inefficiency and waste into clinical process

In the light of these service/specialty and organisation challenges and the ideas put forward by the local clinical teams, the Clinical Senate Team puts forward the following three phase approach.

4. Phase 1 – Implementing changes not requiring re-configuration

There are three main priorities for improvement in Phase 1 – each inter-linked with the other and of equal importance:

- Improving flow for acute medical patients through Southport Hospital supported by a coherent Urgent Care strategy agreed and owned by commissioners and providers across Southport and Formby, South Sefton and West Lancashire.
- Improving emergency surgery facilities in Southport counter-balanced by modernising practice and increased usage of Ormskirk for day case surgery.
- Developing an over-arching plan for the implementation of the Frail Elderly Pathway also agreed and owned by commissioners and providers across Southport and Formby, South Sefton and West Lancashire.

4.1 Improving flow

The Senate Team believe that a significant improvement can be achieved through the implementation of a number of incremental steps resulting in the accumulation of marginal gains.

- Increasing the number of assessment beds in the Emergency Department. At approximately 20, there are too few assessment beds for the number of daily admissions. Significantly increasing the number of assessment beds to as close to sixty as possible (the current guidance is to have at least the same number of assessment beds as daily admissions plus 10%) would enable the unit to turn many more patients around in a 48 hour period. Whilst there is already a multidisciplinary therapy team present, more nursing staff would probably need to be found (as well as the physical space to accommodate these beds. This increased capacity would alleviate pressure on the ED and would have the benefit of better 4 Hour performance and should be an operational priority for the Trust.
- Resolving issues between senior medical staff predominately delivering elective care and those whose work is mainly emergency focused. These issues need to be addressed as a matter of urgency to develop a cohesive plan for the future of the trust. The (unofficial) holding of beds for elective surgical patients to reduce waiting lists and secure tariff related payments together with admitting elective patients as in-patients who elsewhere would be treated as day cases is impacting on flow through the Southport hospital, affecting A&E performance and patient experience (see section 4.2 for further information).

- The Urgent Care / Walk-in Centres/ Out-of-Hours services and the Emergency Departments in the area appear to work in an individualistic manner rather than collaboratively (the sizeable number of patients staying less than 1 day would suggest that there is scope for improvement in the out-of-hospital element of the urgent care system). Collaboration is difficult with multiple providers and commissioning organisations but constructive clinical and organisational leadership is required to make the Urgent Care system work effectively.
- The opening hours of the Urgent Care and Walk In services should also be reviewed with 10pm (or even midnight) being preferable to the current 7:30pm closing times.
- A decision will need to be made on the ongoing provision of hyperacute stroke services. If it is to continue at the Southport site then a separate area (either totally separate or clearly delineated within the ED) needs to be created where suspected patients can be seen by stroke specialist (either consultant or nurse) and thrombolysed when appropriate. However, if this cannot be achieved or if the number of confirmed strokes (not including mimics) presenting falls/stays below 600 cases annually, then arrangements should be made for a neighbouring hyper-acute stroke unit to take on these patients.

4.2 Transforming surgical services

Based on the documentation provided, what was seen during the tour of the unit and the discussions with the clinical staff, the Senate Team believe that the transformation of this service can be achieved through a number of relatively straight-forward steps if supported by committed senior leadership. These steps are:

- To introduce a proper Surgical Assessment Unit as a matter of priority. This would be a major step forward if the Trust can reconfigure the current estate to allow its formation and is a must to improve patient flow. It must be allied to a fully developed “Hot Clinic” and have access to cross-sectional and ultrasound imaging on a daily basis to facilitate the management of the acute patients. The Hot Clinic needs to be led by a senior decision-maker to ensure unnecessary admissions are avoided. The development of a Surgical Admissions Unit at Southport, allied to the Surgical Assessment Unit would also be beneficial.
- To agree a SLA with a neighbouring institution to allow the creation of a “bleeding rota” with a clear management plan for patients presenting with a GI bleed. Currently there is not a formal 24 hour interventional endoscopy service and whilst there are some interventional services on site in Southport, there is not a formal out-of-hours service in place.

Due to the clear critical clinical interdependencies with emergency surgery there must be clear and unambiguous patient pathways to deliver these services through a network solution.

- To cease admitting many planned surgical cases the day before to prevent cancellation because medical boarders occupying beds (e.g. bowel resection and colonoscopy patients being admitted for bowel prep when they could have this at home). This very inefficient practice that has virtually disappeared in many institutions could be easily corrected by clinical leaders committing to change this practice.
- Ormskirk District Hospital is well supplied with theatres but there seems to be reluctance among the General Surgeons perform a significant number of procedures there. There appears no good reason for this and effective usage of this facility would enable better patient flows at Southport. Nurse pre-assessment could be used to identify patients below or approaching ASA Level 3 who could be treated at the Ormskirk site.
- Day-case rates are lower than they should be (e.g. for laparoscopic cholecystectomies and hernias), where a mind-set of *"a day case until proven otherwise*" needs to be adopted (as opposed to the current thinking of "*an inpatient procedure until proven otherwise*". Again, this will free up beds and improve flow for acute and elective patients.
- Some thought should be given to the timing of the post-take ward round and NCEPOD review. If the volume of admissions is large enough it may be that the morning could be used to see all of the previous day's admissions and arrange any investigations with the afternoon used for a surgical list. This would enable greater senior input into the acute surgical patient pathway in terms of review, decision making and subsequent surgery. If the number of admissions is low however, the whole process could potentially be fitted into a morning session.
- Arrangements need to be made for there to be a daily review of medical patients boarding on surgical wards, as when we visited one third of surgical beds were occupied by medical "sleep outs". This could be done by using a peripatetic consultant, or nurse with access to a senior decision-maker. This currently only takes place once or twice a week and there are no discharges at the weekend. This would free up capacity and improve efficiency.
- The proportion of surgeons specialising in colorectal surgery compared with those in upper GI surgery is unbalanced. Workforce planning needs to take place to enable a transition towards a more balanced surgical team across both upper and lower GI surgery when opportunities for recruitment allow.
- With regard to the management of the Deteriorating or Critically Ill Surgical Patient there is good Level 2 and 3 ICU provision but no Level 1 facility. Given the significant co-morbidities in the local population, due to the high proportion of older patients, Southport and Ormskirk would benefit from a PCU (Progressive Care Unit) or Step-down Unit to manage the complex major post-

operative patients which currently go back to the regular ward (unless they have epidurals where these have to go to ICU).There is also a clear and well-founded plan to invest in the Vitalpac Careflow electronic solution to identify the deteriorating patient but it is unclear as to when these will be extant – this should be prioritised and implemented as part of the transformation of this service (whilst it is an IT solution, it resolves a clinical risk so should not be lost in a wider informatics strategy).

4.3 Coordinating the approach to managing the Frail Elderly

From the discussions held with local clinicians and staff from Southport and Ormskirk Hospital NHS Trust and some of its community provider and primary care partners, it is clear that a significant amount of effort is going into the provision and development of services for the frail elderly.

The Senate Team felt that the draft Frail Elderly Pathway that has been developed is fundamentally sound and coherent although additional consideration should be given to which services within the Single Point of Access would benefit from co-location. Further clarifications on the point where appropriate signposting or referral on to formal and informal community services could be coordinated, could be included.

The issue in regards to the approach for the development of services for the Frail Elderly is therefore not the proposed model of care but instead the piecemeal approach to its acceptance and adoption, with only some parts being implemented and some of those not given adequate time to bed-in, has prevented its implementation.

When taking into account the CCGs initiatives in primary care (in the context of the transitional work undertaken by both the new community providers), too many small schemes have been introduced without an overall clear plan to deliver a system wide service.

Short-term evaluations of individual parts of this programme implemented using non-recurring resource will not work for the Frail Elderly as results will always fall outside of the evaluation period and benefits in terms of reduced levels (or mitigated increases) of demand or lengths of stay will only be evident over the medium- to long-term. Given the elderly demographic of the local population using this service (compared to other parts of the country) and the likelihood that this will not change for the foreseeable future, a more co-ordinated long-term approach to investment and development is the only sensible way forward.
Whilst some recent progress has been made in this regards (particularly between certain individuals at an operational level) is vitally important that an agreed strategic approach to investment and development is agreed by the leadership of the Trust,

the CCGs and the two community providers, developing the relationships at an executive level that will enable operational clinical staff and other health professionals to work together effectively. This new relationship does not necessarily need a physical structure but will need clear governance. In the past governance has often narrowly focused on compliance, when in this case it should incorporate a focus on behaviours and accountability to the whole system beyond the individual organisation and professional groupings.

In order for this to happen, there is an urgent need for this vision of the future model of care to be owned by all the commissioners, providers and local authorities involved and for there to be a commitment to its implementation. This will require a leap of faith to be taken by all senior leaders (and an understanding of the importance of this by regulators) in committing to the long-term view to be taken on investment decisions that will support this agreed model of care.

Whilst this vision is being developed, there are a series of actions that Southport and Ormskirk NHS Hospital Trust can undertake in its own right to build a more resilient service that can better meet the demands of the local population. The trust should then look to influence its commissioners and work constructively with community providers and social care to ensure the wider frailty pathway works as seamlessly as possible.

4.3.1 Actions within Southport and Ormskirk Hospital NHS Trust

During the senate visit, the Frail Elderly Team in Southport and Ormskirk shared an outline of their view of how they would begin to implement the integrated Frail Elderly Pathway[1].

On review the Senate Team feel that the planned work force numbers in the proposal may be insufficient to provide an effective, resilient and sustainable service and seem to be based on what the Frail Team think they may realistically be able to secure in terms of funding (as opposed what actually may be needed to deliver a clinically sustainable service that meets the needs of the local population).

The Senate would recommend that more detailed modelling against known and expected numbers of patients in different areas of the service would be helpful to effectively plan the workforce needs.
This modelling work should inform the adequate provision of step up/ down beds; palliative inpatient beds and outreach medical and nursing input; out-reach to specialist wards and orthopaedics for the frailty team to improve care of those not

[1] *"Draft Frailty phased approach: Practical Implementation" – Dr Fraser Gordon, Southport and Ormskirk Hospitals NHS Trust*

currently accommodated in the frailty service; effective primary care identification and assessment of frail elderly; social work and formal caring services.

Whilst it might seem good to start developing the Frail Elderly Pathway by setting up the Frailty Hub, it is much more important to establish effective ways of working in the MDT through a rapid access frailty clinic (i.e. “walk before you can run”). As part of a co-ordinated implementation plan under an over-arching vision for the management of the Frail Elderly, Southport and Ormskirk Hospital NHS Trust should look to implement the following measures.

- Ensure 7 day access to a pharmacist on the FESSU for poly pharmacy assessment and transcription of discharge medications. It would be helpful if this role was flexible to also help patients identified as frail elderly on other wards and it could be a combination of technician and pharmacist roles.
- Start discharge planning from the time of admission with a recommendation to include a social worker on the initial frailty assessment team
- To train and integrate a Frailty practitioner team to take part into the initial frailty assessment service with flexibility to arrange follow up on other specialty wards without requiring additional referral from the ward
- Consider a flying squad from the Single Point of Access (SPA) for rapid assessment
- Complete the work in the trust on electronic discharges emailed direct to practices or sent out via Integrated Clinical Environment (ICE)
- Consider setting up referral / advice and guidance processes before the Hub has been established. The electronic referral system ERS would be a good tool to use for this.
- Consider setting up a ‘delirium’ and / or frailty investigations tab on ICE.

4.3.2 Actions in collaboration with CCGs

Whilst the in-hospital elements of the Frailty Pathway are being implemented, Southport and Ormskirk NHS Hospital Trust should work in conjunction with its community providers and primary care to support the systematic implementation of the pathway can begin to achieve the four main elements of the Frail Elderly integrated pathway:

- Supporting people to remain healthy and independent;
- Appropriate assessment for and provision of care in the community;
- Preventing unnecessary admissions; and
- Effective treatment and avoidance of long hospital stays

The key features of the out-of-hospital pathway that support the in-hospital service within Southport and Ormskirk are outlined in table 1.

	Key features of out-of-hospital services within the Frailty Pathway
Supporting people to remain healthy and independent	• Identifying lifestyle and social needs for individuals and signposting / supporting people to access services in the community. • Access to healthy lifestyle including diet and exercise and harm reduction around stopping smoking and alcohol. • Social support - housing, accessibility to community services, tackling loneliness
Appropriate assessment for and provision of care in the community	• Proactive identification of health needs and risks to health. Early access to therapy services to address falls risks and mobility. • Identification and active assessment of and intervention for polypharmacy. • Appropriate assessment of and management of long term conditions. • Effective and appropriate use of Emergency health care plans. • Early discussions about preferred place of palliative/ end of life care
Preventing unnecessary admissions	• Rapid assessment and access to short medium term increased social care packages and 'intermediate level care in the home for: acute infection – including parenteral antibiotics; management of heart failure and COPD – including access to oxygen. • Access to 'Step up' beds • Access to appropriate palliative/ end of life care in the most appropriate setting / preferred place of care
Effective treatment and avoidance of long hospital stays	• Holistic needs assessment from the care of the elderly team including pharmacist, appropriate therapist and discharge planning from time of admission. • Access to timely diagnostics, therapy services. • Effective care and support to reduce impact of delirium • Access to appropriate palliative care in the most appropriate setting / preferred place of care

During the discussion with primary care clinicians, the Senate Team heard that in the last three months work has begun to align care homes with GP practices.

There is information available from other areas that were involved in the 5 Year Forward View Vanguards for Enhancing Health in Care Homes that may be useful to support this process (e.g. the Newcastle-Gateshead care home project[2]). This information may help inform how this can be done most effectively and the additional service that could be offered. In the Southport and Ormskirk integrated pathway these additional services may be coordinated by the community support hub.

[2] https://static1.squarespace.com/static/5893239037c581b39142e013/t/5955239637c581b92a71485f/1498751895481/OUR+MODEL+DOC-updated-June+%281%29.pdf

5. Phase 2 – Determining future configuration

Even if the incremental changes outlined in Phase 1 are undertaken, further reconfiguration of services across sites will be required. As has been found in previous reviews in the Southport and Ormskirk area, a new build hospital site with good road access to both Southport and Ormskirk purpose built to support a population of 230,000 would be the ideal solution for the Trust (a view held by all concerned as shown by the Deloitte Options Appraisal carried out in November 2015). However, in the current financial climate access to the capital funding required to finance such build seems far from certain and the lead in time for this option would still mean that an interim service reconfiguration across the two current sites and with better working with neighbouring acute providers is still be required.

The main driver behind this further reconfiguration is the need to co-locate the separate Paediatric Emergency Department and maternity services currently on the Ormskirk site with the adult Emergency Department, Emergency Surgery and Intensive Care Services (currently on the Southport site) as a matter of priority.

Trying to staff two EDs with the total number of ED consultants available will be both extremely difficult to operate in the present and will be harder to sustain over the longer term. Whilst there is an attraction in having a Paediatric ED, maintaining it on a separate site to the adult ED is not sustainable and relocating all emergency care on to the single site would seem to be the most appropriate way forward for the Trust.

Co-location of paediatrics with the adult emergency department might help in terms of recruitment and retention, with the possibility of interest from candidates interested in paediatric emergency medicine (from a paediatric or an emergency medicine background).

Co-location of paediatric services with general surgery on a single “hot” site could allow a reduction in the transfer of patients (typically with abdominal pain) to paediatric surgery at Alder Hey. Co-location of paediatric services with adult ED would allow more robust services for the small number of children who require more complicated trauma input (without needing transfer to the Major Trauma Centre).

Further analysis of the attendances at the Paediatric Emergency Department is required to understand what proportion of these attendances do not need to convert to an admission and so could probably have been seen in an Urgent Care setting. Any co-location of the two EDs (Adult and Paediatric) would require estate remodelling to ensure a physically “separate” environment for attending children.

It is the view of the Clinical Senate that the most sustainable of these options would be to introduce the hot site / cold site model as soon as is practically possible. This model is currently being tested at four sites across England and the early evaluations are showing improved efficiency and reduced bed usage.

Clearly there are pro's and con's with both of the potential options for this two site approach with no simple answer to resolution – the 2015 Deloitte options appraisal showed differing views between Trust and CCGs on the preferred option of each. What is clearer now than in 2015 however is that the "do nothing" option (that prevailed through the scoring system established by the process) cannot be preferable to either option now given the fragile nature of the services.

The challenge of introducing a hot site / cold site model across Southport and Ormskirk is that one site has the better building and estate capacity with a population requiring access to maternity and paediatric services (Ormskirk District General Hospital) whilst the other has greater demand for acute services driven by the aged population but in a building which is more cramped and in need of investment (Southport). However, given the current vulnerable state of the services, the declining current operational performance, and the serious financial position, there must be a serious risk of the Trust entering a downward spiral from which it cannot recover; thus a decision does need to be made.

5.1 The case for Ormskirk as the "Hot" site in a reconfigured service

The Ormskirk District Hospital would appear to be a good location for the Hot site in the future configuration until a new build hospital can be realised. Ormskirk has the better estate, significant space to grow, extensive unused theatre and bed capacity and would be cheaper in terms of transitional capital to implement this hot site model.

This additional capacity would improve patient flow and delivery of the NHS Constitutional Standards of a 4 Hour maximum wait in A&E (in higher quality and more affordable estate). To enable this to happen, there would need to be significant development of the current Southport site in particular in regards to the development of an Urgent Care Centre and Step-Down facilities for Frail Elderly patients being discharged from the acute medical unit which would now be in Ormskirk.

This model would also need to be supported by better identification of the frail elderly population within Southport by primary care with access to sufficient Step-Up capacity to avoid a patient's condition deteriorating to the point where acute medical admission is required (which could put an unmanageable strain on ambulance services).

Fuller engagement of North West Ambulance Services is needed to fully model and cost the transport and transfer arrangements needed to make this new service work.

By utilising Ormskirk as the "Hot" site, there would be better use of ED clinical resource as ED consultants based at Southport will no longer need to travel one day a week to Ormskirk to support the Paediatric ED as is the case in the current model. It would also mean the maternity service would be better supported by having enhanced on-site adjacencies at the site closest to the population more likely to utilise the service.

For paediatric services, Ormskirk, due to its central and inland location, offers easier access across a wider area and fewer children and young people and their families would have to travel. It would allow the service to continue to be offered from new, purpose built paediatric facilities whilst continuing to be co-located with obstetric services. In this configuration, there would need to be a paediatric triage site in Southport with children and young people requiring admission needing to travel to Ormskirk.

In terms of the provision of maternity services in this configuration, the relatively low number of births however would mean that the medium- to long-term sustainability of unit would still need to be considered through the Cheshire and Merseyside Women and Children's Partnership review.

The risk associated with this option is that patients who currently self-present to the Southport ED would choose to attend neighbouring providers to the south of Southport rather than travel to Ormskirk (if alternative urgent care provision was not implemented as part of the changes). It is unclear if these providers would have the capacity to cope with this additional demand. Further analysis and modelling will be necessary to understand this.

5.2 The case for Southport as the "Hot" site in a reconfigured service

Whilst the Ormskirk site would appear be the more attractive option as the future "Hot" site, there is also a case to be made for Southport Hospital to be the hot site, given the concentration of the Frail Elderly population around the site (and with future population projections showing that this is unlikely to change in the next decade).

This option would present a real opportunity for the development and exploitation of Ormskirk as a "Cold" site where the quality of estate and readily available theatre and bed capacity mean that a centre of excellence for low acuity elective work, not only for the current population but also to providers in surrounding areas facing

waiting time and bed capacity challenges. There may also be potential to repatriate elective work currently being commissioned by independent sector providers by neighbouring CCGs.

However, relocation of maternity and paediatric services to the Southport site could bring a significant risk that perhaps a third of expectant mothers would choose to deliver in Wigan, Whiston or Liverpool. The number of births would then fall below the level required to ensure clinical sustainability and so maternity and neonatal services would need to be relocated. The consequences of such a change on surrounding hospitals would need to be carefully modelled to determine how many deliveries would no longer take place locally in this scenario.

In the same way the transfer of inpatient paediatric services to the Southport site might lead to more children attending other hospitals (e.g. how many paediatric A&E attendances would return to Alder Hey Children's Hospital), further work to understand if the effects of such a change in patient flow needs to be modelled and reviewed in the light of plans for paediatric inpatient provision in West Lancashire (currently one or two units out of Ormskirk, Whiston and Warrington as described in the Cheshire and Merseyside Women and Children's Partnership: Options development for future service configuration).

In light of this, and in an attempt to better meet the Facing the Future standards, the Trust could consider the implementation of the Short Stay Paediatric Unit (SSPAU) model at the Southport site which could be run in partnership with a bigger neighbouring provider with a full inpatient paediatric service (e.g. Alder Hey) to ensure consultant posts remain attractive to staff.

Having said this, the geography and travel links might not lend themselves so easily to this model as SSPAUs to work best in urban areas where the population density is reasonably high e.g. Salford's relationship with Manchester, Birmingham City Hospital's current relationship with Sandwell and Newcastle's relationship with Gateshead – all located within the same conurbation with distances of only 5-6 miles and travel times under 15 minutes. Given these factors and the current activity levels at the provider, careful evaluation would be needed before deciding not to maintain a full inpatient paediatric service within Southport and Ormskirk Hospital NHS Trust.

5.3 Current view on preferred "Hot" site

Should the full range of services currently provided at Southport and Ormskirk Hospital NHS Trust be retained by the provider (in particular Obstetrics and Paediatrics), then on balance we think Ormskirk as a "Hot" site is the marginally better option. This is due to:

a) the need to collocate adult and paediatric A&E services and emergency surgery, critical care and the blood bank with consultant-led obstetric services; and
b) the population using Women's and Children's services originating substantially from around the Ormskirk site.

Were the full range of services provided out of a hot site at Southport, the demand for maternity services would almost certainly drop to unsustainable levels and the demand for paediatric services would also be severely undermined.

In the Ormskirk "hot site" model, great care would need to be taken with the frail-elderly pathway and great consideration given to the transport arrangements for patients moving between the sites given the congestion on the roads for non-blue-light vehicles.

However, should additional capacity be available for maternity and paediatric inpatient services in neighbouring providers allowing services to be reconfigured on a footprint wider than Southport and Ormskirk Hospital NHS Trust, then this fundamentally changes the view on the location "hot site", and Southport would be preferable because of the closer proximity to the Frail Elderly population in Southport and the significant potentially to develop a "cold site" centre of excellence (ideally on a much wider footprint and potentially in partnership with other providers) at Ormskirk Hospital.

Ultimately the poor quality of the estate would mean that further redevelopment of the Southport site would be needed in the medium term regardless of the services provided from it.

6. Phase 3 - Long term sustainability

Whilst a move to a “Hot” site / “Cold” site model would take Southport and Ormskirk Hospital another step nearer to clinical sustainability, it will always be difficult for Trusts serving small populations to achieve ever-increasing clinical standards whilst competing for scarce workforce in specialist areas. They cannot offer the range of experience or attractiveness of working arrangements (such as frequency of on-call) that larger units can, which will put them more and more at risk of workforce pressures. This will need to be addressed to ensure that the appropriate level of service is still provided in Southport and Ormskirk.

One approach would be to look towards more formalised network arrangements with other local providers through the creation of hospital chains involving the Trust (or its component sites) and larger providers in Cheshire and Merseyside and Lancashire. By maintaining the physical capacity in these sites but bringing the workforce into larger networks (offering a wider range of experiences and potential rotation) may give the best chance for long-term clinical sustainability into the future.

The geographical positioning of the two sites and the divergent population flows into Cheshire& Merseyside and Lancashire mean that natural clinical networks rather than organisational form may be the long-term solution for this Trust.

Under a networked arrangement, the most sustainable model for the Southport and Ormskirk Hospital NHS Trust could be to have A&E, Urgent Care, Frail Elderly Care, Short Stay Paediatric Assessment and Mental Health Crisis service on the Southport site, with inpatient acute medical and acute surgical care also there, whilst other larger neighbouring providers take on provision of obstetrics, inpatient paediatrics and certain aspects of urgent care for conditions such as Stroke, GI bleeding and Acute Cardiac Ischaemia. This would allow Ormskirk to be developed as a dedicated elective surgical centre with no risk of bed closures due to emergency medical pressures and efficient patient centred pathways of care that could then offer a much enhanced patient experience and be more cost effective.

7. Creating the environment for transformation

As outlined earlier, the lack of consistent leadership which has led to the “turmoil of planning” we heard described during our clinical session both demotivates staff and undermines efforts to bring Southport and Ormskirk “back onto its feet”. Nevertheless, difficult but vital decisions need to be made.

In order for this to happen there needs to be consistent and clear leadership from the Trust Executive who will give support to the cadre of excellent clinical leaders that exists at associate medical director and clinical specialty team level.

The Executive should work through the local STP to ensure both alignment with plans for the larger area and also engagement of the local clinical commissioning groups needed to support the transformation of Southport and Ormskirk Hospital NHS Trust, particularly in regards to their responsibility to lead public consultation on service change.

Again, working through the local STP leadership ensure that the correct regulatory environment is formed by NHS Improvement and NHS England to allow time for the clinical strategy to embed and the long-term investment decisions linking to its implementation take precedence over short-term financial decision-making.

8. Next steps

This report gives the view of the Northern England Clinical Senate Team based on the initial assessment of the challenges (and opportunities) facing Southport and Ormskirk NHS Foundation Trust. It is for the Trust to ultimately determine how it responds to this advice but it is hoped that it presents a pragmatic and rational set of actions that can begin immediately whilst setting the direction for the next phase of work that is necessary.

At the point of writing this report, a more definitive view cannot be given on either the location of the “hot site” in the “hot site / cold site” model or the potential for the “cold-site / cold-site” model as the appropriate level of activity and transport modelling was not available and service provision / configuration outside of Southport and Ormskirk Hospital NHS Trust is outside of the Terms of Reference for this piece of work.

Involving the relevant STPs and having a full analysis of activity, patient flows and transport and travel implications of potential future configuration options will be necessary – firstly to ensure the time and effort associated with reconfiguration is worthwhile (and sustaining) and secondly to ensure that neighbouring providers are no adversely affected by any unintended consequences in changes to the location of services.

The Clinical Senate will continue to make itself available to provide independent clinical advice to the Trust and STP(s) as the plans for Southport and Ormskirk Hospital Trust are developed further.

Appendix 1 - Terms of Reference

The Northern England Clinical Senate has been asked for support to co-design clinically sustainable options for the Trust and the wider community, in addition to its advisory role in providing strategic independent advice and guidance to commissioners and other stakeholders. As a result of this support it is envisaged a further Clinical Senate will be required to undertake the review and assurance stages of the formal review process to maintain the independence and integrity of subsequent reporting to regulators.

The Sefton Transformation Programme wishes to bring together Trust, local clinicians and Clinical Senate to co-design clinically sustainable options for the future in order to:

1. Understand, develop, establish and assess the overall service needs for the population.

2. Identify and confirm the services provided locally that are facing challenges to their sustainability.

3. Undertake a service level assessment of existing services, categorising them into;
    a) Services delivered locally by the local providers.
    b) Services delivered locally by local providers in partnership with other off patch providers.
    c) Services provided at a distance, accessed by the local population.

4. Consider previous work undertaken when identifying options for in-hospital service provision e.g. The Deloitte Review etc. and use this as a platform upon which to propose options, based on “place based” need.

5. Conduct an options appraisal process for the future delivery of services to be provided for the population, based upon;
    a) Services delivered locally by the local providers.
    b) Services delivered locally by local providers in partnership with other off patch providers.
    c) Services provided at a distance, accessed by the local population

6. Make recommendations to the Trust and commissioners on clinical sustainability options.

Aims, objectives and scope of the Clinical Senate Co-design (co-design, advice, guidance and support)

The aim of the independent clinical co-design, advice and support is to co-design with local clinicians sustainable clinical options, and provide advice on these to the Sefton Transformation Programme. In doing this it is assumed:

- These services are identified within the Scope section of these Terms of Reference below;
- The co-design, advice and support will take account of the demographic, geographical and population context. It will provide an assessment of the ability of the co-developed options to deliver good clinical outcomes and positive experiences for service users;
- Due consideration is made of 'left shift' out of hospital solutions within these options
- Consideration is made of the full range of possibilities within the system, i.e. options are not limited to existing organisational structures or locations but stem from the core purpose of delivering the best sustainable health and care services for the population of Sefton.

The objectives of the independent clinical co-design team are to:

- Support the development of sustainable clinical pathway options for the future.
- Assess the strength of the clinical case for change, identifying where the co-developed models are credible and robust, highlighting any areas of concern and making suggestions for improvement.
- Identify, consider and recommend opportunities for specialties/services, using suggested best practice.
- Provide clinical advice on the emerging clinical models by assessing the supporting evidence and adherence to national guidelines. In addition, an assessment of the ability of the models to achieve patient choice and seven day working will be undertaken.
- Ensure alignment with the 5YFV and commissioning priorities.
- Consider the potential impact of service change proposals on interdependent services, e.g. implications for provision of other specialties or for specialised services

Scope of the co-design

The Clinical Senate will look at the clinical evidence base and co-design with other local clinicians a range of options to support the Acute Services and Care Pathway re-design work streams, offering advice, guidance and support in regards to the safety, quality and sustainability of future models of care.

The scope of this work will include the following services/specialties:

- Establishing an integrated approach to caring for our frail elderly population, ensuring that a robust integrated pathway is in place across the whole health and care system
- Establishing a model for A&E & Urgent Care, including patient flow, linked to the 5YFV Acute Hospital Review
- Providing clarity on the safety of emergency surgery and emergency care and care for the deteriorating patient at Southport & Ormskirk
- Co-production of options for the future of Women's and Children's Services across Sefton
- Co-design of plans for collaboration with other local providers in the following specialties - Cardiology, Stroke and Respiratory

For these services the clinical senate will focus on the co-design of:

- all hospital based services
- options for sites at which in-hospital services will be located and their co-dependencies, considering network opportunities, new hospital build and co-production of services
- options for providing services in the community that are currently provided in-hospital

The following areas are out of scope:

- Assessing the financial viability and sustainability of individual service lines;
- Back-office administrative and non-clinical support services
- Managerial models of delivery of clinical support services across different trusts (although the requirements for access to these services in an appropriate timescale is within scope)
- Clinical services already provided (or where there are already plans for them to be provided) by a regional or sub-regional network (e.g. major trauma, vascular surgery, hyper-acute stroke service)

Appendix 2 - Panel Membership

Core Team

- Prof Andrew Cant - Consultant in Paediatric Immunology and Infectious Diseases and Director of the Children's Bone Marrow Transplant Unit, The Newcastle upon Tyne Hospitals NHS Foundation Trust. Northern England Clinical Senate Council Chair
- Dr Robin Mitchell - Clinical Director for the Northern England Clinical Networks. Northern England Clinical Senate Member. Formerly Consultant in Anaesthetics and Intensive Care at County Durham and Darlington NHSFT

Emergency Department and Acute Medicine

- Mr Andy Simpson - Consultant in Emergency Medicine, North Tees and Hartlepool NHS Foundation Trust. Northern England Clinical Senate Council Member
- Dr Peter Weaving – GP in Carlisle and Emergency Department clinician for the North Cumbria University Hospitals NHS Trust. Northern England Clinical Senate Council Member
- Dr Jean MacLeod - Associate Medical Director and Consultant in Diabetes Acute Medicine North Tees and Hartlepool NHS FT. Director of Quality, Research and Standards, Royal College of Physicians of Edinburgh. Northern England Clinical Senate Council Member.
- Dr Mike Jones - Consultant Acute Physician, University Hospital of North Durham. Director of Training, Royal College of Physicians of Edinburgh and Clinical Lead for the Acute and General Medicine Workstream of the Get It Right First Time Programme. Northern England Clinical Senate Council Member

Emergency Surgery

- Mr John Ausobsky - Consultant (General) Surgeon, Bradford Teaching Hospitals and Regional Advisor to the General College of Surgeons and Training Programme Director for General Surgery for Yorkshire and Humber. Yorkshire and Humber Clinical Senate Member
- Mr Barry Slater - Consultant Colorectal Surgeon, Northumbria Healthcare NHS Foundation Trust. Northern England Clinical Senate Assembly Member

Frail Elderly Services

- Dr Jon Scott - Consultant Physician / Geriatrician, South Tyneside NHSFT Northern Foundation and School Director, Health Education North East. Northern England Clinical Senate Council Vice-Chair
- Prof David Colin-Thome - Ex-National Director of Primary Care, DH and now independent health care consultant. Northern England Clinical Senate Council Member
- Dr Katie Elliott - Salaried GP, CRUK Strategic GP and Deputy Clinical Lead Northern England Cancer Alliance. Northern England Clinical Senate Council Member

Women and Children's Services:

- Dr Steve Sturgiss – Consultant Obstetrician at The Newcastle Upon Tyne Hospitals NHS Foundation Trust and Clinical Lead for the Northern England Maternity Clinical Network. Northern England Clinical Senate Council Member
- Dr Geoff Lawson - Consultant Paediatrician Obstetrician, City Hospitals Sunderland NHS Foundation Trust and Chair of Northern England Child Health Network. Northern England Clinical Senate Council Member
- Dr Helen Simpson – Consultant Obstetrician, South Tees Hospitals NHS Foundation Trust. Northern England Clinical Senate Assembly Member
- Dr Mark Anderson - Consultant Paediatrician, The Newcastle upon Tyne Hospitals NHS Foundation Trust. Northern England Clinical Senate Assembly Member

Appendix 3 - Documentation reviewed

The following documentation was provided by Southport and Ormskirk Hospital NHS Trust prior to the review sessions:

- Southport and Ormskirk Hospital NHS Trust – Clinical and Financial Sustainability Review: Final Case for Change (November 2015)
- Southport and Ormskirk Hospital NHS Trust – Clinical and Financial Sustainability Review: Final Options Evaluation Report (November 2015)
- Draft Integrated Frailty Pathway
- Care For You Service Review Challenge Session output plan on a page
- Draft Integrated Frailty Pathway Project Initiation Document
- Draft Emergency Surgery, Emergency Care and Deteriorating Patient Project Initiation Document
- Draft Model for A&E and Urgent Care Project Initiation Document
- Draft Sustainable model for Women and Children's Services Project Initiation Document
- Cheshire and Merseyside Women and Children's Partnership: Options development for future service configuration (July 2017)
- Cheshire and Merseyside Women and Children's Partnership: Women and Children's Services Programme Update (September 2017)

The following information was provided by the trust following the review sessions:

- Details of opening hours of local walk-in centres
- Copy of draft Mortality Dashboard
- Details of paediatric urgent care activity at the Ormskirk District General Hospital site
- Details of the clinical leadership structure of Southport and Ormskirk Hospital NHS Trust
- CQC Insight report November 2017
- Draft Frailty phased approach: Practical Implementation (Dr Fraser Gordon, Southport and Ormskirk Hospital NHS Trust)

Appendix 4 – Clinical Senate visit programme

Date and session	Senate Team	S & O Representatives
Wednesday 6th December ED and Acute Medicine	• Mr Andy Simpson • Dr Mike Jones • Dr Peter Weaving • Dr Jean MacLeod • Prof Andrew Cant • Dr Robin Mitchell	• Dr Dave Snow - Clinical Director and Consultant in Adult and Paediatric Emergency Medicine • Dr Paddy Macdonald - Associate Medical Director, Medicine, • Jacqui Flynn - Assistant Director of Operations • Ruth Stubbs - Head of Nursing Urgent Care, • Jane Lawson - Matron Urgent Care • Tracy Greenwood - Programme Lead, Patient Flow • Dr John Caine - GP, Chair of West Lancashire CCG • Dr Tim Quinlen - GP, Clinical Director for Urgent Care' Southport & Formby CCG and 'Chairman of the Regional A&E Delivery Board Sub-Committee'
Thursday 7th December Frail Elderly	• Dr Jon Scott • Dr Katie Elliott • Prof David Colin-Thome • Prof Andrew Cant • Dr Robin Mitchell	• Dr Fraser Gordon - Consultant Physician and RCP Tutor • Nicola Ivanovich - Head of Therapy and Rehabilitation Services • Dr Emily Ball - GP, Southport & Formby • Dr Emily Arnold - GP, Southport & Formby, • Amanda Houghton - Transition Service Manager, Lancashire Care NHS Foundation Trust • Jane Ayres, Senior Practice Pharmacist
Thursday 7th December Site visit to Ormskirk	• Prof Andrew Cant • Dr Robin Mitchell	• Lynne Eastham, Head of Midwifery & Nursing • Dr Helen Bradshaw, Consultant Gynaecologist and Obstetrician
Thursday 7th December Options for future hospital provision	• Prof Andrew Cant • Dr Robin Mitchell	• Karl McLuskey - Director of Strategy & Outcomes, South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group • Stuart Jackson - Associate Director of Finance & Strategic Financial Planning, Southport and Ormskirk Hospital NHS Trust
Friday 8th December Emergency Surgery	• Mr Barry Slater • Mr John Ausobsky • Dr Robin Mitchell	• Penny Sinclair - Matron for Planned Care • Dr Chris Goddard - Consultant in Anaesthesia and Intensive Care Medicine and Associate Medical Director for Patient Safety • Mr Paul Ainsworth - Consultant Colorectal and General Surgeon • Dr Rob Cauldwell - GP and Chair of Southport & Formby CCG • Helen Baythorpe – Assistant Director of Operations Planned Care • Kath Higgins - Head of Nursing, Planned Care

Friday 8th December Women and Children's	• Dr Helen Simpson • Dr Stephen Sturgiss • Dr Geoff Lawson • Dr Mark Anderson • Prof Andrew Cant	• Dr Ted Adams - Consultant Obstetrician and Gynaecologist, Clinical Director and Chief Clinical Information Officer/Clinical Audit Lead/ NCEPOD Ambassador • Lynne Eastham - Head of Midwifery & Nursing • Shirley Coward - Matron in Paediatrics • Dr May NG - Associate Medical Director for Specialist Services and Consultant in Paediatrics and Paediatric endocrinology • Dr Shyam Mariguddi - Clinical Director Paediatrics and Neonates and Consultant Paediatrician

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**25th JUNE 2018**
LEAD:	**MR JIM BIRRELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Committee's attention was again drawn to the cancellation of Group meetings because of lack of quoracy. Both the Clinical Effectiveness and Mortality Operational Group meetings scheduled for June were cancelled, which will almost certainly result in delayed action.
- There is a potential problem with junior doctor cover at night. Options for resolving include the increased use of other healthcare professionals.

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)

- Discussions are taking place with St Helens & Knowsley NHS Trust regarding responsibility for the appointment of volunteers.
- The Committee has asked for further information on the treatment of fractured neck of femur patients, particularly those not treated within 36 hours.
- The Datix IQ Mortality module, which will help to facilitate the completion of Structured Judgement Reviews (SJR's), will go live on July 1st 2018.
- The Trust is commencing a Care of Older Peoples Review that will draw on best practice from elsewhere. This work could have a major benefit on the quality of care provided for elderly patients.

ASSURE

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

- On behalf of the Board, the Committee approved the 2017/18 Quality Accounts so they will now be uploaded to the NHS Choices website. Approval was also given to the Patient Experience Annual Report.
- The Pneumonia Clinical Evaluation has been completed and the results highlighted both the complexities of diagnosis and the importance of recording all co-morbidities.
- The Trust's Quality Impact Assessment process is functioning effectively, to date 38 CIP schemes have been assessed.

New Risk identified at the meeting	• The Committee reviewed the Board Assurance Framework and suggested that the risk assessments for both Strategic Objective 1, (absence of clear direction, etc) and Strategic Objective 6, (inability to provide direction and leadership) could be reduced because of progress on the Strategic Direction and substantive appointments to the Executive Team.

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

PUBLIC TRUST BOARD

4 July 2018

Agenda Item	TB188/18	Report Title	Quality Improvement Plan Progress Update
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ✓To Assure ☐ For Information		☐ To Note ☐ To Receive

Executive Summary

This 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.

The plan will be delivered through discreet single actions or larger improvement projects. All groups have met and established terms of reference and governance arrangements and will meet regularly with the Director of Nursing to review progress. The Trust will also retain focus on the domains and core services which are Inadequate or Require Improvement to ensure they move to good.

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*
☐ **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 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 18 June 2018

2. BACKGROUND

Following the publication of the Trust CQC Inspection Report in March 2018, a detailed quality improvement plan has been developed for all the must and should do actions and governance arrangements have been agreed.

Trust Ratings (Fig1.1)

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.

3. Update on Actions

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 / Well Led (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.

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.

Rating	Must Do	Should Do	Total
Delivered and Sustained	1	0	1
Action Completed	0	0	0
On track to deliver	58	38	96
No progress / Not progressing to Plan	0	0	0

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.

4. Quality Improvements

Following a review of the current Improvement Plan by the Director of Nursing, it has been decided that the plan will be delivered through discreet single actions or larger improvement projects. All groups have met and established terms of reference and governance arrangements and will meet regularly with the Director of Nursing to review progress. The Trust will also retain focus on the domains and core services which are Inadequate or Require Improvement to ensure they move to good.

Improvement Projects are listed in the table below:

Improvement Project	Lead	Accountable Committee / Group
Environment and Cleanliness	Head of Estates / Head of Facilities with Executive Support	FP&I / IPC Committee
Access and Flow	COO	FP&I / Quality & Safety
Governance / Well Led • Governance Structure • Clinical Governance • OD • Other	Company Secretary / Director of Nursing / Associate Director of HR & OD	Quality & Safety Committee / FP&I and Workforce
Clinical Care • Deteriorating	TBC Associate Medical Director for Patient Safety	Quality & Safety Committee Mortality Operational Group (MOG)

Patient • Infection Prevention Control (IPC) • Medicines Management • Patient Experience • Accuracy and Security of Patient Documentation • Mandatory Training / Competencies of Clinical Staff • Nutrition • Health & Safety • Resus Trollies	Head of IPC Chief Pharmacist Deputy Director of Nursing TBC Head of Education and Training / Clinical Leads Nursing / AHPs H&S Chair Chair of Medical Devises	IPC Committee Drugs and Therapeutics Committee Patient Experience Group Nursing Documentation Group / Information Governance Workforce Committee Quality & Safety Health & Safety Committee Medical Devises

A further theme has been identified relating to the care of older people, especially those with dementia, in order to establish priorities for this work a review has been commissioned, it is anticipated that this work will take place in July 2018.

The new monthly Performance Review Boards (PRBs) will include and deliver the function of QID going forward and each Improvement Group will report into a committee or sub-committee of the Board.

5. CONCLUSION AND NEXT STEPS

Following discussions with CBUs six improvement actions have been identified to potentially move from amber to green (Action Completed), they currently awaiting evidence review and Executive approval, they will be presented to Quality & Safety Committee in July 2018 to support status.

Ref	Action	Current Status	Proposed Status
14 (2017)	The provider must ensure that patients are treated with dignity and compassion and that their dignity and privacy is maintained at all times while they are in the emergency department.		
03 (2017)	The provider must ensure the Trust has an effective system in place to meet their legal obligations in relation to fit and proper persons employed at director level.		
53 (2017)	The provider must ensure that patients' privacy dignity and respect is maintained at all times and that patients cannot be overseen or heard by inappropriate persons when receiving care and treatment.		

97 (2017)	The administration area for community midwives must be fit for the purpose for which it is being used, including provision for Regulation 10(1)a ensuring the privacy of a service user when speaking on the telephone and between professions		
81 (2017)	The trust should consider how all midwives can have timely access to patient information including any safeguarding concerns.		
76 (2017)	The provider should explore the reasons for higher readmission rates at this location for elective surgery.		

6. 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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4th July 2018

Agenda Item	**TB189/18**	**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 progress of the Reducing Avoidable Mortality Project, the roll out of the Structured Judgement Review and analysis of Trust mortality data.

Contents:

Strategic Context – Learning from Deaths and Reducing Avoidable Mortality

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

Measuring Mortality

- Summary Hospital-level Mortality Indicator (SHMI) - 1st October 2016 to 30th September 2017
- Hospital Standardised Mortality Ratio (HSMR) - January 2018
- Disease-Specific Mortality – January 2018
- Mortality Dashboard Highlights – April 2018

Reducing Avoidable Mortality (RAM) Project

- Updates on project work streams, key risks and milestones.
- Collaborative Working with Dr Foster and the Advanced Quality Alliance (AQuA).
- Update on the 'Developing Trust Capacity & Approach to Learning from Deaths' external mortality review of Pneumonia & Stroke Deaths May 2017 to April 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*
☐ **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)*

A quarterly update report on Learning from Deaths activity and the Reducing Avoidable Mortality Project is to be provided as requested to the July 2018 Southport Improvement Board.

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
2.0	**Background (Strategic Context)**	The Royal College of Physician's Structured Judgement Review method will drive a 'Learning from Deaths' culture, to increase patient safety and reduce mortality. Training across the Trust will be completed in June, with a Go Live date of 3rd July 2018. 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.
3.0	**Measuring Mortality - Mortality Ratios**	Both the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain high and above expected levels. SHMI for the rolling 12 month period of 1st October 2016 to 30th September 2017 has been reported at 117.39. This is higher than the ratio for the same period the previous year, which was reported at 108.7. The 12 month rolling HSMR for January 2018 is 136.8, a significant increase on December 2017 when the rolling 12 month position had been 114.42. The HSMR for the same period the previous year had been reported at 118.48.
4.0	**Reducing Avoidable Mortality Project**	A detailed update is provided on key activity and all six work streams of the project, risks and milestones. A status update is also given on the External Mortality Review as well as recent meetings with Dr Foster and the Advanced Quality Alliance (AQuA).
Appendices		
1	**Mortality Dashboard Summary**	An overview of the monthly in-house Mortality Dashboard Report is included as Appendix 1. 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 Trust will go live with the Royal College of Physician's Structured Judgement Review method on 3rd July 2018. The method has been developed to provide a robust and standardised assessment of deaths with an outcome of improved learning from deaths.

An in-house screening tool will be used by junior doctors for all deaths; the information from which will trigger the requirement for a Structured Judgement Review. In addition, a random sample of 10% of deaths will also be reviewed on an ongoing basis.

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. Regular 'Lessons Learned' and 'Learning from Excellence' newsletters will disseminate learnings across the Trust.

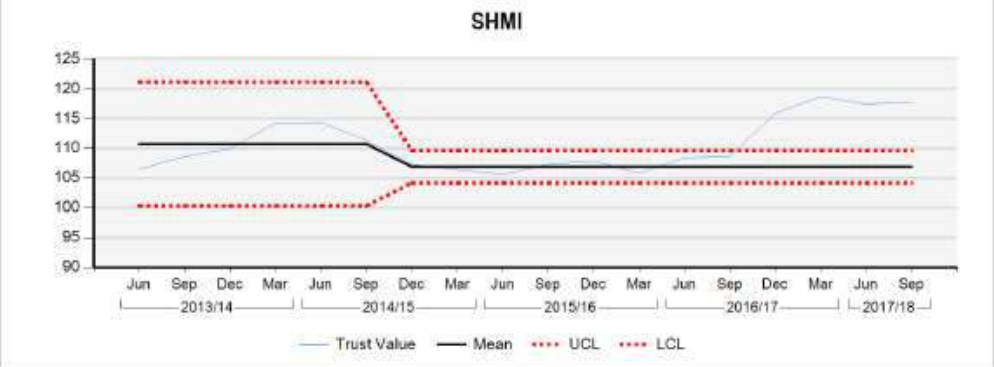
3.0 Measuring Mortality

3.1 SHMI & HSMR

3.1.1 Summary Hospital-level Mortality Indicator (SHMI):

The latest available reportable period for SHMI (for the rolling 12 month period from 1st October 2016 to 30th September 2017) reports a mortality ratio for the Trust of 117.39. (This is representative of 1,356 actual deaths over an expected figure of 1,152 deaths).[2] This ratio is higher than that for the same month the previous year, which had been reported at 108.7.

The SHMI ratios for January 2017 to December 2017 should have been available on 21st July 2018; however the NHS Digital website is currently reporting a delay in their publication for operational reasons.

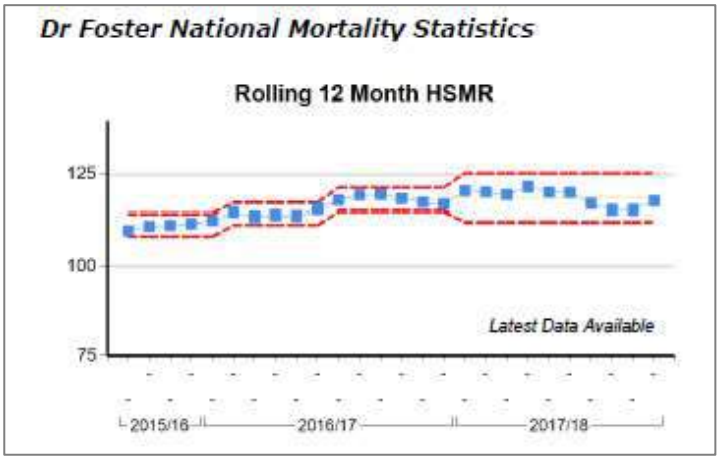


[2] The SHMI is reported quarterly and is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which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

3.1.2 Hospital Standardised Mortality Ratio (HSMR):

The HSMR is provided nationally by 'Dr Foster' and applies to in-hospital mortality (excluding palliative care). The 12 month rolling HSMR for January 2018 is 136.8 remains high and outside of expected limits and is a significant increase on December 2017, when the rolling 12 month position had been 114.42. The HSMR for the same period the previous year had been reported at 118.48.

A review into the depth of coding, undertaken by the Coding Team has shown that there is a need for more efficient recording of comorbidities in patient notes; the current blockage to the delivery of this activity is staff time. As part of the RAM Project, plans are underway to enable access to GP records in A&E, so that these can be added to the patient file to provide a clear and full picture of the patient's comorbidities.



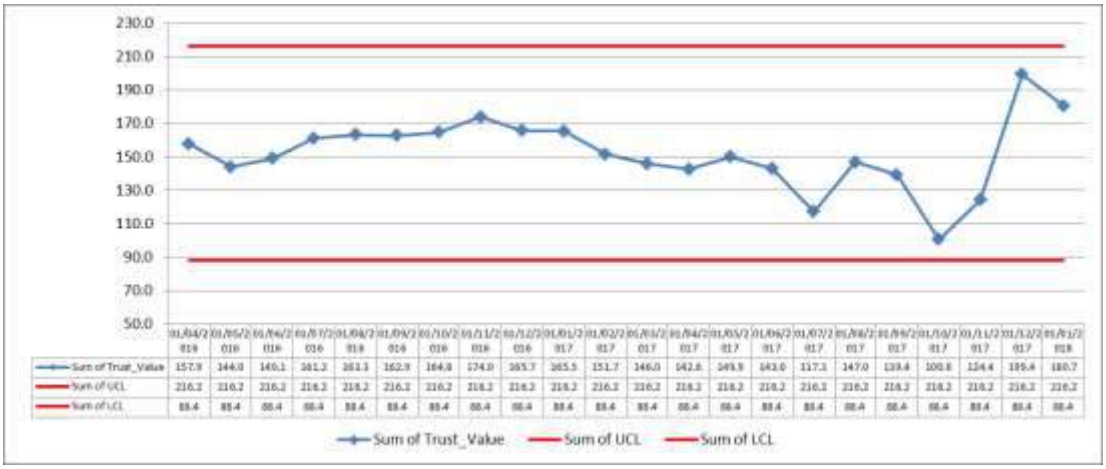
3.2 Disease-Specific Mortality – January 2018

3.2.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

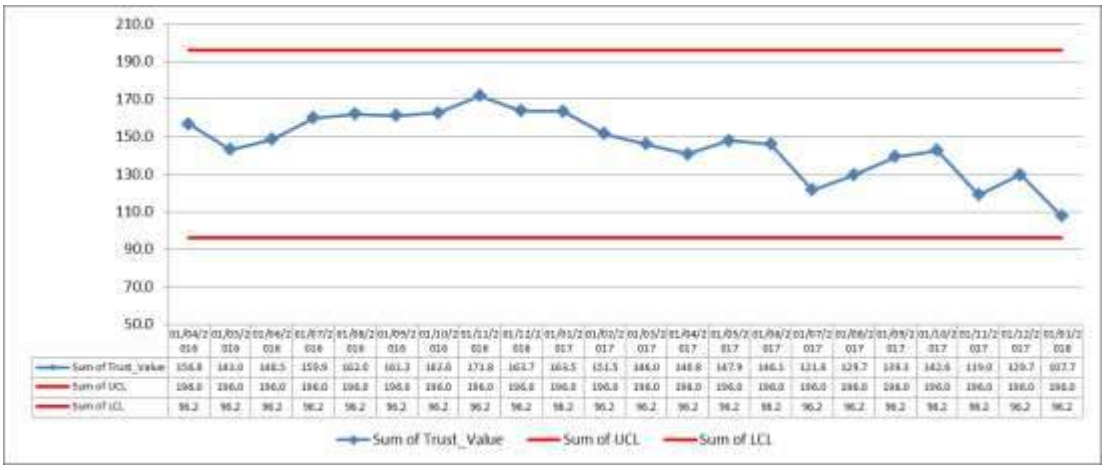
The rolling 12 month local Standardised Mortality Rate (SMR) for:

- Lower Respiratory Tract Infection (LRTI) dropped from 197.1 in December 2017 to 180.7 in January.
- Acute Bronchitis dropped from 126.1 in December to 107.7 in January.
- Pneumonia SMR rose from 125.7 in December to 134.2 in January.

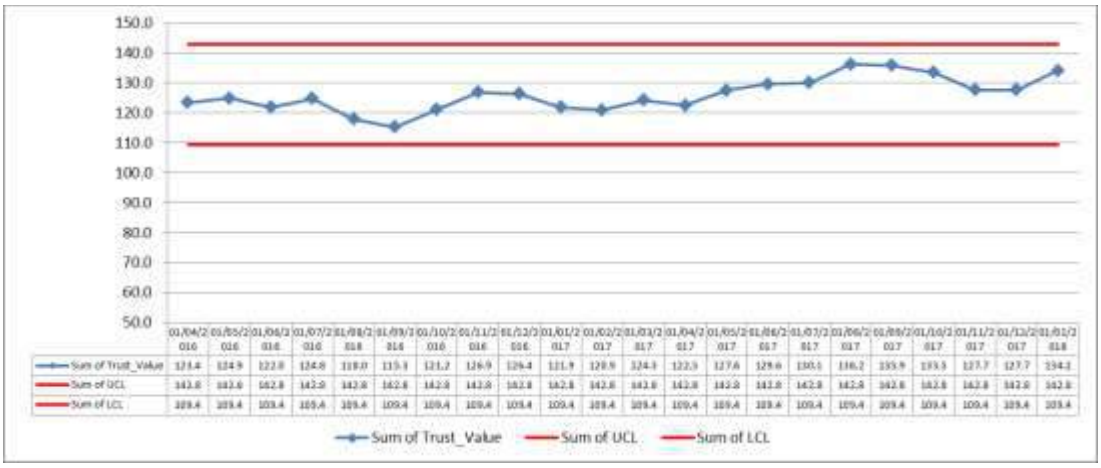
The direction of travel for a three diagnoses shifted in January from December. As previously reported, Dr Chris McManus, Consultant in Respiratory Medicine undertook a diagnostic accuracy checking exercise over the winter months. He found that a significant number of cases had been misdiagnosed (pneumonia can only be diagnosed from an x-ray and even then there are atypical representations); he has given recommendations for a pneumonia pathway which will be created as part of the RAM Project.



Lower Respiratory Tract Infection



Acute Bronchitis



Pneumonia

3.2.2 Stroke

The ratio for Stroke has continued its trend of increasing marginally to 142.7 in January up from 141.1 in December 2017. The reasons behind this are to be discussed at the July Mortality Operational Group.

As noted in previous reports, despite the high SMR ratios for stroke, the Sentinel Stroke National Audit Programme (SSNAP) reported a ratio of 100 for the Trust for

November 2017. Their ratio is based upon the results of 44 key indicators which are grouped into 10 domains covering key aspects of stroke care: scanning, admission to a stroke unit, thrombolysis, specialist assessments, occupational therapy, physiotherapy, speech & language therapy, MDT working, standards by discharge and the discharge processes; providing a clear indication of the levels of care provided for stroke patients.

Stroke

3.2.3 Septicemia (Except in Labour)

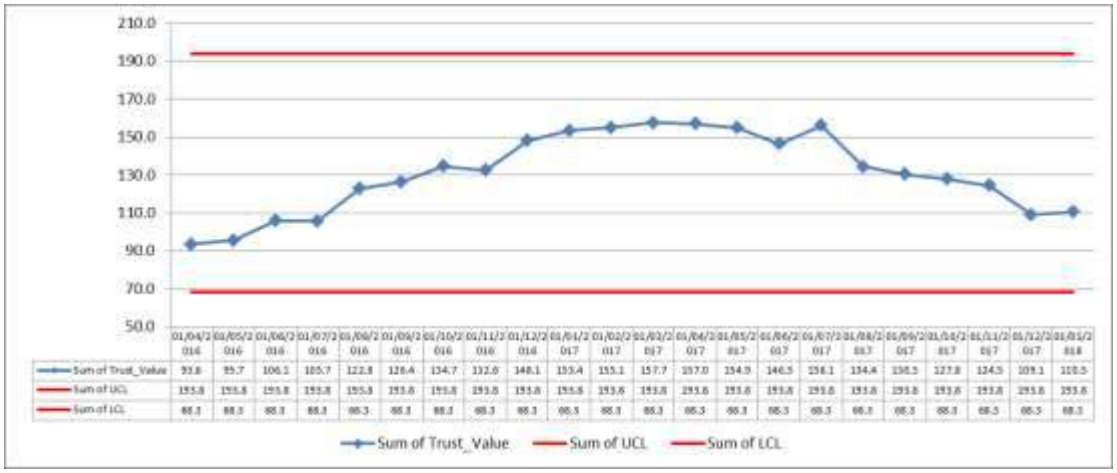
The rolling 12 month SMR for septicemia rose in January to 94.3 from 85.2 in December but continues to hold the ratio below the target of 100.

As reported last month, there has been a problem in that patients who are deteriorating due to sepsis on wards have not being picked up and coded accordingly. The Trust's Sepsis Pathway has been updated and new guidance is currently being rolled out across the Trust as part of the 'Care Pathways' work stream of the RAM Project.

Septicemia

3.2.4 Urinary Tract Infection

The rolling 12 month SMR for Urinary Tract Infection for January 2017 was 110.5 up on 106.5 in December 2017. This indicator was last below 100 in May 2016.

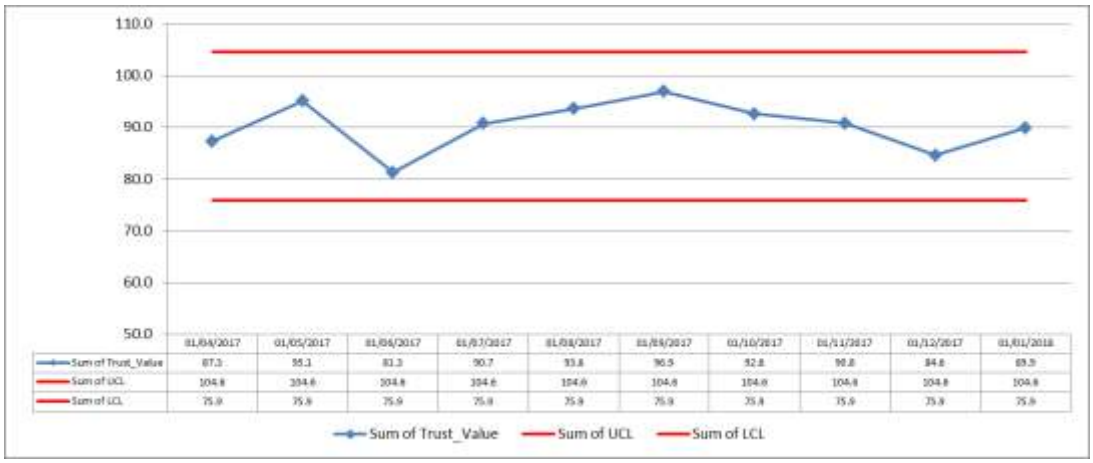


Urinary Tract Infection

3.2.5 Acute Kidney Injury

The 12 month rolling SMR for January 2018 was 89.9; this was a slightly increase from December but a distinct improvement on 118.5 in November 2017.

The new clinical pathway for Acute Kidney Injury has been signed off by the Clinical Effectiveness Committee and revised paperwork is to be rolled out across the Trust before the end of July.



Acute Kidney Injury

3.3 Crude Mortality:

The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for April 2018 was 30.4 against a target of 31.0 (Planned Care 29.9 and Urgent Care 78.5).

4.0 Mortality Dashboard Highlights – April 2018

4.1 There were no preventable deaths reported for April 2018.

4.2 98.13% of patients received harm free care.

4.3 Only 6.7% of all in-hospital deaths were attributable to patients who had been in hospital for less than one day, this is a significant decrease to the previous month when it had accounted for 28%.

4.4 12 patients whose deaths were recorded in April had been ward outliers during their inpatient stay.

4.5 One learning disability death reported for April 2018, taking the total year to date to eight. Dr Chris Goddard, (Associate Medical Director for Patient Safety) met with Dr Dominic Slowie, (National Clinical Director for Learning Disability for NHSE) and colleagues from both Southport and Formby CCG and West Lancashire CCG on 1st May, to discuss issues around the Learning Disabilities Mortality Review programme (LeDeR). Activity to ensure the integration of learning disabilities mortality review and the Structured Judgement Review is scoped as part of the 'Learning Culture' project work stream.

4.6 53 deaths were within 30 days post discharge, of these 20 were on the Gold Standard Framework at the time of discharge and of these 13 had been on the GSF on admission. (The Gold Standard Framework is the scheme for those requiring End of Life Care).

4.7 The average length of stay for patients who died within 30 days of discharge was 14.1 days. The average number of days between discharge and death for patients who died within 30 days of discharge was 13.0 days.

4.8 The total number of days between those identified as being Medically Optimised for Discharge (MOFD) and the point of discharge[3] was 286 against a Trust target of 162. This highlights the size of the issue of timely discharge.

As part of the 'Future Care Planning' work stream, activity is scheduled to improve identification and communication of those who are thought to be in their last year of life with the 'Individual Care Plan for Those Thought Likely to be Dying'. The plan will support the continuous care for the patient in the comfort of their own home and help prevent against hospital admissions; this in turn will impact the number of days between MOFD and the point of patient discharge.

4.9 The percentage of deaths within 30 days of surgery was 0.26% for Elective Surgery and 6.97% for Emergency Surgery. Within the context of the local demographic, previous research has shown the average age of those attending surgery at the Trust is in excess of the average life expectancy.

4.10 The sickness absence rate for medical staff for April was 1.98% (1.93% Planned Care and 2.93 % for Urgent Care) while for nursing and midwifery staff it was 6.01% (5.97% for Planned Care and 6.83% for Urgent Care).

4.11 The safe staffing ratio (the ratio of the proposed number of nursing staff required to ensure a safe staffing level and the actual number of nurses working those shifts) was 86.61% (80.84% for Planned Care and 92.13% for Urgent Care).

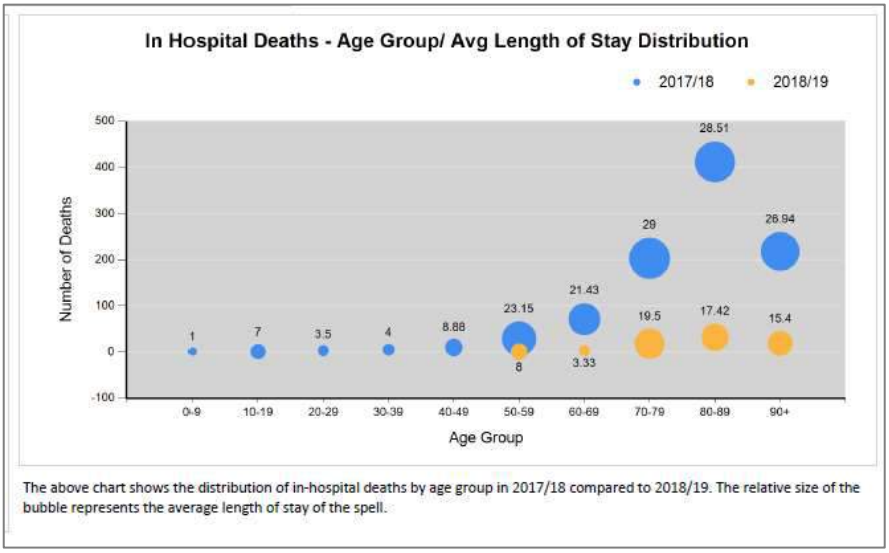
4.12 The average time that patients (who subsequently died) waited in A&E (arrival to departure) was 9.0 hours compared to the 6.4 hour average waiting time (arrival to departure) for patients who did not subsequently die.

4.13 The average time in hours that patients (who subsequently died) waited in A&E from decision to admit to departure was 5.3 hours, was only marginally higher than the average 4.8 hours of waiting time for patients who did not subsequently die.

4.14 The percentage of episodes of Z51.5 Palliative Care Coding has increased significantly for a second consecutive month to 22.97%. This accurately representative figure is high in comparison with the 12% which had been reported before a retrospective review had been undertaken by Dr Karen Groves, Consultant in Palliative Care. Training is required going forward, to ensure that all assessments undertaken by the Specialist Palliative Care Team (SPCT) are clearly documented in the patient notes; once a patient is moved onto an Individual Care Plan the associated booklet is to be used as the patient's main care record, filed correctly for ease of coding by the Coding Team.

4.15 The chart below shows the distribution of in-hospital stays by age group (with the relative size of the bubble represents the average length of stay of the spell). Both the average length of stay and the number of deaths for 2018/19 have reduced against the figures for the same time last year, across all age groups.

[3] For patients who subsequently died within 30 days of discharge, who had a GSF alert.



The above chart shows the distribution of in-hospital deaths by age group in 2017/18 compared to 2018/19. The relative size of the bubble represents the average length of stay of the spell.

5.0 Reducing Avoidable Mortality Project (RAM)

All six work streams of the Reducing Avoidable Mortality are live, with activity driven through weekly Project Group Meetings and from August onwards, through bimonthly Steering Group Meetings. A detailed update of the project activity is provided below with a BRAG rating against progress and an estimated completion percentage.

5.1 RAM Project Highlights

- The revised Sepsis Pathway and new guidance sheets are currently being rolled out across the Trust.
- The revised AKI Pathway and new guidance sheets are to follow suit in July.
- VitalPac upgrades are to go ahead as timetabled (version 3.5 in June and 3.6 in August); NEWS2, AKI and Sepsis bolt-on modules will be available with version 3.6.
- The Surgical Assessment Unit is scheduled to open in mid-July 2018.
- The launch, use and development of the Safety Hub continues in line with the proposed plan.
- The Structured Judgement Review method is to go live in the Trust on 3rd July 2018; consultants are shadowing the External Mortality Review Team over the month of June to observe their use of the Datix SJR Tool.
- Work has commenced on a standalone business case for a 24/7 Outreach Team which is essential to the success of the mortality project. This has been logged as a project risk.

5.2 Collaborative Working with Dr Foster and the Advanced Quality Alliance (AQuA)

5.2.1 Dr Foster:

A meeting with Dr Foster (Healthcare intelligence provider) took place in May to review the bespoke services available to the Trust as part of the existing contract. The Trust's Information Department have a long term working relationship with Dr Foster with access to a dedicated Intelligence Specialist and their online Healthcare Intelligence Portal (HIP).

It has been agreed with Dr Foster, that they will:

- Produce reports on stroke and pneumonia mortality by the end of July for analysis alongside the findings of the External Mortality Review.
- Report on benchmarking against depth of coding and palliative care coding insights.
- Undertake modelling to assess the impact on the SHMI, of changing the coding for ambulatory care patients to inpatient status.

5.2.2 Advanced Quality Alliance (AQuA):

Members of the RAM project group and Quality Team met with the Advanced Quality Alliance (AQuA) and the Innovation Agency, Academic Health Science Network for the North West Coast[4] on 30th May to discuss opportunities for support and improvement. The following offers of support, networking and benchmarking came out of the meeting:

- The Trust has been invited to two AQuA workshops on 'Improving Outcomes for Frail Patients' in December 2018 and February 2019.
- The Trust has been invited to join the upcoming AQuA Mortality Collaborative.
- Learnings on cultural engagement from Mersey Care are to be supplied by the Innovation Agency.
- The Innovation Agency to provide examples of Learning from Excellence from the West of England, Patient Safety Collaborative.
- AQuA has provided a contact at Portsmouth Hospitals NHS Trust regarding 'Learning from Excellence' activity.
- AQuA to provide information from Lancashire Teaching Hospitals and Scottish Trusts on embedding 'Hospital At Night' initiatives to empower teams to make decisions.

The group is to meet again in September, ahead of which, remote activity is coordinated via a shared action log.

5.3 'Developing Trust Capacity & Approach to Learning from Deaths' an External Mortality Review into Pneumonia & Stroke Deaths - May 2017 to April 2018.

The commissioned external mortality review is currently being undertaken by a team of eight clinicians and nurses over six days between 31st May and 3rd July. The final report is due before the end of July and will be presented to the September Trust Board.

To date, 80 of the 200 planned reviews have been completed, and of these, seven require a second review. The main findings and themes of the review will be presented for discussion to the consultant body at the Grand Round on Friday 29th June 2018. This will ensure that the review team have consultant feedback as part of their investigation.

[4] The primary role of the Innovation Agency is to form a network of NHS organisations, universities and businesses and achieve measurable results to identify and address unmet needs, prioritise areas for improvement, expedite innovation and enable research.
http://research.northwest.nhs.uk/research_networks/nw-coast-academic-health-science-network-nwcahsn/

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		20th June 2018
Reported to		Quality and Safety Committee

Key	
Blue	Activity completed
Red	Significantly delayed and/or of high risk
Amber	Slightly delayed and / or of low risk
Green	Progressing on schedule

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**		Pathway is being rolled out.	G	100
	Community Sepsis Pathway		Created and approved by South Sefton CCG for SOHT, NWAS & SSCCG. SOHT in talks with WLCCG for potential adoption.	G	100
	AKI Pathway		Signed off at Clinical Effectiveness Committee 24/05. Paperwork to be rolled out aross the Trust before the end of June 2018.	G	80
	IV Fluid Therapy (NICE 174)		Go Live' date for the new IV Fluid paperwork is 10th September.	G	55
	External Mortality Review: *'Developing Trust Capacity & Approach to Learning from Deaths' to review Pneumonia & Stroke deaths from May 2017 to April 2018.*		Review started on 31st May; an update on findings to date to be provided separately. An interim status report will be given to the Grand Round on 29th June. The final report to be presented to the Trust Board on 6th September.	G	30
	Upper GI Bleed		SOHT COO liaising with COO Aintree to formalise a Service Level Agreement for out of hours cover for emergency out of hours interventional endoscopy.	A	30
	VitalPac Upgrades (3.5 & 3.6)		Upgrade to 3.5 on track for end June 2018. Upgrade to 3.6 on track for August 2018.	G	90
	NEWS 2 (National Early Warning Scoring)		NEWS 2 is a module on of VitalPac 3.6 which is required by April 2019 in A&E for the purpose of Sepsis CQUINs	G	NA
	Timely Emergency Surgery / Surgical Assessment Unit		Surgical Assessment Unit (SAU) scheduled to open mid July 2018.	A	90
	Timely Emergency Surgery / Minor Surgery Patients		Discussions are underway for a process to return minor surgery patients to parent ward after surgery	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 Set Up**		Physical IT set up installed and tested	G	100
	Safety Hub Reporting		There are issues with the ability to fully report based upon a deficit of information put into Medway at ward level	R	40
	Safety Hub Go Live		Go live 18th June 2018 of Escalation Meetings	A	80
	Bed Meetings & Medical Handover Meetings		Operational Meetings are occuring (8th June 2018) Resuscitation, Bed Managers and Outreach Team to also move to Safety Hub after Escalation Meetings have been embedded.	A	20
	Named accountable person allocated against every patient.		Discussions have commenced to implement this.	A	10
	Pathways for escalation to be designed and rolled out.		To commence 2nd July 2018.		NA
	Policy for the Policy for the Clinical Ownership and Review of Outlying Patients		This was to be presented to Mortality Operational Group 11th June 2018 but the meeting did not go ahead.	A	30
	Ensure **optimum use of Careflow / VitalPac** to improve patient safety.		Work to commence 2nd July 2018		NA
	Joint working between **Transform Palliative Care Team and the Outreach Team.**		Work to commence 2nd July 2019		NA

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	G	80
	SJR Tool in DATIX IQ Cloud Go Live.		Launch date on track for launch on 3rd July.	G	80
	Consultants to sit with External Mortality Review Team for **best practice use of SJR Tool.**		Consultant observations have started; to continue until 3rd July 2018	A	30
	Alternative process in place if **DATIX IQ Cloud** cannot be delivered by 3rd July 2018 (to use RCP SJR tool in the interim).		No longer required	B	NA
	SJR Mortality Reviews to be factored into job planning.		July 2018		NA
	Link Risk and Mortality Data: Formal process for triangulation of SJR method, Serious Incidents and Mortality Data		Work to commence July 2018.		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'**		Form 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 (FESSU). To be developed & rolled out	A	20
	Advance Care Planning: training and awareness is to rolled out		Work to commence July 2018		NA
	Alternatives to admission: to be developed as part of a second stage of project: to involve Clinical Commissioning Group		Work to commence July 2018		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		Process scoping required to acheive this.		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	**Understand and Communicate Mortality Data:** Mortality Reporting to QSC and Trust Board to be reviewed and updated		The Mortality Dashboard and Mortality Report have been revised and updated to provide increasingly insightful information with which to understand the issues surrounding mortality. Meetings with the Advanced Quality Alliance (AQuA) and Dr Foster are taking the conversation further to embed further opportunities for improvement.	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 CBUs (SJR / Mortality rates and findings).**		To commence once the SJR method is being used in the Trust; information will be fed into the Mortality and Morbidity Meetings and through Lessons Learned newsletters.		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**		A new business case for a 24/7 Critical Care Outreach Team is being written; meetings to support this are in the diary for w/c 18th and 25th June. This requirement is essential to the success of the project.	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.		NA
	Workforce to Deliver Seven Day Service Provision		Seven Day Services Project is looking into the impact and implications of the requirement for	A	10

Key Milestones

Key Milestones	Start date	End date	BRAG	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 18th 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	A new business case is being prepared showing the return on investment to the Trust

Top Risks and issues to achieving programme objectives

Risk	RAG	Mitigation Activity	RAG After Mitigation	Comments
If the Business Case for the 24/7 Outreach Team is not successful then this poses a significant risk to the successful delivery of the project's aim: to reduce mortality by April 2019.	R	While there is a Critical Care Outreach Team during the week, the Business Case is to extend the Team to provide full 24/7 cover. If the full requirement cannot be fulfilled a wider discussion will be needed to understand alternatives with which to deliver the required cover.	A	A new business plan is being written with a clear indication of the return on investment.
There are issues with the ability to provide robust reporting in the Safety Hub for Escalation / Bed / Resus and Outreach meeting based upon a deficit of information put into Medway at ward level.	R	Project Group to meet on Friday 23rd June to discuss the root cause issues. Guidance and training are likely to be the first steps to mitigate the issue, although the main blockage is likely to remain the amount of time required to input the required information and inadequate levels of workforce to deliver, at ward level.	A	Issue raised at a project meeting on Tuesday 19th June. Issue to be escalated to the August Steering Group
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 Training and Development 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 June 2018

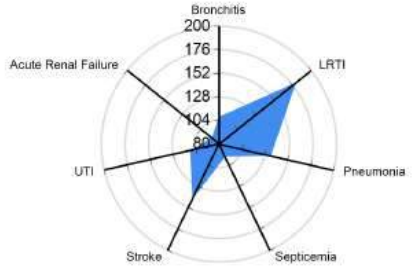
Southport & Ormskirk Hospital NHS

Dr Foster National Mortality Statistics

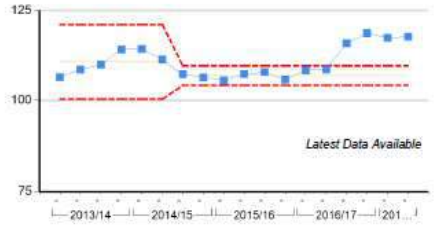
Rolling 12 Month HSMR

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

Local HSMR January 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: 0

0%

YTD Deaths of Patients with GSF Alert: 16

21.6%

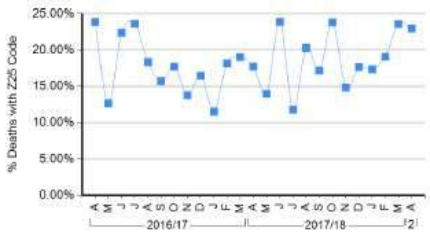
Deaths Post Discharge

Avg Spell LOS whilst admitted: **22.1**

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

YTD Deaths of Patients with GSF Alert: 13 — **24.5%**

Palliative Care Coding %



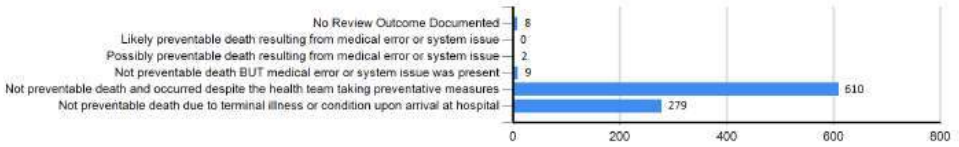
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Sepsis, unspecified	15	▲
Lobar pneumonia, unspecified	7	▼
Pneumonia, unspecified	6	▶
Unspecified acute lower respiratory infection	4	▼
Acute renal failure, unspecified	3	▼

Mortality Reviews

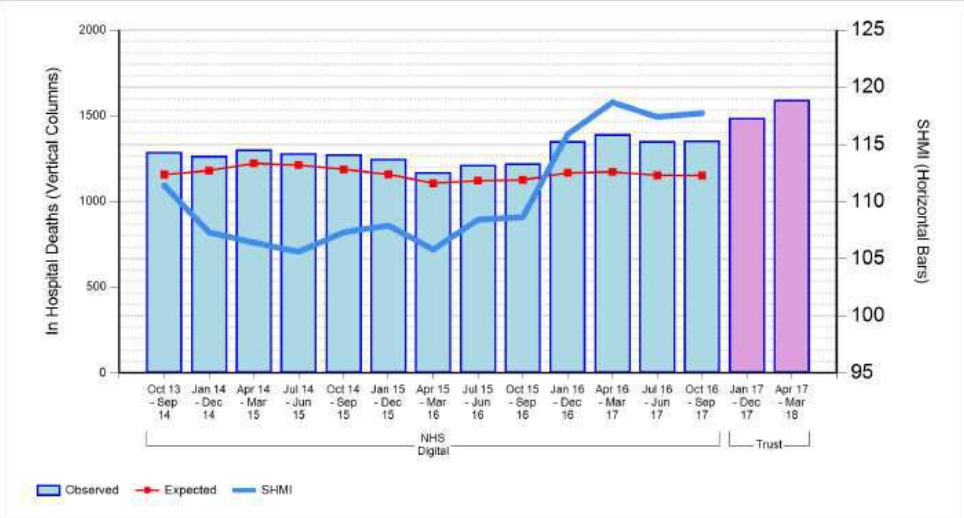
	2017/18											2018/19
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Reviews Completed	89	62	53	77	71	53	64	80	108	77	91	83
Reviews %	95.7%	92.5%	77.9%	111.6%	110.9%	84.1%	118.5%	94.1%	89.3%	86.5%	85.8%	112.2%

Mortality Review Outcomes - Last 12 Months



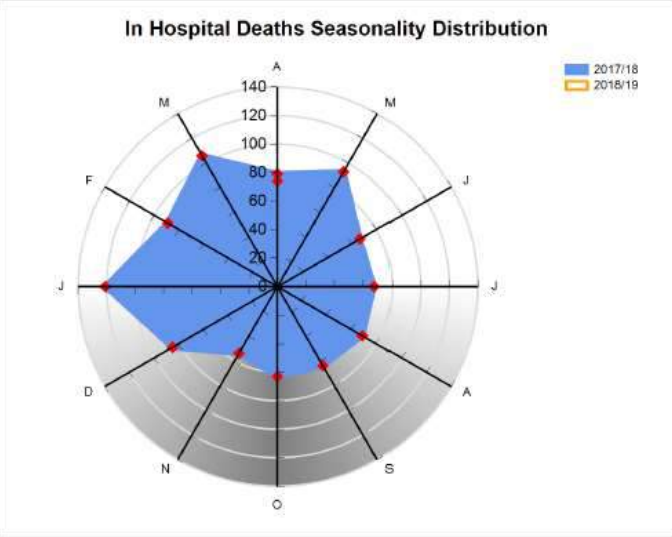
SHMI Breakdown

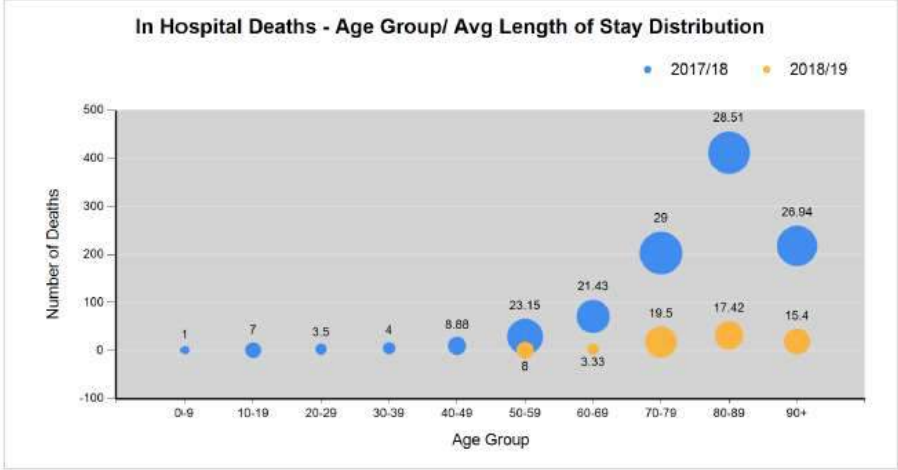
Southport & Ormskirk Hospital NHS



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 2017/18 compared to 2018/19. The relative size of the bubble represents the average length of stay of the spell.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4th July 2018

Agenda Item	**TB190/18**	**Report Title**	**Monthly Safer Staffing Report**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Carol Fowler Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓To Note ☐ To Receive	

Key Messages and Recommendations

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

This report presents the safer staffing position for the month May 2018. 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 May 2018 against the accepted national level of 90%:

- **Trust overall % fill rate 87.12%**
- 82.58% Registered Nurses (RN) on days
- 82.92% Registered Nurses on nights
- 95.62% Care staff on days
- 93.66% Care staff on nights

- **Trust vacancy:**
- 11.46% (100.58wte) Registered Nurse vacancies at band 5 and above
- 10.31% (38.72wte) Healthcare assistant vacancies band 2 and above.

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

	Funded WTE	Contracted WTE
Registered	865.53	766.96
Non-registered	377.8	338.84
Total	1243.33	1105.8

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, 1862, 1132, 278
Other List (Rationale) _____
☐ Service Change
☐ Statutory requirement

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

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

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

To note this report

Previously Presented at:

☐ Audit Committee ☐ Charitable Funds	☐ Quality & Safety Committee

☐ Finance Performance & Investment Committee	☐ Remuneration & Nominations Committee ☐ Workforce Committee

1. Aim of the Report

To inform and provide monitoring to the board of the latest position in relation to nursing and midwifery staffing developing future reporting in line with the full expectations of NHS England National Quality Board (NQB) and Care Quality Commission.

2. Background

The NQB 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 May 2018.

3. Overall Fill Rates

The May 2018 submission indicates a trust fill rate for registered nurses on days 82.58 %, non –registered nurses days 95.62%. Fill rate of registered nurses nights 82.92% and 93.66% for Non-registered nurse's nights.

The Clinical Business Unit (CBU) and corporate nursing and midwifery leads have in place daily safe staffing huddles to monitor, manage and ensure that the workforce is safe. The daily morning safe staffing huddle acts as a confirm and challenge session focusing on ensuring safe staffing levels whilst highlighting roster efficiency. Actions are captured to inform medium and long term plans in the delivery of efficient utilisation of trust staffing tools and ultimately inform future workforce planning.

4. Improvement in clinical nursing and midwifery productivity

The nursing and midwifery leads are working with NHS Improvement (NHSI), the trust informatics and healthroster leads and have begun to strip back and review current dashboard reporting to enable real time and accurate data to be available to assist in supporting safe staffing levels.

Challenges have been identified in relation to eRostering processes and governance, inclusive of the principles and best practice around rostering. Training dates facilitated by NHSI planned during July 2018 will identify the principles of safe staffing, what we are good at now, risks and next steps.

Establishment setting is being revisited supported by the Bi-annual staffing reviews recently completed. Confirm and challenge sessions lead by CBU heads of nursing are planned within June 2018.

Care Hours Per Patient Day (CHPPD) is reported externally. As data analysis and reporting is developed the nursing and informatics leads will review CHPPD reporting internally to support planned against actual CHPPD each month.

5. Recruitment and Retention

The recruitment and retention of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge. Trust workforce data shows there were 11.46% Registered nurse Vacancies (100.58WTE) and 10.31% non-registered nurse vacancies (38.72WTE) at the end of May 2018 across the Clinical Business Units.

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 28th June 2018 to coincide with Armed Forces week.

The trust is out to advert for non – registered care staff to support filling the current vacancy by 1st September 2018. The NHSP care support worker development program will continue to support the attrition rate across the year.

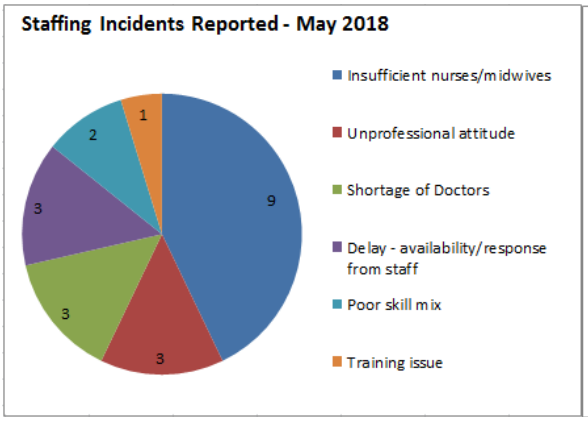
The trust is out to advert for registered nurses to support the current vacancy position with particular emphasis on recruiting to night contracts following feedback from ward leaders and previous interest expressed through potential candidates.

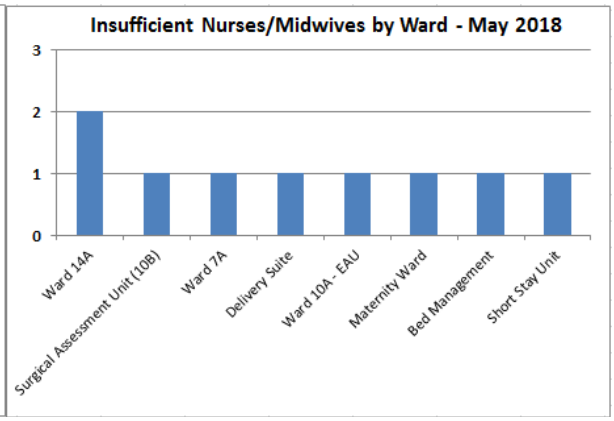
A recruitment campaign with presence at the next RCN Jobs fair event in Dublin in October 2018 is confirmed with further opportunity in March 2019.

The trust has recruited to a further 6 nursing associate roles and remains engaged with the nursing program and opportunities

The Trust remains engaged with the North of England Nursing Workforce Group with agenda items covering The Health and Care Workforce Strategy for England to 2027 and Age profile/impact of nursing workforce in the North.

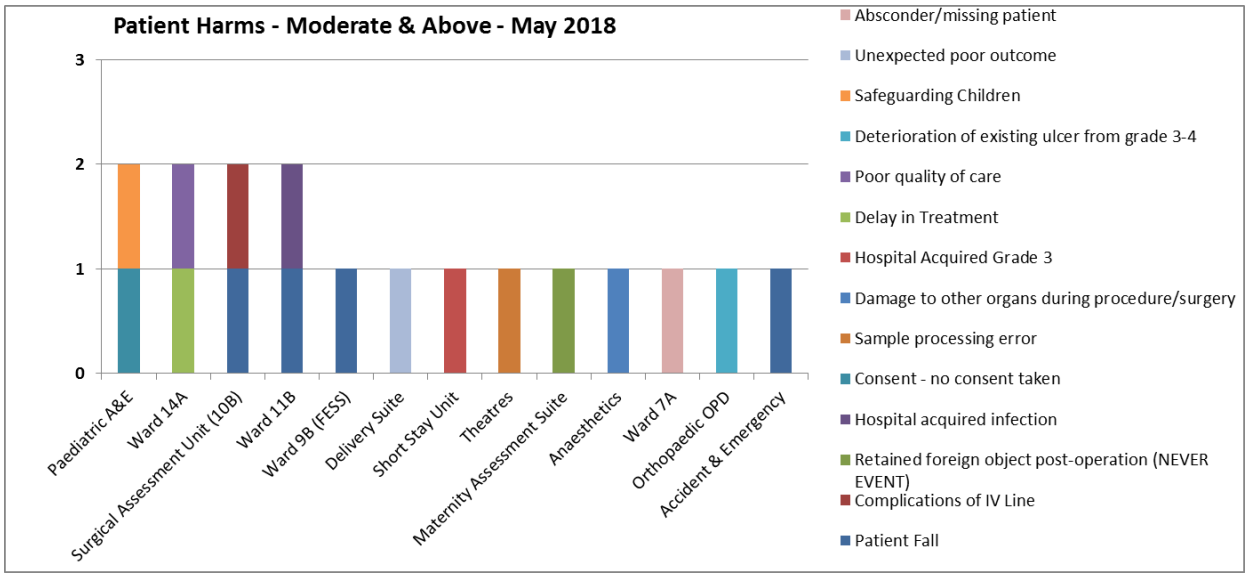
6. Staffing Related Reported Incidents





21 staffing incidents were reported in May, the same number as the previous month, of which nine reported insufficient nurses or midwives. Incidents highlight movements of both registered and non-registered nurses between wards to mitigate safe staffing issues. The incidents highlight failures to provide the adequate nurse levels for patients who require closer monitoring i.e. patients with dementia and clinically unwell patients. 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.

7. Inpatients experiencing moderate harm or above in May 2018



17 moderate harm or worse incidents reported in May 2018, 4 of which were patient falls. Two grade 3 pressure ulcers (including deterioration from grade 2 - 3) were reported.

There is a relationship between staffing related incidents and adverse patient harms however our current data isn't reliable enough for us to establish those links. We believe we have under reporting of incidents and under utilisation of the red flag system. Real time daily staffing tracking 'red flags' to identify potential staffing issues combined with a rigorous focus on eRostering is a targeting improvement plan over June/July 2018.

Summary

The report has presented information on staffing headcount fill rates on inpatient wards for the month of May 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 data being supportive to continued review of establishments required during the month of June 2018. Future reporting will advise on these outcomes.

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 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 25 June 2018
Lead:	Jim Birrell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- the delivery of cancer waiting time targets continues to be a challenge so the Committee has requested a report outlining the factors creating the problem and proposed remedial action
- there are ongoing issues with the VitalPAC system but renewed efforts are going in to avoid direct impacts on patient care; remaining issues will be resolved with upgrade to versions 3.5 and 3.6.
- the Trust's average length of stay remains an area of concern but investigations into both the causes of the problem and potential solutions are underway. An update will be provided to the July FP&I Committee

ADVISE

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

- work on the Trust's Strategic Direction is progressing and it is anticipated that there will be sufficient data available in the next two months for the organisation to prepare an outline longer term financial plan
- based upon recent under-performance, the Committee has requested an assessment of the potential implications for both quality and finance of consistently achieving safe staffing levels

ASSURE

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

- the unidentified 2018/19 CIP is approximately £2.5m but workshops are taking place with a view to bridging the gap
- emergency care performance has improved and an updated action plan incorporating seven high impact actions is being finalised

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
4 JULY 2018

Agenda Item	TB192/18	Report Title	Integrated Performance Report
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Executive Directors		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☑ To Note ☐ To Receive

Executive Summary

Part 1
The Integrated Performance Report (IPR)

- The report highlights the indicators that require discussion by Trust Board.
- A number of 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.

Part 2
4 Hour Standard Performance Report for May 2018 including update on the Patient Flow Improvement Board (PFIB).

- The 4 hour standard improved 2.98% against the previous month.
- The Trusts performance deteriorated towards the end of the month at Southport & Formby District General Hospital (SDGH). This was due to operational pressures experienced over the spring bank holiday weekend. The recovery following the period was slow and not stabilised by month-end. The performance deterioration can be attributed to two major factors (detailed in the paper).
- From April 2018, the Trust has an improved rate of performance and is now reporting performance similar to the national average.
- The seasonal changes have supported performance improvement as per historical trends however the rate of improvement is faster than neighbouring acute hospitals. Due to the improvements made within emergency flow, despite increased attendances of 578 patients in ED in May 2018 compared to January 2018 each patient's has spent on average 100 minutes less in the department.
- The report also confirms the next steps (phase) of the improvement work which is focused on reducing unnecessarily prolonged stays in hospital and reducing LoS.
- The interventions being prioritised for are primarily aimed at the Trust, but refers to how our system partners, social services, the voluntary/third sector, independent care providers and

unpaid carers can play a supporting role

The Board is asked to note:

- The Integrated Performance report and highlight any further assurance necessary in relation to areas of poor performance
- Progress on the 4 hour standard in May 2018
- Endorse and support next steps in the improvement work and provide challenge in order that the appropriate levels of accountability are in place to maintain focus
- Acknowledge the key risks that may impact on next steps and offer guidance on actions which may reduce likelihood

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)*	

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

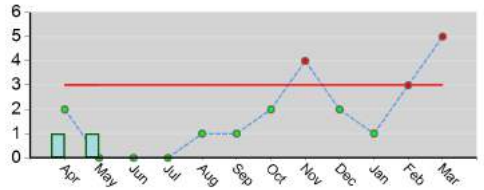
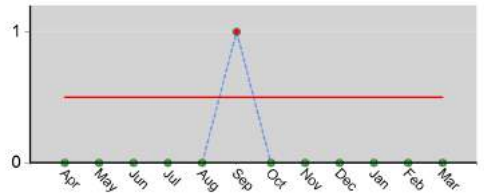
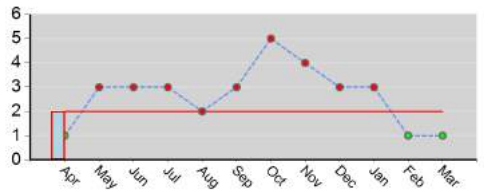
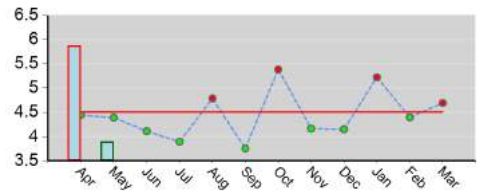
Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - May 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	May 2018 we had 1 hospital acquired (15A) and 2 community acquired Clostridium difficile infections. 1 community was taken via GP service and 1 was admitted via A&E.	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	There were no MRSA cases in May 2018. 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	There were no hospital acquired Escherichia coli for May 2018, 18 community acquired case were identified. There have been 2 hospital acquired cases in 18/19 thus far.	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 51 falls were reported through DATIX in May 18. 34 (67%) Urgent Care, 14 (27%) Planned Care. 3 (6%) occurred in other areas, 28 (56%) of falls were reported as no harm, 18 (36%) were reported as low harm. There were 3 falls reported at moderate level of harm. 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	

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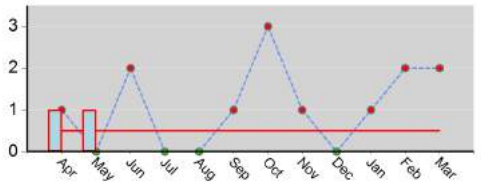
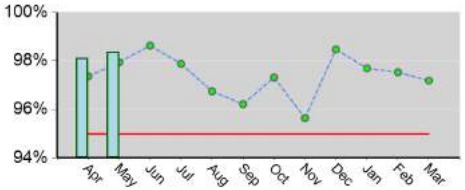
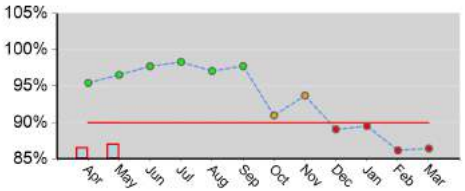
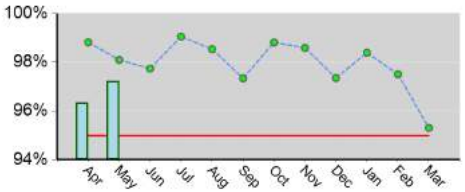
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Hospital Pressure Sores	Number of reported Trust acquired pressure sores graded between 3 and 4. Threshold: 0. Collaborative goal: Elimination of grade 3 and 4 pressure ulcers plus 25% reduction overall. Line = Last Financial Year Bar = This Financial Year	There was 1 grade 3 pressure ulcer reported in May. The Ulcer occurred on the Short Stay Unit and is due to go to an investigation panel on Thursday 28th June.	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 May. On the day of census (n= 372) the Trust reported 7 patient harms which were made up of I x DVT (11b), 3 x PE (9a &10a) and 3 new UTI's across wards 9a, 9b and Spinal HDU.	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 in month not achieved against National accepted level of 90% - Safe staffing maintained across clinical areas supported by temporary workforce incl bank & additional hours worked by substantive staff & Agency block booking. Staffing huddles mitigate risk areas daily & embedding of Health-Roster utilisation and reporting. Scrutiny into trust safe staffing reporting systems continues with site visits from NHSI to support this work expected during June 2018.	Quality & Safety Committee	
VTE (Venous thromboembolism)	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Compliance for VTE assessment remains above the threshold of 95%. The Trust proforma for assessment of VTE continues to be monitored using an audit approach which includes monthly point of prevalence surveys as part of the NHS Safety thermometer. It is also now part of the Southport and Ormskirk Clinical Accreditation Scheme in line with the CQC's Key Lines of Enquiry, of which non-compliance is reported as part of feedback which initiates an individualised area action.	Quality & Safety Committee	

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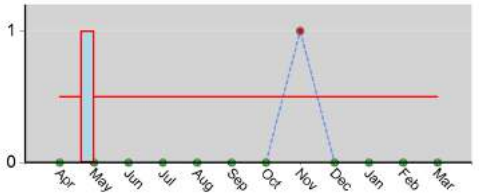
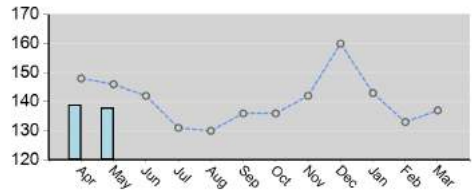
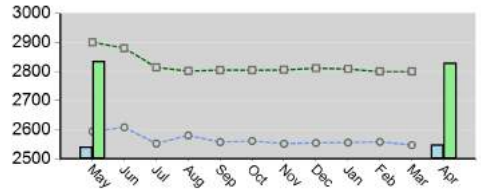
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death. Line = Last Financial Year Bar = This Financial Year	There was 1 Never Events reported for May. The CBU was Women & Children's and the incident relates to a retained foreign object post-delivery of a baby.	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 138 in May 2018 bucking the current trend.	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 10.0% (April 9.9%). There are 292 WTE vacancies in the Trust.	Finance, Performance & Investment Committee	

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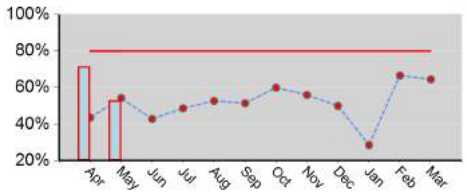
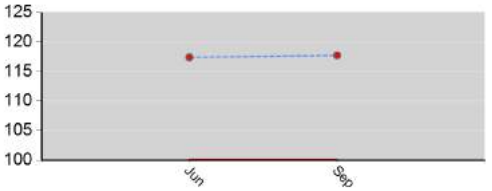
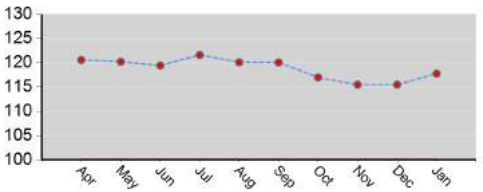
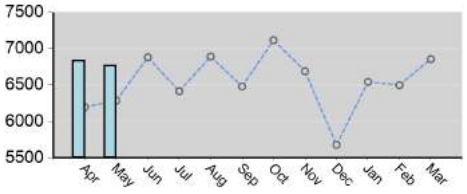
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Stroke 90% ward stay	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Previously reported performance may change as a result of validation. Line = Last Financial Year Bar = This Financial Year	Performance was recorded at 52.9% in May.	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 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 has commenced and will be concluded on 3rd July, the findings will be reported to the September Board. 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. An action plan for sustainable quality improvement activity with Advancing Quality Alliance (AQuA) and the North West Innovation Agency; has been created on the back of the Mortality Improvement Meeting of 31st 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	January 2018 = 136.8 which remains high and outside of expected limits and a significant increase on Dec17. The ratio could be improved if the depth of coding was increased to include patient comorbidities. The inclusion of comorbidities will increase the relative risk of dying, into the ratio calculation, which in turn will reduce the HSMR. An External Mortality Review into Pneumonia, Lower Respiratory Infections, Bronchitis and Stroke has commenced and will be concluded on 3rd July, the findings will be reported to the September Board. 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. An action plan for sustainable quality improvement activity with Advancing Quality Alliance (AQuA) and the North West Innovation Agency; has been created on the back of the Mortality Improvement Meeting of 31st 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 dipped slightly in May 2018 with a reduction of 69 from April 2018. Number of referrals 6,777.	Finance, Performance & Investment Committee	

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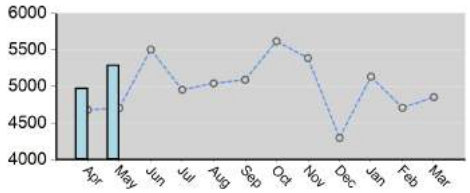
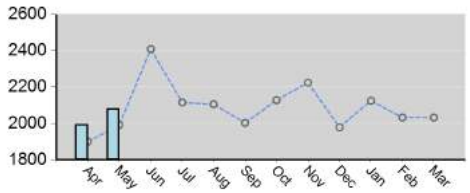
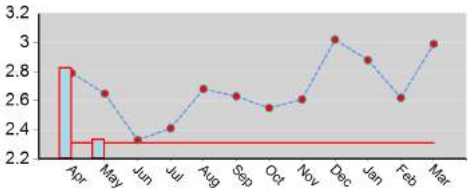
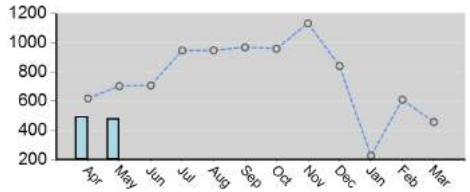
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
First Appointments	The number of patients seen in a first appointment including where the patient is seen in an outpatient clinic and has a procedure undertaken. Line = Last Financial Year Bar = This Financial Year	The Trust has seen an increase of 315 first appointments in May 2018 at 4,983.	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 May 2018 has increased by 88 after March 2018's reduction on previous months.	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 May continues to reduce. 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 continue to be monitored and reviewed. The Acute continues with its commitment to commission 12 additional beds within private sector as 28day step down beds. Daily board rounds and weekly LOS meetings continue. funding in place for Integrated discharge team, interviews to take place in June. new discharge lounge to be opened in June to support morning discharges.	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 although there has been a slight decrease in May. 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. current acute DPT remain in seconded posts to support board rounds and identify delays. interviews set for June for new IDT .	Finance, Performance & Investment Committee	

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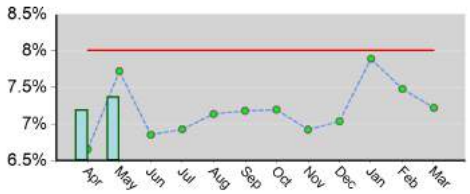
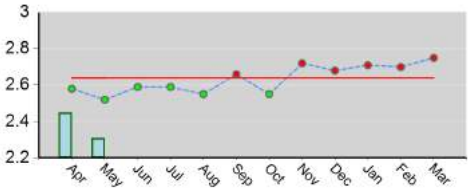
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better. Line = Last Financial Year Bar = This Financial Year	The DNA rate remains within threshold at 7.4%.	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 : follow-up ratio for the Trust is 2.31 and is within threshold.	Finance, Performance & Investment Committee	

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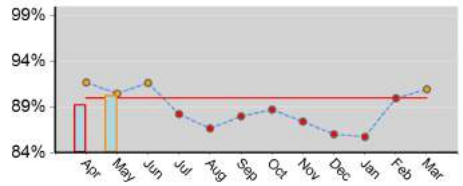
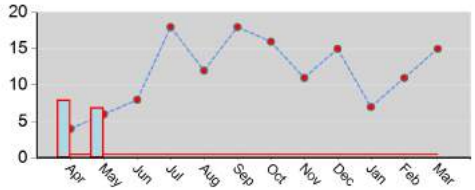
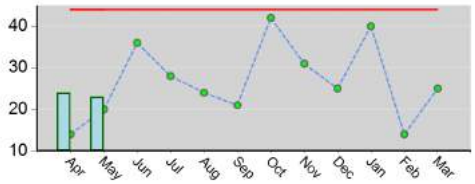
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Friends and Family Test	Friends and Family Test. The proportion of patients that would recommend the Trust to their friends and family. Threshold: 94%, Fail: 90%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The percentage of patients that would recommend the Trust to Friends & Family improved to 90.3% in May from 89.3% in April. This is against a Trust response rate of 7.6% which is 1.5% higher than April. For May CBU recommending percentages are Specialist 90%, Planned care 95.7% and Urgent Care 80.2%.	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 May there were 7 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 23 for the month of May, 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	

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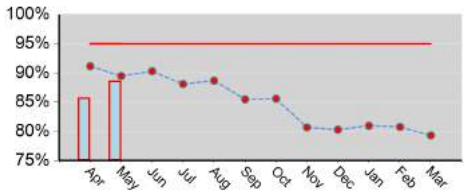
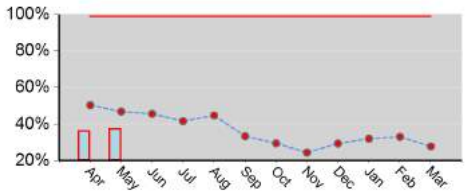
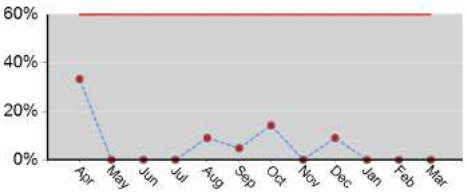
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher. Line = Last Financial Year, Bar = This Financial Year.	Performance was recorded at 88.7% in May. There was a 5.1% increase in attendances in May compared to May 17 (an extra 230 patients compared to last year). The previous year had seen an increase of over 300 patients compared to the previous year so there has been a growth of over 500 patients in 2 years for the month of May. May saw an increase in patients streamed to minors pathways. ED held an enhanced care week with all SPAs and admin sessions for 1 week cancelled to increase consultant support in the department. On a number of occasions across May, 40% of attendances were minors. ED continues to work with EY partners addressing improvements at the front door whilst work continues to inpatient flow.	Quality & Safety Committee	
Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes. Line = Last Financial Year Bar = This Financial Year	Ambulance handovers within 15 minutes remains a significant challenge with the current ED estate. A number of meetings have been held across North Mersey to review challenges in ambulance handovers. Clinical teams from neighbouring acute trusts have recognised the difference in demographics of the Southport population and the challenges this presents with very few fitting 'fit to sit' initiatives. The planned estate work due for completion Sept 2018 will see 4 dedicated cubicles for ambulance patients, and triage and reception moved to the front door of the department. The much needed additional clinical assessment space will aid more timely ambulance handovers. In the interim, an improvement programme around triage is due to commence later this month with the ED nursing team to ensure consistency and drive improvements.	Quality & Safety Committee	
TIA (Transient ischaemic attack)	Proportion of patients diagnosed with a TIA Treated within 24 hours. Threshold 60%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Performance was recorded at 0% in May.	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	Performance was recorded at 92.98%, just below the 93% target. We have experienced some teething problems with the new ERS paperless referral system, this is expected to be resolved by next month.	Finance, Performance & Investment Committee	

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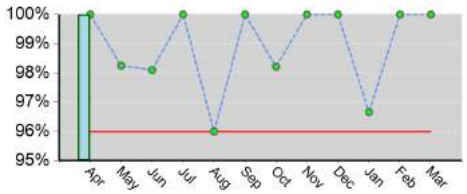
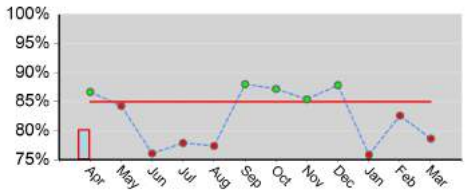
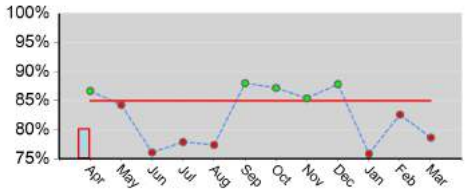
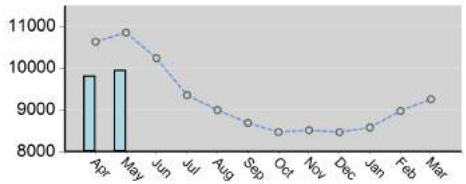
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Target 96%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Compliance was recorded at 100% in April for the 3rd month running.	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	Performance was recorded at 80.3% in April, below the 85% target. Issues remain around reporting times for radiology and capacity for appointments in endoscopy.	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 April there were 3 full breaches - 1 in lower GI, 1 Haematology and 1 upper GI. There were 9 half breaches; 1 gynaecology, 2 head & neck, 2 lung, 3 upper GI and 1 urology.	Finance, Performance & Investment Committee	
Waiting list size	The number of RTT patients currently waiting. Line = Last Financial Year Bar = This Financial Year	The RTT waiting list size has increased by 146 to 9964. This continues the month on month trend since October 2017.	Finance, Performance & Investment Committee	

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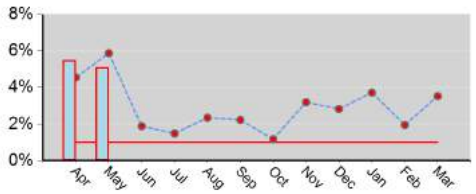
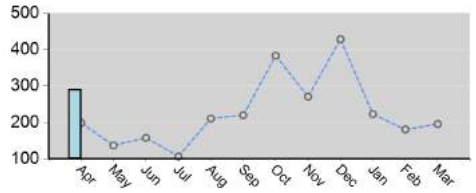
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower. Line = Last Financial Year Bar = This Financial Year	Performance was recorded at 5.1% in May. Colonoscopy continues to be an issue. Reduced nurse Staffing levels have contributed to a loss of capacity. WLI sessions are happening on Saturdays. An action plan is underway to facilitate the opening of an additional room. Workforce to be identified to enable 4 rooms to be functional. Update next month. Radiology - Overall issue with lost capacity due to Bank Holidays, plans in place to get back on track. 2 loum radiologists appointed in May to assist with backlog and demand. Cystoscopy , capacity for both OPD and Inpatient waiting lists will be reviewed and update next month. Urodynamics - lists cancelled due to a broken machine, machine now working. Lists were scheduled for Southport whilst the machine was being repaired.	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 met the 92% threshold at 94.3%. Patients continue to be booked in chronological order. This does not reflect sub-specialties eg, General Surgery 88.4% and Trauma & Orthopaedics 84.2%.	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 April there were 292 delayed bed days due to delayed transfers of care. 246 bed days were due to patient/family choice, 14 due to awaiting completion of assessment, 9 due to awaiting a place within a Nursing Home, 7 due to awaiting further nonacute NHS care and 16 due to awaiting community equipment/adaptations.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - May 2018

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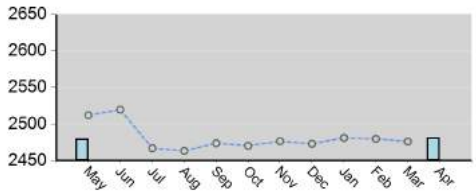
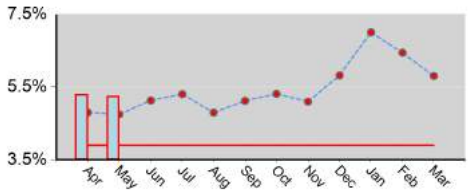
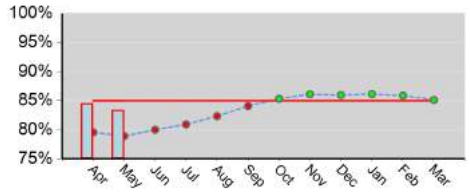
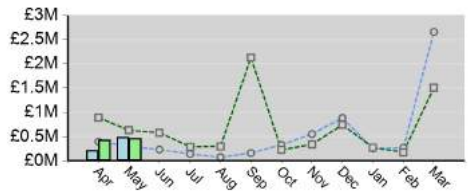
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
WTE (Whole time equivalents) in post	The number of WTE staff with substantive and fixed-term contracts employed directly by the Trust. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.	The number of WTE staff with substantive and fixed-term contracts has decreased slightly in month to 2480.	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 5 month trajectory in reducing sickness absence, however the levels are still high and the Trust is not near attaining its target of 4%. A new Sickness Absence Administration team	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	The Trust has seen a downward trend for mandatory training compliance for the second month running. To mitigate this, the roll out of the My ESR project (Manager/Employee Self Service) has been fully implemented. The move to e-Payslips is expected to expedite the full transition to MyESR with a proposed final date for paper payslips in August 2018, following which MyESR training will become business as usual. eLearning has fully replaced Trust based e-Readers ensuring that staff have their learning assessed providing improved assurance of their competence in those subjects. The You Choose mandatory training days continue providing the face to face subject offering. In May 2 x classes were cancelled: conflict resolution due to an insufficient No of delegates and moving and handling due to no suitable training room provision. In May 2018, 92 x delegates DNA'd at mandatory training, the latest DNA report has been shared with line managers across the Trust following the reinstatement of the monthly mandatory training reports. A Clinical Competence Working Group will be established to deliver on the CQC must/should do actions in relation to mandatory clinical competence (July 2018).	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	Cumulatively the Trust has spent £714k against a budget of £901k. Expenditure has increased in May with the main driver being replacement radiology equipment (£280k). Spend is well controlled and monitored on a monthly basis with regular Capital Investment Group meetings.	Finance, Performance & Investment Committee	

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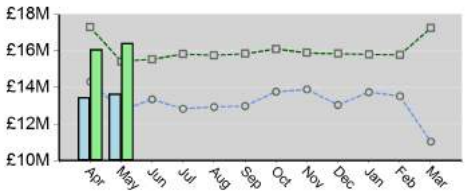
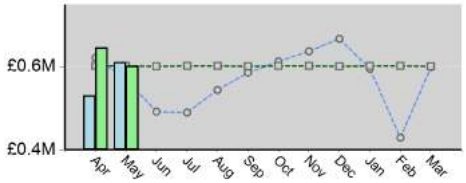
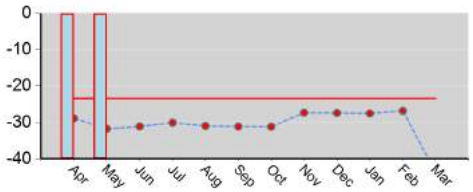
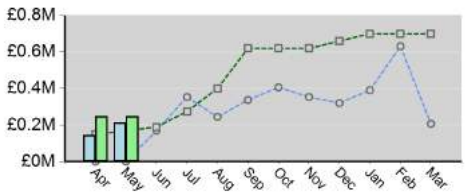
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Income & Expenditure	This indicator looks at the relationship between Trust income and Trust expenditure at monthly intervals. Green = Expenditure, Blue = Income Line = Last Financial Year, Bar = This Financial Year	The Trust achieved the planned deficit in month 2 of £2.8M. Income and pay favourable variances mitigated the in month overspend on 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 May within the NHSI plan is £602k. The actual spend in May is £611k. NHSI have set an agency cap of £5.6M for the full year and the Trust awaits formal communication regarding the proposed reduction to the cap by a further £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. Recruitment to vacancies substantively and improved bank fill rates using the TempRE system are the key actions required to achieve this target.	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 low which is reflective of the work required to deliver some of the schemes from month four onwards. The plan was to deliver £250k in month 2; the actual CIP delivered was £215k (YTD plan £500k, actual £360k). Business Units have been given a stretch target of £8.4M to identify in 2018/19 due to the underperformance identified to date and the current risk status of some of the significant schemes.	Finance, Performance & Investment Committee	

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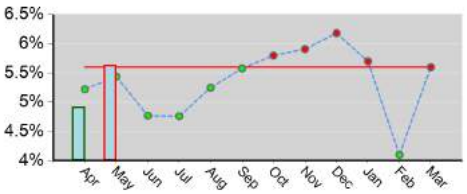
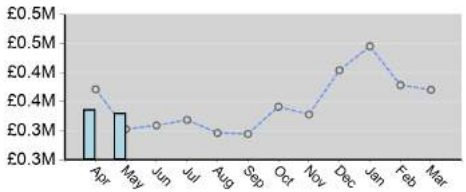
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system. Line = Last Financial Year Bar = This Financial Year	The proportion of the workforce spend made up of Agency workers increased above threshold to 5.64% in May from 4.92% in April 18. 3.26% was accounted for Doctors,1.67% Nurses, 0.52% Admin staff,0.13% AHP's and 0.05% Other.	Finance, Performance & Investment Committee	
Cost of staff sickness	In month based on staff sickness records. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.	The cost of staff sickness in-month in May 2018 was £330k a slight reduction from April.	Finance, Performance & Investment Committee	

PART 2

4 Hour Standard Performance Report for May 2018, including update on the Patient Flow Improvement Board (PFIB).

1. Executive Summary

The report confirms the key factors associated in the Trusts ability to deliver the constitutional 4 hour standard for May 2018. The 4 hour standard improved 2.98% against the previous month (table 1 and 2).

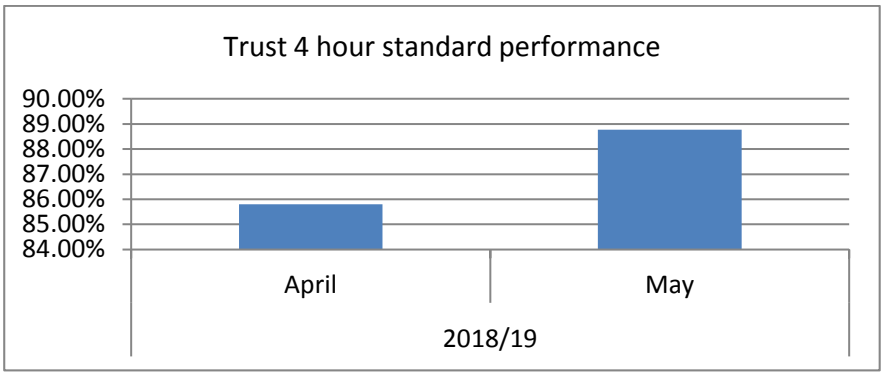


Table 1 – Trust 4 hour performance (April and May 2018)

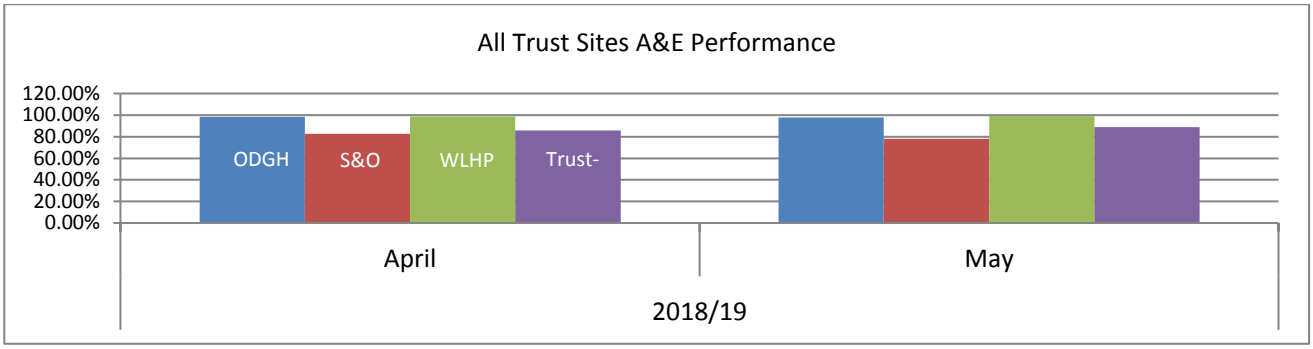


Table 2 – Trust 4 hour performance by site

The performance reported for May was the first time in 2018 that a reporting month outperformed the previous year (table 3).

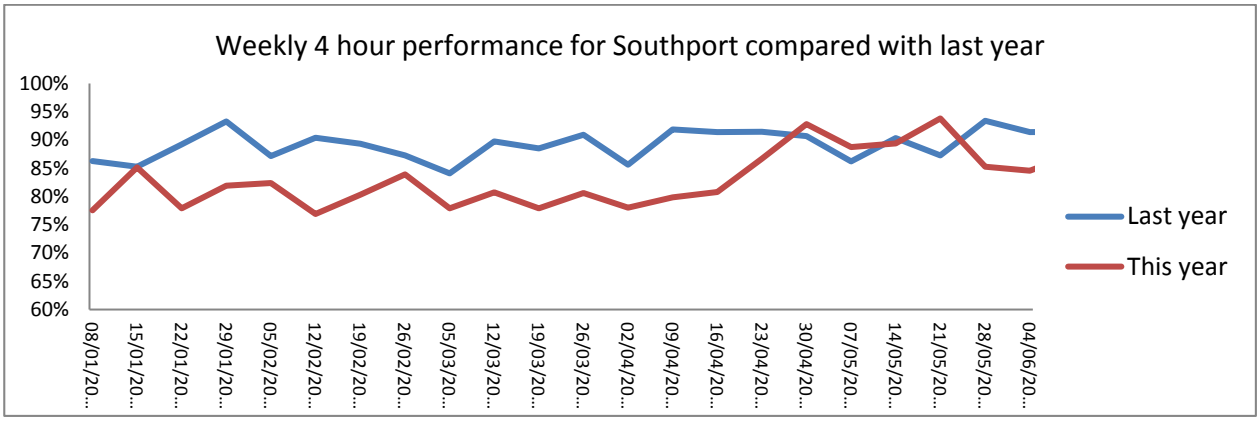


Table 3 – weekly 4 hour performance for 2018 compared with last year

2. May 2018 Performance Overview

The Trusts performance deteriorated towards the end of the month at SDGH. This was due to operational pressures experienced over the spring bank holiday weekend. The recovery following the period was slow and was not stabilised by month-end. The performance deterioration can be attributed to two major factors.

Factor one - ED process delay

The ED internal process delays are due to capacity not being robust enough to meet expected demand. The Trust experienced operational pressures in providing sufficient medical seeing power to provide consistent and reliable capacity to meet expected demand. The Trust is over-reliant in the utilisation of temporary clinical staff (i.e. locum / agency) to support fill rate (due to vacancies) of rotas across a number of senior decision making grades. The inability to cover shifts with temporary staff has led to a reduction in performance against **time to treatment % metric**. The reduction in performance in the time to treatment % metric has a direct relationship with the 4 hour performance (table 4).

The Trust has approved a renewed ED workforce plan which offers a sustainable solution. It is envisaged improvements will be made from August onwards and fully implemented by January 2019 through a phased (and progressive) approach. This is subject to a successful recruitment process.

Factor two – high occupancy levels at SDGH

The Trust continues to experience challenges in high occupancy levels at SDGH which is mainly down to the historical poor performance in the **stranded patient metrics**. The Trust has delivered an overall improvement (i.e. reduction) in the number of stranded patients occupying an inpatient bed in May 2018 however further improvements are required. The current high numbers in stranded patients at the Trust is the main reason behind the continued pressures in the congested ED. The Trust has previously been too full to treat 95% of A&E patients within four hours.

Reducing bed occupancy to improve flow through the system greatly improves the working and care environment, reduces A&E crowding and enables patients to be treated in the right bed by clinical teams with the right skills. The stranded patient metric is a critical metric to improve bed occupancy and reduce length of stay (LoS).

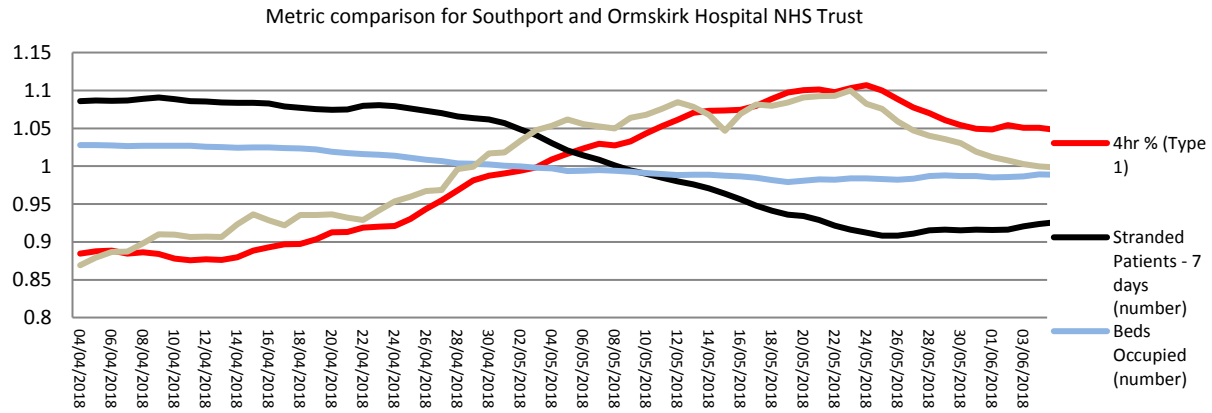


Table 4 – metric comparison against 4 hour performance

3. May 2018 Progress – six month reflection

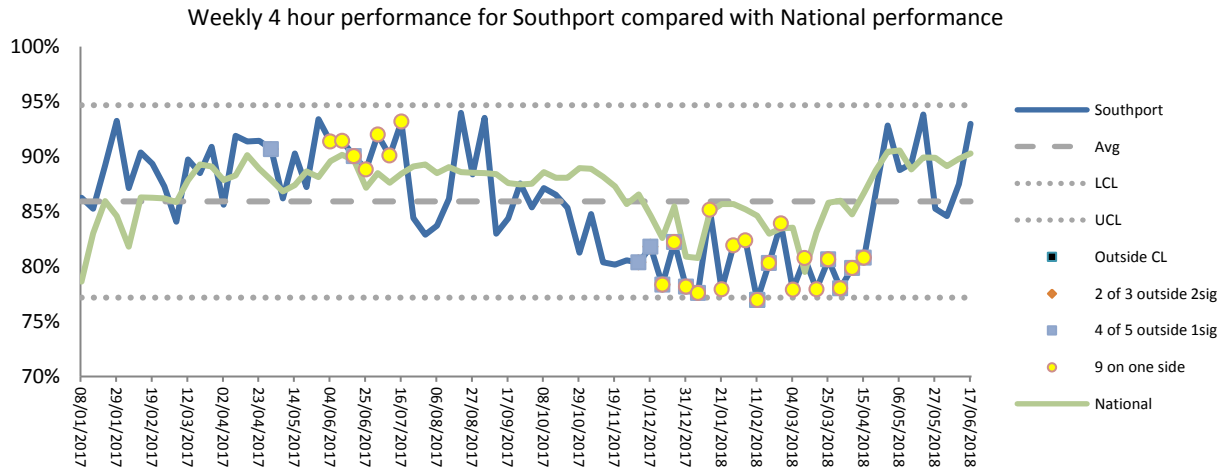


Table 5 – 4 hour performance compared with National performance

From April 2018 the Trust has an improved rate of performance and is now reporting performance similar to the national average (table 5). The seasonal changes have supported performance improvement as per historical trends however the rate of improvement is faster than neighbouring acute hospital Trusts.

Due to the improvements made within emergency flow, despite increased attendances of 578 patients in ED in May'18 compared to Jan'18, each patient has spent on average **100 mins less** in the department. As highlighted within table 6 below, the performance has improved significantly against all key metrics. Appendix one provides the detail outlining the set of interventions delivered within each PFIB workstream to improve patient flow.

KPIs	Trust Performance	SDGH performance	Non Admitted Performance	Admitted Performance	Time to Triage	Patients seen within 60 Mins	Average time to DTA	Patient Corridor Time	12 Hr Breaches	ACU Activity	Direct Admission to Base Ward	Discharges before 12 PM	Discharges
Jan'18	80.90%	53.90%	71.77%	21.32%	6.95%	43.67%	264	247.05	63	491	36%	144	1326
May'18	88.80%	74.80%	88.64%	60.04%	70.66%	42.75%	209	73.11	0	536	29.58%	261	1875
Improvement	7.90%	20.90%	16.87%	38.72%	63.71%	-0.91%	-21%	-70%	-100%	9%	-6.04%	81%	41%

Table 6 – patient flow metrics monitored at PFIB since January 18

4. Next steps (post June) – Reducing LoS and 'winter ready'

Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare-associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning). The benefits of reducing the time a patient occupies a hospital bed are clear, but achieving it has proven difficult, particularly during winter.

The Trust must prioritise resource to implement evidence based approaches proven to reduce LoS (see Figure 1). NHS Improvement has recently mandated (June 2018) acute hospital trusts (and system partners) to reduce the number of stranded patients occupying an inpatient bed by 25% – 30% across quarter 2 to support winter preparedness.

The interventions required for improvement in this area are primarily aimed at the Trust, but refers to how our system partners, social services, the voluntary/third sector, independent care providers and unpaid carers can play a supporting role. These tactics must of course be carefully considered and implemented with an eye to local circumstances. One size does not fit all. The Trust must adopt an effective improvement approaches and in particular plan, do, study, act (PDSA) cycles to ensure that new approaches are implemented in a way that works locally and can be sustained.

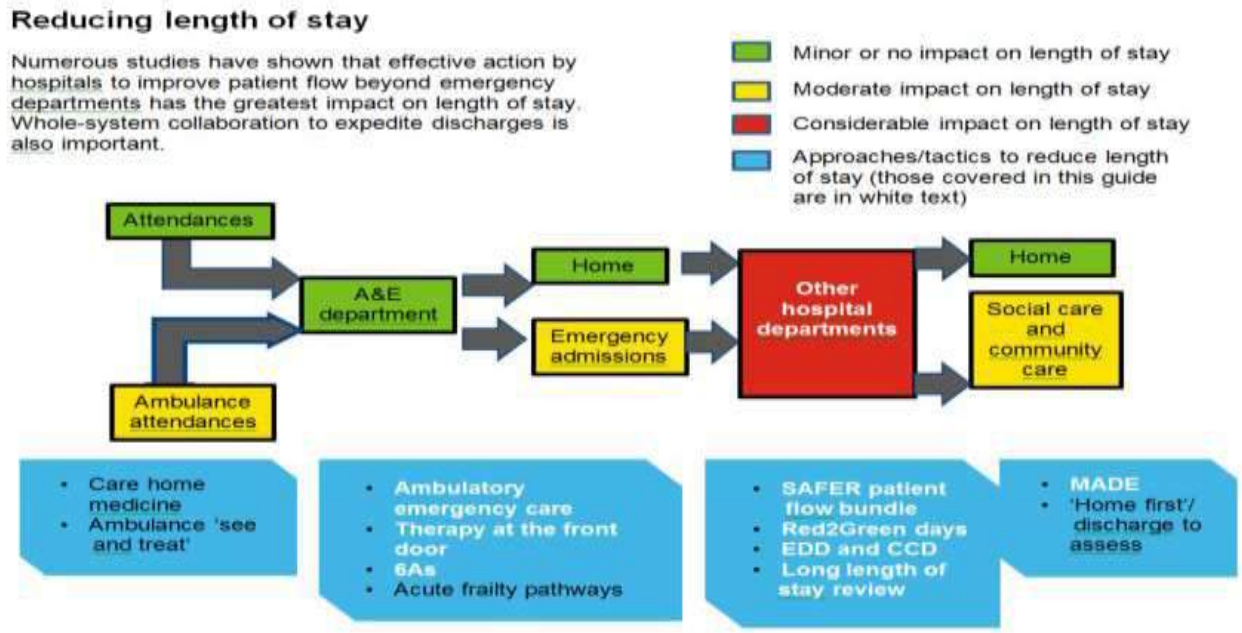


Figure 1 – NHS Improvement national guidance to reducing long hospital stays (June 2018)

The Trust is underway in assessing the key priority actions that will support reducing LoS and improve bed occupancy. The Trust has scheduled workshops to co-design the next phase of the improvement effort with clinicians and managers at the Trust (and partners). The key priority actions will inform the winter plan which will be available for review in August 2018.

Proposed High Impact Actions to reduce LoS and support 'winter ready'

1. Improve ODGH utilization to help address high occupancy rates at SDGH
2. Systematic implementation of the SAFER patient flow bundle and Red2Green days
3. Introduce regular 'system-wide senior leadership' Multi Agency Discharge Events (MADE)
4. Embed the Trust discharge team function
5. Enhance therapy / frailty services at the front door
6. Right size and maximise assessment unit functions (i.e. Ambulatory Emergency Care and Surgical Assessment Unit)
7. Support ED to develop resilient capacity (e.g. rotas) and capacity (department reconfiguration) adopting best practice approaches

The delivery and implementation of the high actions will aim to achieve a 30% reduction in the stranded patient metric. The intended outcome is to reduce LoS, improve bed occupancy rates and enhance patient flow resulting in the overall achievement of the Trust's 4 hour performance trajectory.

Risk Reporting

The following high-risks have been identified by PFIB members and, if not addressed, will impact negatively on delivery and sustainability of the improvement programme. A number of actions have been completed to mitigate high-risk factors however due to difficulty and / or complexity remains.

Risk 1: Due to a lack of improvement resource and methodology the sustainability of the improvements delivered and future interventions are at risk.

Risk 2: On-going gaps in ED medical staffing has led to increased time to first seen in ED and deterioration in 4 hour performance.

Risk 3: On-going gaps in nurse staffing at ward level is delaying internal actions required to deliver timely and effective discharge.

Risk 4: Lack of accurate reporting for MOFD and DToC cohort. The Trust has no process to capture at any point in time the reason for delays and waits (internal and external).

5. Conclusion

The Board is asked to note:

- Progress on the 4 hour standard in May 2018
- Appendix 1 confirming the set of interventions delivered within each key PFIB workstream to improve emergency patient flow.
- Endorse and support next steps and provide challenge in order the appropriate levels of accountability are in place to maintain focus
- Acknowledge the key risks that may impact on next steps and offer guidance on actions which may reduce likelihood

Steve Christian

Acting Chief Operating Officer

June 2018

Appendix 1 - - Interventions delivered in PFIB workstreams (January – May 2018)

Workstream	High impact changes	Interventions
ED Workstream	Improve non admitted performance	**Opening Clinical Decision Unit** • New area opened on 30/04/2018 • Area for patients who are likely to go home to wait for test results
	Improve ED grip and control	**Development of nurse coordinator competency framework and two-hourly ED huddles** • Training package for nurse coordinators in ED to develop leadership capacity of managing flow through ED with intense focus on no corridor waits • Fixed agenda huddles in ED to provide 'command and control' of departmental status, including action plan at patient level
	Substantive workforce planning	**Demand and capacity analysis of medical rotas** • Deep-dive analysis into current medical workforce staffing levels and gaps to be bridged to deliver 4-hour standard
	Locum staffing improvement	**Delegated authority of locum staffing to ED** • Recognition that requiring senior executive sign-off for filling of locum shifts at escalated rates led to staffing levels and quality, unable to deliver 4-hour standard • This prompted the need for a new mechanism to be put in place to allow earlier filling of unallocated shifts
Assessment and Ambulatory Care Workstream	Improving utilisation of ACU	**Case note audit of high volume underutilised pathway** • Manual case note audit revealed ~5 chest pain patients managed through ED when could be ambulated per day
		Writing of ACU SOP • SOP formalising agreed roles and responsibilities and patient cohort to be accepted on ACU to tackle perceived inconsistencies
	Acute Medical workforce planning	**Interim Acute Medical workforce paper drafted** • Recognition of impact of Acute Medicine on A&E Performance and potential to improve with greater capacity

Workstream	High impact changes	Interventions
Patient Flow Workstream	Creation of a single Patient Flow & Escalation Policy	• Draft of Patient Flow & Escalation Policy, to be signed off by PFIB (28/06) and ready for Trust Policy approval process • Creation of automatic Trust Trigger tool to determine escalation level • Refresh of role based action cards aligned to escalation levels to facilitate consistent decision making
	Creation of a ED Trigger & Escalation Policy	• Draft of ED Trigger & Escalation Policy, signed off by PFIB (28/06) and ready for Trust Policy approval process • Creation of automated live ED Trigger tool • Introduction of trigger based actions cards aligned
	Improved pre-12pm & total discharges	• Profiling of daily admissions required by ward level • IDT role and update of MOFD patient list • Facilitation of MADE events • Identification and process for golden patients
	Best practice bed management	• Updated bed meet agenda, roles and responsibilities • Focusing on delivery of admitted pathways via assessment • Bed manager competency framework developed • Updated information recording and communication from bed meetings
	Discharge Lounge	• Identification, process mapping and use of interim discharge lounge
	Dovehaven escalation capacity	• Set-up, SoP and process for identification and transfer of patients to Dove haven escalation capacity

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

4 July 2018

Agenda Item	**TB 193/18**	**Report Title**	**Director of Finance Report - May 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

The Trust has planned for a year end deficit of £28.8m.

The control total of £6.9m deficit (including Provider Transformation Funding (PSF) of £6.781m) could not be achieved and, therefore, the Trust will not receive PSF.

For the first two months the Trust's financial performance to the end of May is a deficit of £5.407m against a deficit plan of £5.679m which is £273k better than plan.

Income is currently performing to plan.

Total expenditure is within plan at month 2 YTD although some investments made in 2018/19 have not yet been appointed to substantively (eg Programme Management Office, CBU restructure).

Total agency spend rose in month 2 (£610k) and the current rate of expenditure would mean the NHS-I cap of £5.6M will be breached.

Capital expenditure is within the plan and is effectively managed through the Trust's Capital Investment Group (CIG).

The Trust continues to require cash support as it is trading with a deficit each month and continues to provide a rolling 13 week cash forecast to NHS-I.

There are a number of risks in delivering the year end deficit of £28.8M

Following Expert Determination the Trust must agree new local tariffs for ACU.

There is a risk that commissioners will apply sanctions as the Trust cannot sign up to its control total. The value of the sanctions that could be applied after two months is £476k, mainly for A&E performance and ambulance handovers.

The Trust Board are advised that on current run rate and CIP delivery the Trust deficit for the year would be in excess of £30m.

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

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 2 (the financial period ending 31st May 2018).

2. Executive Summary

2.1. The Trust has planned for a year end deficit of £28.8m.

2.2. The control total of £6.9m deficit (including Provider Transformation Funding (PSF) of £6.781m) could not be achieved and, therefore, the Trust will not receive PSF.

2.3. For the first two months the Trust's financial performance to the end of May is a deficit of £5.407m against a deficit plan of £5.679m which is £273k better than plan.

2.4. Income is currently performing to plan.

2.5. A&E activity is up by 4.25%; resulting in a financial impact of £60k

2.6. Elective activity is down by 12.3%; resulting in a financial impact of -£243k

2.7. Non elective activity is up by 7.8%; resulting in a financial impact of £593k.

2.8. The YTD non elective favourable variance has been reduced by to £300k take account of the results of the Expert Determination decision on Ambulatory Care Unit (ACU) activity; discussions with CCG's imminent to agree a local price.

2.9. A further reduction (£132k) has been applied in relation to activity in the recently opened Clinical Decisions Unit (CDU).

2.10. Outpatient activity is down by 7%; resulting in a financial impact of -£124k.

2.11. Other activity accounts for the remaining £116k above plan.

2.12. Total expenditure is within plan at month 2 YTD although some investments made in 2018/19 have not yet been appointed to substantively (eg Programme Management Office, CBU restructure).

2.13. Total agency spend rose in month 2 (£610k) and the current rate of expenditure would mean the NHS-I cap of £5.6M will be breached.

2.14. The table below is the I&E statement for May:

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	148,848	24,778	24,748	(30)	12,420	12,426	6
PP, Overseas & RTA	1,378	230	310	81	115	99	(16)
Other Income	11,914	2,008	2,061	53	1,019	1,128	109
Total Income	**162,140**	**27,016**	**27,119**	**104**	**13,554**	**13,653**	**99**
Operating Expenditure							
Pay	(126,869)	(22,001)	(21,624)	377	(11,028)	(10,831)	197
Non-Pay	(52,903)	(8,834)	(8,994)	(160)	(4,397)	(4,630)	(233)
Total Expenditure	**(179,772)**	**(30,835)**	**(30,618)**	**217**	**(15,425)**	**(15,461)**	**(36)**
EBITDA	**(17,633)**	**(3,819)**	**(3,499)**	**321**	**(1,871)**	**(1,808)**	**63**
Non-Operating Expenditure	(11,217)	(1,870)	(1,876)	(6)	(935)	(935)	(1)
Retained Surplus/(Deficit)	**(28,850)**	**(5,689)**	**(5,375)**	**315**	**(2,806)**	**(2,743)**	**62**
Technical Adjustments	63	10	(32)	(42)	6	(40)	(46)
Break Even Surplus/(Deficit)	**(28,787)**	**(5,679)**	**(5,407)**	**273**	**(2,800)**	**(2,783)**	**16**

2.15. Capital expenditure is within the plan and is effectively managed through the Trust's Capital Investment Group (CIG).

2.16. The Trust continues to require cash support as it is trading with a deficit each month and continues to provide a rolling 13 week cash forecast to NHS-I.

2.17. There are a number of risks in delivering the year end deficit of £28.8M

2.17..1. Following Expert Determination the Trust must agree new local tariffs for ACU.

2.17..2. There is a risk that commissioners will apply sanctions as the Trust cannot sign up to its control total.

2.17..3. The value of the sanctions that could be applied after two months is £479k, mainly for A&E performance and ambulance handovers.

2.18. On current run rate and CIP delivery the Trust deficit for the year would be in excess of £30m.

3. Income performance

3.1. The Trust has achieved the total income budget for May.

3.2. The issue regarding the tariffs for Ambulatory Care Unit (ACU) has still not been agreed. As such the income position currently reflects the decision reached by the Expert and is a "worst case scenario".

3.3. The Clinical Decision Unit (CDU) was opened at the end of April. This resulted in a rise in non elective activity and, as such, income was reduced until the pathway and tariffs have been agreed with commissioners.

3.4. The Trust may be subject to sanctions in 2018/19 for non compliance with performance standards. The income position does not include any reduction for sanctions. The likelihood of

sanctions being applied this year will be discussed with commissioners.

4. Expenditure

4.1. Total underlying expenditure levels for pay remain consistent compared to last year, with the increase being attributed to the provision for the pay award within pay reserves and some known non pay increases such as CNST premium and NHS contracts increasing from 1 April (eg Pathology)

4.2. Pay expenditure in May is consistent with previous month's performance. A 2% accrual of the pay budget (£400k) has been actioned against reserves rather than allocated across all pay lines. The 2018/19 pay award is due to be paid in July with arrears in August so a monthly accrual will continue to be made. Other known expenditure has also been accrued on a monthly as it is expected that the full reserve will be utilised within 2018/19. eg Clinical Excellence Awards

4.3. All pay budgets are underspent in month except for nursing with is overspent by £36k in month. This is partially a result of having to employ staff at premium rates secured through Thornberry.

4.4. Non pay budgets overspent in month. Some of the overspend has been mitigated by pay underspends relating to radiology services procured differently this financial year.

5. Agency spend

5.1. The Trust has spent £610k on agency staff in May (6.4% 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. NHS-I have not yet formally communicated the reduction to the Trust's agency cap (for the loss of community services) although this was expected to be in the region of £0.7M.

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

5.4. Executive Directors have been tasked with developing plans to replace/stop agency spend within senior manager/A&C.

5.5. NHS-I visit the Trust on 21 June 2018 to conduct a review of agency controls and offer their assistance.

5.6. Nurse agency spend is £181k in May which is the highest since July 2017. Despite this the nurse budget is close to balanced.

5.7. 65% of the monthly nurse agency spend is within A&E (£118k); with the remaining spend incurred in medical wards, ITU, spinal injuries and theatres. 71% of May's agency spend is within Urgent Care CBU.

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

5.9. Medical wards and A&E also have high bank usage; Planned Care (35%) and Urgent Care (52%) account for most of the nurse bank spend.

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

5.11. The cost of providing cover for nurse sickness in May was £96k (bank £77k; agency £19k) based on the information provided by NHSP.

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.

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

5.16. A revised escalation procedure is under discussion which plans to speed up decision making but also take into consideration the required executive authorisation before shifts are booked.

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

5.18. The cost of providing cover for medical sickness in May was £10k (£7k bank; £3k agency based on the information provided by TempRE.

6. Cost Improvement Plan (CIP)

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

6.2. This figure rises to £7.5M to take account of the balance to FYE of 2017/18 schemes. These schemes have already been delivered in 2017/18 but are included to be consistent with monthly reporting to NHS-I.

6.3. The performance to date is shown in the table below:

	Annual	YTD			In month		
	Plan	Plan	Actual	Var	Plan	Actual	Var
	£000	£000	£000	£000	£000	£000	£000
18/19 Plan	7,006	409	270	(139)	205	170	(35)
17/18 balance to FYE	535	90	90	0	45	45	0
Total	**7,541**	**499**	**360**	**(139)**	**250**	**215**	**(35)**

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-I usually in the second working week of the month and this forms the basis of any cash draw downs in the future month (May's cash flow was sent on 12th April).

7.3 Note that the borrowing profile has now been updated in the 2018/19 plan resubmission made on 30th April. This shows increased borrowing in the first 3 months in line with the deficit and then reduced borrowing later as the CIP starts to make inroads.

7.4 The Trust borrowed £2.178m in May. This was the maximum available facility at the time as the calculation was still based on the March plan submission. Note that as the Trust has not agreed its control total with NHS-I, there is a punitive interest rate charge of 3.5% (normally 1.5%).

7.5 Performance against the cash target in May was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	2,032	2,532	Brought forward balance.
Cash inflows	15,703	16,291	Two months of VAT recovery at £693k compared to a plan of one month at £250k.
Cash outflows	-16,735	-17,442	Additional cash used to pay suppliers. In addition stafflow outflows now average £125k per week whereas the plan is £94k per week.
Closing balance	**1,000**	**1,381**	

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 June's loan request of £2.479m was approved under emergency powers on 24th May and ratified at Private Board on 6th June.

8. Capital

8.1 A more detailed capital plan is now shown which includes commitments. This provides a better model for decision-making purposes particularly as the medical equipment line is managed on a contingency basis.

8.2 The main driver of spend in May has been related to the replacement of radiology equipment within the managed service programme (£280k in month).

8.3 Donated asset spend of £52k in month relates to a fogging machine and patient couches for the Surgical Assessment Unit purchased by the charity.

8.4 The deeds of variation in connection with the Radiology contract remodelling have now been received and these are with the Trust's solicitors for review. The plan is for theses to be signed and sealed by the end of June 2018.

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 committee. Full CQUIN delivery has been assumed in May's income.

10. Risks

10.1. Although the full impact of a reduced tariff for ACU follow ups has been provided for in May's position this could contribute adversely to future month's financial performance if it is not mitigated by other areas of income or a satisfactory outcome to the creation of a local tariff.

10.2. No provision for contract sanctions has been accrued into the May financial position (£479k).

10.3. CIP delivery of £7M in year

11. Recommendations

11.1. The Board is asked to discuss the contents of the report and in particular note the current financial performance and risk.

Southport and Ormskirk Hospital NHS Trust

Statement of Comprehensive Income (Income & Expenditure Account)

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
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Other Income	11,914	2,008	2,061	53	1,019	1,128	109
Total Income	**162,140**	**27,016**	**27,119**	**104**	**13,554**	**13,653**	**99**
Operating Expenditure							
Pay	(126,869)	(22,001)	(21,624)	377	(11,028)	(10,831)	197
Non-Pay	(52,903)	(8,834)	(8,994)	(160)	(4,397)	(4,630)	(233)
Total Expenditure	**(179,772)**	**(30,835)**	**(30,618)**	**217**	**(15,425)**	**(15,461)**	**(36)**
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Retained Surplus/(Deficit)	**(28,850)**	**(5,689)**	**(5,375)**	**315**	**(2,806)**	**(2,743)**	**62**
Technical Adjustments	63	10	(32)	(42)	6	(40)	(46)
Break Even Surplus/(Deficit)	**(28,787)**	**(5,679)**	**(5,407)**	**273**	**(2,800)**	**(2,783)**	**16**

Statement of Financial Position (Balance Sheet)

Southport & Ormskirk Hospital NHS
NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	30/05/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	126,458	(332)	(31)
Other assets	1,382	1,717	335	24
TOTAL NON CURRENT ASSETS	**128,172**	**128,175**	**3**	**(7)**
CURRENT ASSETS				
Inventories	2,454	2,445	(9)	(59)
Trade and other receivables	9,591	8,127	(1,464)	(177)
Cash and cash equivalents	1,079	1,381	302	(1,149)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**11,953**	**(1,171)**	**(1,385)**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(24,928)	303	1,026
Provisions	(131)	(137)	(6)	3
PFI/Finance lease liabilities	(1,746)	(1,746)	0	0
DH revenue loans	(4,220)	(4,220)	0	0
DH Capital loan	(400)	(400)	0	0
Other liabilities	(471)	(131)	340	7
TOTAL CURRENT LIABILITIES	**(32,199)**	**(31,562)**	**637**	**1,036**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(19,609)	(534)	**(349)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**108,566**	**(531)**	**(356)**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(71,532)	(4,917)	(2,178)
PFI/Finance lease liabilities	(13,807)	(13,945)	(138)	(208)
DH Capital loan	(1,400)	(1,200)	200	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(86,943)**	**(4,843)**	**(2,386)**
TOTAL ASSETS EMPLOYED	**26,997**	**21,623**	**(5,374)**	**(2,742)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	97,241	0	0
Retained earnings	(83,484)	(88,858)	(5,374)	(2,742)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**21,623**	**(5,374)**	**(2,742)**

In month material movements are as follows:

Cash was utilised to pay suppliers and this explains the decrease of cash and the reduction of trade payables.

The only other significatn movement was the draw down of a DH loan for £2.178m which was used to fund the deficit.

Retained earnings decreased by £2,742k in line with the in month deficit excluding technical adjustments.

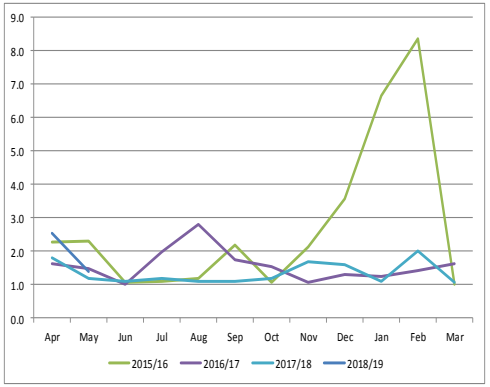
Statement of cash flows

NHS Southport and Ormskirk Hospital NHS Trust

The Trust held enough cash to cover 2.5 days of operating expenditure at the end of May 2018 (April = 5 days).

	Actual Apr-18	Actual May-18	Plan Jun-18	Plan Jul-18	Plan Aug-18	Plan Sep-18	Plan Oct-18	Plan Nov-18	Plan Dec-18	Plan Jan-19	Plan Feb-19	Plan Mar-19	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,217)	(2,330)	(2,550)	(1,846)	(1,975)	(2,095)	(1,403)	(1,491)	(2,287)	(1,545)	(2,138)	(1,994)	(23,871)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)		(20)			(15)				(39)		(131)
Depreciation and Amortisation	523	524	519	519	519	518	519	519	518	519	519	518	6,234
Impairments and Reversals	0	0											0
(Increase) in Inventories	(50)	59										(9)	0
(Increase) in Trade and Other Receivables	976	153										(1,129)	0
Increase in Trade and Other Payables	135	(859)	423	(403)	(23)	830	(5,005)	(246)	549	(171)	690	2,273	(1,807)
Increase in Provisions	(3)	(3)		(17)			(20)			(17)			(60)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(1,608)	(1,767)	(1,479)	(747)	(5,924)	(1,218)	(1,220)	(1,214)	(968)	(341)	(19,635)
Cash Flows from Investing Activities													
Interest Received	1	3	1	1	1	1	1	1	1	2	1	1	15
(Payments) for Intangible Assets	(36)	(65)	(110)	(85)	(38)	(40)	(54)	(24)	(38)	(25)	(23)	(8)	(546)
(Payments) for PPE and investment property	(215)	(606)	(737)	(709)	(726)	(739)	(363)	(313)	(190)	(433)	(253)	(198)	(5,482)
Receipts from disposal of fixed assets	0	0											0
Receipt of cash donations to purchase capital assets	5	52		20			15				28		120
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(846)	(773)	(763)	(778)	(401)	(336)	(227)	(456)	(247)	(205)	(5,893)
Cash Flows from Financing Activities													
Public dividend capital received													0
Public dividend capital repaid													0
Loans received from DH	2,739	2,178	2,479	2,718	2,452	2,811	7,138	1,897	1,897	1,897	1,897	1,897	32,000
Loans repaid to DH	(200)	0					(200)						(400)
Capital element of finance leases	(8)	(8)				(545)		(114)			(219)		(894)
Capital element of PFI, LIFT	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(14)	(161)	(756)
Interest Paid	(99)	(103)	(148)	(104)	(136)	(484)	(144)	(150)	(193)	(153)	(184)	(1,058)	(2,956)
Interest element of finance lease	0	0					(314)	(5)			(205)		(524)
Interest element of PFI, LIFT	(80)	(80)	(96)	(60)	(60)	(96)	(60)	(60)	(96)	(60)	(60)	(96)	(904)
PDC dividend (paid)/refunded	0	0					(81)					(36)	(117)
Net Cash Inflow/(Outflow) from Financing Activities	2,338	1,973	2,074	2,540	2,242	1,525	6,325	1,554	1,447	1,670	1,215	546	25,449
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(380)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(79)**
Cash - Beginning of the Period	1,079	2,531	1,380	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,079
Cash - End of the Period	**2,531**	**1,380**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

Month end cash balances held in the last 3 years



NHS Southport and Ormskirk Hospital NHS Trust

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2018/19 £'000	YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0072	870	100	28	72	135		870	163	707
	Beds / Trolleys	G0060	50	50	0	50	51		50	51	(1)
	Sub total MEDICAL DEVICES		**920**	**150**	**28**	**122**	**186**	**0**	**920**	**214**	**706**
IM&T	Electronic Patient Record	F6409	190	0	7	(7)	26		190	33	157
	Vitalpac	G0007	30	3	1	2	0		30	1	29
	eDMS	F6447	160	27	0	27			160	0	160
	Wireless network upgrade	G0073	150	150	0	150		303	150	303	(153)
	Server warehouse infrastructure incl. storage	G0078	75	75	25	50	0		75	25	50
	Telephony system replacement	G0059	120	120	0	120			120	0	120
	Cyber security	G0071	50	9	0	9			50	0	50
	Fixed network infrastructure	F6498	100	16	0	16	9		100	9	91
	Datacentre	G0075	50	0	0	0			50	0	50
	Virtual desktop infrastructure	G0076	25	3	2	1			25	2	23
	Equipment refresh	G0077	50	8	0	8			50	0	50
	Sub total IM&T		**1,000**	**411**	**36**	**375**	**35**	**303**	**1,000**	**374**	**626**
ESTATES	GE Turnkey works for Radiology equipment replacement programme		400	0	0	0			400	0	400
	Southport A&E Redesign	G0068	350	100	149	(49)	30		350	179	171
	Ward reconfigurations	G0064	140	40	24	16	1	117	140	142	(2)
	Medical gasses	G0067	30	30	8	22	1	8	30	17	13
	UPS Theatre	G0053	50	50	0	50			50	0	50
	Waste management storage facilities		100	0	0	0			100	0	100
	Theatre airplant controls		45	0	0	0			45	0	45
	Generator connectors		65	0	0	0			65	0	65
	Fire compartmentation	G0052	165	0	13	(13)			165	13	152
	Fire Precautions - Fire Doors	G0019	45	0	0	0			45	0	45
	Discharge lounge	G0074	70	35	33	2	13	42	70	88	(18)
	Spinal isolation works		200	0	0	0			200	0	200
	Capital team	F6305	155	30	36	(6)		119	155	155	0
	Aseptic isolator		30	0	0	0			30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**1,845**	**285**	**263**	**22**	**45**	**286**	**1,845**	**594**	**1,251**
FACILITIES	Catering equipment	G0026	100	0	0	0			100	0	100
	Sub total FACILITIES		**100**	**0**	**0**	**0**	**0**	**0**	**100**	**0**	**100**
	CONTINGENCY	**F6301**	**319**	**55**	**50**	**5**			**319**	**50**	**269**
	Capital plan excluding donations and IFRIC 12		**4,184**	**901**	**377**	**524**	**266**	**589**	**4,184**	**1,232**	**2,952**
OTHER	Donated assets	000000	120	0	57	(57)			120	57	63
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	2,168	0	280	(280)			2,168	280	1,888
	Sub total Donations and IFRIC 12		**2,288**	**0**	**337**	**(337)**	**0**	**0**	**2,288**	**337**	**1,951**
	TOTAL CAPITAL SPEND		**6,472**	**901**	**714**	**187**	**266**	**589**	**6,472**	**1,569**	**4,903**

Actual cumulative spend £714k. On top of this there are orders out to the value of £266k plus verbal commitments of £589k.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

4th July 2018

Agenda Item	TB194/18	Report Title	Board Assurance Framework
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

What?

The BAF is continually being developed in line with changes occurring in the Trust on a regular basis. The BAF is now on Datix, the Trust's Risk Management System and Executive Leads can now access the BAF to review and update it as necessary. They will work closely with the Senior Information Analyst for Quality & Datix Project Lead. The Company Secretary will provide independent challenge

So What?

A lot of work is being done to mitigate the risks that could prevent the Trust from achieving its strategic objectives. The Action Plans to close gaps in Controls and Assurances are being addressed with relevant timelines. Some actions have been completed; others are near completion whilst others still need significant work to mitigate risks. The Risk Scoring Matrix is attached for reference:

Likelihood (L)	Severity (S) Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	5 (M)	10 (H)	15 (Ex)	20 (Ex)	25 (Ex)
Likely (4)	4 (M)	8 (H)	12 (H)	16 (Ex)	20 (Ex)
Possible (3)	3 (L)	6 (M)	9 (H)	12 (H)	15 (Ex)
Unlikely (2)	2 (L)	4 (M)	6 (M)	8 (H)	10 (H)
Rare (1)	1 (L)	2 (L)	3 (L)	4 (M)	5 (M)

Risk equals Likelihood (L) multiplied by Severity (S)

RISK GRADE	LOW RISK (Score of 1- 3)	MODERATE RISK (Score of 4- 6)	HIGH RISK (Score 8- 12)	EXTREME RISK (Score > 15)

Risk 1: *Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards* is the focus of a lot of attention via the Acute Sustainability work and the Sefton Transformation work. The Chief Executive's focus on getting the strategic direction of the Trust on the right course has been strengthened with the appointment of a Director of Strategy.
This risk had a score of 15= Extreme, but given the actions that have been taken to mitigate the risk it now has a score of 12=High

Risk 6: *Establish a stable, compassionate leadership team* has received mitigating actions with the appointment of a substantive Chief Executive, the appointment of a Director of Strategy, Interim Chief Operating Officer and the appointment the Company Secretary on a fixed term contract to embed and sustain governance arrangements in the Trust. Given reports from the CQC, NGO and the longstanding Cultural Review, the appointment of an Equality & Diversity Lead has given significant assurance to this risk. This score has been downgraded from 12 to 9 and remains High

The scores of the other risks remain the same. Despite some positive steps to mitigate them; they were not considered as sufficiently significant to warrant a reduction in their scores. See below:

Approved Objective	Principal Risk	Last Score	Current Score
SO1 Agree with partners a long term acute services strategy	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards	**15 3x5 (LxC) Extreme**	**12 3x4 (LxC) *Downgraded to High***
SO2 Improve clinical outcomes and patient safety	Poor clinical outcomes and safety records	**15 3x5 (LxC) Extreme**	**Unchanged**
SO3: Provide care within agreed financial limit	Failure to live within resources leading to increasingly difficult choices for commissioners	**16 4x4 (LxC) Extreme**	**Unchanged**
SO4 Deliver high quality, well-performing services	Failure to meet key performance targets leading to loss of services	**16 4x4 (LxC) Extreme**	**Unchanged**
SO5 Ensure staff feel valued in a culture of open and honest communication	Failure to attract and retain staff	**12 3x4 (LxC) High**	**Unchanged**
SO6 Establish a stable, compassionate leadership team	Inability to provide direction and leadership	**12 3x4 High**	**9 3x3 (LxC) Unchanged**

What Next?

Executive Leads have to work to ensure that the deadlines for completion of actions are realized otherwise the scores will remain static and pose significant risks to the Trust's strategic objectives.

Key Actions needed are:

Strategic Risk	Actions needed
Principal Risk 1: Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards	• Develop, implement, embed and review • Communication and Engagement Strategy • Consider the need for review of strategic planning • Produce reports on Operational Plan to the Board
Principal Risk 2: Poor clinical outcomes and safety records	• Freedom to Speak Up Champions to be appointed across the Trust • Develop the Experience of Care Strategy (including FFT)

	• Finalise Workforce & OD Strategy Implement Recommendations of Culture Review • Robust medical job planning process to be in place • Operational Plan to be finalised to include all service pathways • Develop, implement, embed and review Strategic Plan
Principal Risk 3: Failure to live within resources leading to increasingly difficult choices for commissioners	• Modelling of options likely to emanate from Clinical Senate • Ensure consistency of financial analysis, reporting and control across all areas within the Trust • Roll out of HFMA modules to all relevant staff and reinstate budget holder workshops • Financial Turnaround Director 3 month appointment-need continuity post April 2018 • Implement the KPMG CIP Review Recommendations • CIP Plan Workshop to be convened • Re-advertise for PMO Team members
Principal Risk 4: Failure to meet key performance targets leading to loss of service	• Engagement of EY to address A&E performance and patient flow issues • HR to take urgent steps to amend Sickness Absence Policy • IT Strategy to be developed • Address issues with diagnostic waiting times • Development of a clear and concise integrated performance framework and associated report • Secure the services of external consultant to review RTT processes relating to no incorrect reporting and no harm to patients
Principal Risk 5: Failure to attract and retain staff	• Succession Planning Strategy in Workforce & OD Plan • Workforce Strategy to be developed • Communication & Engagement Strategy to be developed • As part of Annual business cycle develop Cycle of Board Development • Re-instate Annual Staff Award • Exit Interview Procedure to be developed and activated
Principal Risk 6: Inability to provide direction and leadership	• Establish Board Development Programme • Set-up diversity training for staff • Develop Staff engagement strategy • Develop Organisational Development Plan • Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed • New Staff Engagement Policy to be developed Develop and Implement Leadership Model • Develop and Implement Recruitment & Retention Strategy • Joint Workforce & OD Strategy

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

Add actions with milestones and Leads here	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ✓ Finance, Performance & Investment Committee	✓ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

Board Assurance Framework report

NHS
Southport and Ormskirk Hospital
NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
25/01/2018	1783	Chief Operating Officer	Audley Charles	Principal Risk 1: Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards			
Description	Potential Cause: Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels • Lack of robust plans across healthcare systems • Loss of Commissioner support • Inability to respond to requirements to flex capacity as there is a mismatch with their plans. Potential Effect: Loss of existing market share. • Stranded fixed costs due to poor demand management / QIPP. • Difficult to manage capacity plans. Potential Impact: Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance.						
Controls	Sefton Transformation Board Strategy developed with commissioners. Compliant Contracts in place for 2017/18. Commissioner alignment meetings in place. Contingency plans for withdrawal from services developed. Care For You Initiative. STP Board to Board meetings with CCGs. Local Delivery Systems x 2 Operational Plan Clinical Senate Report IT Strategy Tri-Board with CCG's Healthwatch liaison meetings Developing Experience of Care Strategy Friends and Family Test Local Patient Questionnaires and feedback Patient representation at meetings Patient Survey Dementia Friends Complaints and Compliments Policy			Gaps in Controls	Operational Plan not visible and sighted Communication and Engagement Strategy not in place Business Case		

	Safe at All Times Vanguard and partnership working - mutual aid Local Authority Scrutiny A&E Delivery Group Commissioner Contract and Quality Meetings Discharge to assess with community providers and commissioners RAS GIRFT Acute Sustainability Programme								
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Unlikely (3)	Catastrophic (4)	12	High Risk	15	10	High Risk	12/06/2018	12/09/2018
Assurance	CEO's reports to Board (L1) Director of Clinical Services reports re review of services (L1) reported to Board. Finance Reports include contractual and commissioning issues, where relevant reported to Board (L1) Progress of agreeing contracts reported via Finance to Board annually (L1) Business Cases involving commissioners reported, where these occur, reported to Board (L1) Minutes of Network/Alliance meetings (L2) Update reports from Community Partnership Network (L2) Minutes of Monthly Contract Review Meetings (L2) Monthly CEO Patch Meetings (L2) Quarterly review against plan (Titration system) Monthly meetings with CCG's CBU's Governance Meetings FP&I Reports Weekly Executive Team Meeting DOF's Monthly Report to Board Operational Plan reporting to Board now in place						**Gaps in Assurance**	Review of relationship management processes may be required. Periodic reports on externally facing activities	
Action Plan	Develop, implement, embed and review Communication and Engagement Strategy Consider the need for review of strategic planning Produce reports on Operational Plan to the Board						**Action Plan Due Date**	29/06/2018 29/06/2018 30/04/2018	**Action Plan Rating** Little or No Progress Made Completed Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1822	Director of Nursing & Quality	Audley Charles	Principal Risk 2: Poor clinical outcomes and safety records			
Description	Potential Cause: • Failure of national performance target (cancer, RTT) • Failure to reduce delayed transfers of care in the changing NHS environment Potential Effect: • High numbers of people waiting for transfer from inpatient care. • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience. • Failure of KPI's and self- certification • Reputational damage leading to difficulty in recruitment. Potential Impact: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation. • Failure to meet contractual requirements.						
Controls	Staff engagement strategy Quality Visits by NEDs and EDs Duty of Candour Healthwatch Review Freedom to Speak Up Speak Up Champion (NED appointed by Board) Speak Up Guardian Appointed Freedom to Speak Up/Raising Concerns Policy Monthly CBU Quality and Safety Reports Incident Reporting Quality Account CQC Improvement Plan Partnership working across STPs Trust SCOPE Values "Safe at all times" Programmes established Weekly sustainability scrutiny meetings with plan monitoring/ QIA process Embedded Governance structure and processes National surveys for service users Patient forum and patient groups You said, we listened, we did boards Lessons learned feedback CBU has recruited additional resource within the Governance team Trust Vision and Values Strategic Objectives Board Assurance Framework Extreme Risk Register Operational Plan Apprenticeship Strategy HR Policies Care for You programme Staff Engagement			**Gaps in Controls**	Low response rate on Friends & Family Test with unfavourable results Clinical leadership development to provide a culture of trust and candour Perceived inequity of treatment or rewards between and within staff groups No Stakeholder Engagement Strategy Communication and Engagement Strategy not in Place IMT strategy not finalised Staff survey for 2017/18 received, identified areas where Trust performing worse than national average: Support from immediate managers, effective team working, staff able to contribute towards improvements at work, quality of appraisals and fairness and effectiveness of procedures relating to reporting incidents.	

	Maternity services Strategy Results from 2017/18 Staff Survey show the Trust is performing better than national average for; staff working extra hours, staff suffering work related stress, staff experiencing discrimination at work, staff witnessing potentially harmful errors and staff attending work despite feeling unwell Organisational Development Strategy went to Trust Board June 2018 Quality Improvement Strategy in place (went to Board May 2018)									
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Possible (3)	Catastrophic (5)	15	Extreme risk	15	12	High Risk	12/06/2018	12/09/2018	
Assurance	Workforce & Organisational Development Committee (L3) STEIS and Incident Reporting (L2) Developing Gap in Care Strategy (L1) FPPT Report (L3) Governance Reports (L2) Staff Magazine (L1) Integrated Performance Report Director of Clinical Services reports re review of services (L1) Emergency Planning Annual Report (L1) Weekly Quality Improvement Development Group (L1) Patient Flow Project by EY (L3) Quality & Safety Committee Trust Board Clinical Effectiveness Committee Weekly Patient Flow Project Report to ETM						**Gaps in Assurance**	No Engagement Strategy		
Action Plan	Freedom to Speak Up Champions to be appointed across the Trust Develop the Experience of Care Strategy (including FFT) Finalise Workforce & OD Strategy Implement Recommendations of Culture Review Robust medical job planning process to be in place Operational Plan to be finalised to include all service pathways. Develop, implement, embed and review Strategic Plan						**Action Plan Due Date**	31/07/2018 29/06/2018 31/05/2018 29/06/2018 29/06/2018 29/06/2018 30/06/2018	**Action Plan Rating**	Little or No Progress Made Little or No Progress Made Completed Little or No Progress Made Moderate Progress Made Moderate Progress Made Actions Almost Completed

Strategic Objective		SO3 - Provide care within agreed financial limit				Link to BAF	
Business Unit		Executive Management		**Specialty**		**Location**	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**			
04/04/2018	1823	Director of Finance	Audley Charles	Principal Risk 3: Failure to live within resources leading to increasingly difficult choices for commissioners			
Description	Potential Cause: • Failure to deliver the required levels of CIP. • Failure to effectively control pay and agency costs. • Failure to generate income from non-core healthcare activities • Failure to manage outstanding historic debt. • Services display poor cost-effectiveness • Failure to streamline corporate services. Potential Effect: • Additional CIPs may need to be identified and delivered. Potential Impact: • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention.						
Controls	5 year long term financial model (LTFM) Cash support through agreed loan arrangements Annual Financial Plan including target to reduce underlying deficit Financial governance arrangements in place at a number of levels: FP&I Committee/CBU's Monthly governance meeting and performance meetings with Execs Directorate (budget scrutiny at this level) CIP Board, CIP planning processes and PMO co-ordination of planning and delivery. CIP reviews through fortnightly Sustainability Servicing meetings. Director of Finance Report to FP&I and TB Sefton Transformation Board Monthly Improvement Meeting Additional finance resource secured via NHSI PMO Lead appointed						**Gaps in Controls**	Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate Modelling of Care for You programme into 5 year LTFM to provide savings from any reconfiguration in line with STP strategy 2018/19 CIP Plan contains high risks Interviews for PMO Team did not result in full appointments Lack of immediate consultation around service reconfiguration Financial Turnaround Director Business Case awaiting approval from NHSI

Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	Extreme risk	16	12	High Risk	12/06/2018	12/09/2018

Assurance	Finance, Performance & Investment Committee (L2) NHSI Quarterly Review Meeting (L3) Internal Audit plan (L3) Fortnightly Sustainability Scrutiny meetings (L1) BAF-Quarterly to Board and Audit Committee (L1) 13 week rolling cashflow forecast agreed by NHSE (L1) CBUs Financial Managers & Budget Holders (L1) CIP Reviews through fortnightly Sustainability Scrutiny Meetings Finance, Performance & Investment Committee Internal and External audit reports and opinion at Audit Committee Performance Meetings Executive Team Meeting Weekly Update	**Gaps in Assurance**	Lack of robust Financial recovery Plan that delivers an acceptable I&E deficit positon

	Turnaround Director appointed in January 2018 to develop Financial Recovery Plan.				
Action Plan	Modelling of options likely to emanate from Clinical Senate Ensure consistency of financial analysis, reporting and control across all areas within the Trust. Roll out of HFMA modules to all relevant staff and reinstate budget holder workshops Implement the KPMG CIP Review Recommendations CIP Plan Workshop to be convened Re-advertise for PMO Team members	**Action Plan Due Date**	29/06/2018 29/06/2018 29/06/2018 31/10/2018 30/06/2018 & 30/09/2018 20/06/2018 01/07/2018	**Action Plan Rating**	Little or No Progress Made Little or No Progress Made Little or No Progress Made Moderate Progress Made

Strategic Objective	SO4 - Deliver high quality, well-performing services			Link to BAF	
Business Unit	Executive Management	**Specialty**		**Location**	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
04/04/2018	1824	Chief Operating Officer	Audley Charles	Principal Risk 4: Failure to meet key performance targets leading to loss of services

Description

Potential Cause:
- Failure to deliver NHS Constitutional Targets
- Failure to deliver the quality aspects of contracts for the commissioners
- Patients experience indicators may show a decline in quality
- Breach of CQC regulations
- Poor Bed Management processes impact on patient safety

Potential Effect:
- Poor patient outcome and standards of care.
- Inaccurate or inappropriate media coverage or reputational damage

Duplication of services with negative impact on CIP

Potential Impact:
- Potential loss of licence to practise.
- Potential loss of reputation.
- Financial penalties may be applied.
- Poor NHSI Governance Risk Rating
- Increased Agency Fees

Controls	Gaps in Controls
Performance Management framework (awaiting sign-off following changes to NHSI's SOF and CQC inspection regime) Performance Development Framework (signed-off by Board) IM&T Strategy Data Quality Policy & Reporting Integrated Performance Report & FP&I & Trust Board A & E Estates Redesign Plan Weekly monitoring against cancer targets EY Patient Flow Improvement nears completion CBUs Governance processes Risk Registers Leadership Executive Group Team Meetings EY Rapid Governance Review undertaken, new structures proposed Director of Strategy appointed, separate to COO role Acting Chief Operating Officer appointed with plans to recruit substantively 12 Hour Trolley Wait Policy in place	Delivery of A&E 4 hour target Management of sickness absence Sickness Absence Policy requires review and approval Recruitment of Medical and Nursing staff remains a challenge Maintaining EY's Patient Flow Improvement Programme post 30 June 2018

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	Extreme risk	16	12	High Risk	12/06/2018	12/09/2018

Assurance	Gaps in Assurance
Performance and Investment Committee NHS Improvement Board Monthly Mortality Operational Group Monthly Performance Frameworks meeting CBU Governance meetings	A&E 4 hour target longstanding issues in relation to poor patient flow and subsequent impact Sickness absence amongst the worst rates of all acute Trusts. Poor performance a longstanding issue Mixed sex accommodation –due to poor patient flow across the

	QIA process to approve all CIPs Monthly contract meeting with Commissioners Engagement of EY to address patient flow Monthly Report to FP&I committee Monthly Report to Q&S Committee Report to Mortality Operational Group Monthly Trust-level and CBU-level dashboard for performance forum Monthly Reports presented to CBU governance meetings Performance against A&E 4 hour target report to Board monthly About to implement new escalation actions and processes and procedures for 4 hour target		hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready to be moved to a general ward. Diagnostic waiting times not met Communication and Engagement Strategy not in Place No clear and concise integrated performance framework and associated report Mortality: above expected limits for some time		
Action Plan	Engagement of EY to address A&E performance and patient flow issues continuing HR to take urgent steps to amend Sickness Absence Policy IT Strategy to be developed Address issues with diagnostic waiting times Development of a clear and concise integrated performance framework and associated report Secure the services of external consultant to review RTT processes relating to no incorrect reporting and no harm to patients	**Action Plan Due Date**	29/06/2018 31/07/2018 04/07/2018 29/06/2018 29/06/2018 29/06/2018	**Action Plan Rating**	Moderate Progress Made Little or No Progress Made Moderate Progress Made Little or No Progress Made Moderate Progress Made

Strategic Objective		SO5 - Ensure staff feel valued in a culture of open and honest communication				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1825	Director of HR	Audley Charles	Principal Risk 5: Failure to attract and retain staff			
Description	Potential Cause: • Difficulty recruiting and retaining high-quality staff in certain areas • Low levels of staff satisfaction, health & wellbeing and engagement • Insufficient provision of training, appraisals and development. Potential Effect: • Low levels of staff involvement and engagement in the trust's agenda. • High than average vacancy rates. • Failure to deliver required activity levels / poor staff productivity • Higher than average sickness rates Potential Impact: • Poor patient experience and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation embed new ways of working. • CEO/Senior Team Visits • CEO Focus Group • Reduced ability to deliver high quality service with low morale • Poor response to NHS Staff Survey						
Controls	Organisational Development Strategy Improved recruitment and induction processes Staff engagement and awareness programme in place Divisional Staff induction Corporate staff Induction Education and development processes in place Appraisal compliance and training attendance monitored Mandatory training PDR Robust employment checks (FPPT) Disclosure Barring Service (favour CRB) Quality Visits by NEDs and EDs Professional Bodies Checks and Balances for clinicians (NMC/GMC) Duty of Candour/Safe Care HealthWatch Review Staff Survey Sickness Absence Policy – under review Staff Engagement Strategy Speak Up Champion & Guardian Recruitment Strategy Retention Strategy Annual staff Appraisal Executive blog Freedom to Speak Up Guardian appointed			Gaps in Controls	Lack of local in year feedback in relation to staff views / staff surveys Temporary status of staff in leadership roles can have an adverse impact on staff engagement Recruitment & Retention of staff Strategy No formal comprehensive Exit Interview Procedure		

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Possible (3)	Major (4)	12	High Risk	12	9	High Risk	12/06/2018	12/09/2018

Assurance	ADHR of Workforce Reports to Board (L1) Staff survey and values update work reported specifically and through Quarterly workforce reports to Board (L1) Annual NHS Staff Survey (L3) NHSI's Single Oversight Framework-Workforce metrics (L3) Appraisal and PDRs (L1) Staff Induction (L1) Workforce & OD Committee Weekly Executive Team Meeting Monthly Corporate Induction Monthly JNC meeting Bi-Monthly JSMC meeting Monthly E&D meeting CEO Walkabout Weekly Joint Quality Visits by NEDS and Executive Directors Working with NHSI on Recruitment and Retention Board Development Plan and Board Development Workshops in place	**Gaps in Assurance**	No Communication & Staff Engagement Strategy Survey Action Plans - value based interviewing project Inability to finance key projects relating to staff development Staff Survey update report to the Board		
Action Plan	Succession Planning Strategy in Workforce & OD Plan Workforce Strategy to be developed Communication & Engagement Strategy to be developed As part of Annual business cycle develop Cycle of Board Development Re-instate Annual Staff Award Exit Interview Procedure to be developed and activated	**Action Plan Due Date**	31/05/2018 31/05/2018 29/06/2018 30/04/2018 31/07/2018 29/06/2018	**Action Plan Rating**	Completed Completed Little or No Progress Made Completed Moderate Progress Made Little or No Progress Made

Strategic Objective		SO6 - Establish a stable, compassionate leadership team				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1826	Director of HR	Audley Charles	Principal Risk 6: Inability to provide direction and leadership			
Description	Potential cause: • Ineffective leadership • Inadequate management practice Potential Effect • In low staff morale, • Poor outcomes & experience for large numbers of patients; • Less effective teamwork; • Reduced compliance with policies and standards; • High levels of staff absence; and • High staff turnover Potential Impact • Poor quality of patient service • Poor recruitment and retention of staff • Inability to provide viable patient care						
Controls	Trust's Vision & Values Single Leadership Plan accepted by NHSI Substantive CEO appointed Training, education and development (TED) strategy & programmes based on training needs analysis. Leadership and people management policies, processes & professional support (including management training & toolkits) Staff support and occupational health and wellbeing arrangements at Trust, CBU and Service levels Monthly and quarterly monitoring of workforce performance Deep dive reports to Committee investigating specific issues when required Staff communication Grievance & Disciplinary Policies Data Protection Policy (General Data Protection Regulations) Staff Survey Employment checks FPPT & Code of Conduct Compliant PDR Non-Executive directors' (NED) Skills mix Academic & Professional qualifications Unitary Board: Non-Executive and Executive directors are jointly responsible for decisions taken by board Governance Structure Board Development Session Board Timeout Sessions HR Governance Meetings Workforce and OD Committee Healthcare Leadership Model (-self-assessment tool 360 degree appraisals/- Edward Jenner online leadership programme/Management & Leadership Apprenticeships) Essential HR skills for managers Substantive E&D Manager in post Director of Strategy Appointed Interim COO appointed whilst recruitment for substantive role onlgoing		Gaps in Controls	Lack of local in year feedback in relation to staff views / staff surveys IPR to include information in relation to vacancy levels by CBU and by staff group Temporary status of staff in leadership roles can have an adverse impact on staff engagement Recruitment & Retention of staff Organisational Development Plan Equality & Diversity Policy Monitoring and reporting to Board and committees Access to leadership development programmes for clinicians	

	Shortlisting taken place for substantive Medical Director post Company Secretary appointed on 1 year fixed term contract to embed and sustain work started in August 2017. Plans in place to appoint substantively after this period.								
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Major (3)	9	High Risk	12	6	High Risk	12/06/2018	12/09/2018
Assurance	Workforce & Organisational Committee (L1) Staff Survey (L2) Staff Side Meeting with Management (L2) Trust's Vision and Values (L2) Internal Audit Reports (L3) Fit and Proper Persons' Test(FPPT) (L3) Directors' Code of Conduct (L2) Declaration of Interest for Board and Senior Managers (L2) Gifts and Hospitality & Commercial Interest Policy (L2) Standard of Business Conduct and Conflict of Interest Policy (L2) PDRs (L1) Board of Directors Annual FPPT and Code of Conduct (L2) LA reports to Audit Committee (L3) External Auditors Reports (L3) Counter Fraud Report to Audit Committee (L3) Declaration of Interests at every Board and Committees (L2) Health and Wellbeing Action Plan Education & Monitoring Report Monthly Workforce & Organisational Committee Monthly Remuneration Committee Monthly Leadership Executive Group Weekly Executive Team Meeting IPR to Board Monthly Annual Health & Safety Report HR & Workforce Report Ad hoc reports to Board (Staff Survey, Board Development, Board Induction) Corporate Induction Bi-Annual Staffing Report NEDs' Induction Pack in place						**Gaps in Assurance**	Staff Engagement Strategy Workforce Strategy Staff Survey Action Plan New Conflict of Interest Guidance not yet formalised in an approved policy Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation Communication and Engagement Strategy not in Place No Healthcare Leadership Model - self assessment tool 360 degree appraisals Lack of robust Executive Director's Induction Pack Lack of NEDs Development Programme		
Action Plan	Establish Board Development Programme Set-up diversity training for staff Develop Staff engagement strategy Develop Organisational Development Plan Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed New Staff Engagement Policy to be developed Develop and Implement Leadership Model Develop and Implement Recruitment & Retention Strategy Joint Workforce & OD Strategy						**Action Plan Due Date**	30/04/2018 31/07/2018 29/06/2018 31/05/2018 31/07/2018 29/06/2018 31/07/2018 31/07/2018 31/05/2018	**Action Plan Rating**	Completed Completed Little or No Progress Made Completed Moderate Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Completed

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PUBLIC TRUST BOARD
4 July 2018

Agenda Item	**TB194/18**	**Report Title**	**Trust Board Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Mandy Power, Assistant director Integrated Governance		
Action Required *(Definitions below)*	X To Approve X To Assure X For Information	☐ To Note ☐ To Receive	

Executive Summary

Since the last meeting no new risks have been put on the extreme risk register.

Since the last meeting, one risk has been escalated to the extreme risk register.

- 1132- AED staffing. Risk has increased from high to extreme due to over reliance on locum staff, loss of regular agency locums due to capped rates and reduction in fill, rates of new locum doctors. Significant pressures during late shift and weekends.

- Mitigations:
  - Short-term: shifts are being covered by locums and Executive Team has agreed to remunerate with escalated rates in order to maintain patient safety.
  - Long-term: the workforce plan has been approved which follows recommended good practice of appointing to Physician Associated and ANPs.

- New consultant appointed this month

No risks have been removed from this risk register this month.

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*

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

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

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
25/04/2017	1549	Executive Medical Director	Sanjeev Sharma	Postgraduate Medical Education 'enhanced monitoring' GMC/HENW				
Description	Health Education England and the GMC have placed Southport & Ormskirk NHS Trust under enhanced monitoring. 'Enhanced monitoring' is the process the GMC uses to ensure resolution of significant concerns that that they believe could adversely affect our patient safety, doctors' progress in training, or the quality of the training environment. If we fail to meet the compulsory requirements that HEE and the GMC have set then this may lead to the removal of trainees from the Trust with the resulting impact of the inability to provide safe patient care, sustainability of services, reputational damage and potential recruitment and retention issues.							
Controls	Medical Education is reported at CBU Governance Monthly Meetings The Director of Medical Education meets weekly with the CBU AMD's and has a fast track process directly to the Board The 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 committe level HEE NW Action Plan is a standing agenda item at MEC with clearly assigned leads to specified actions Paediatric department has developed processess 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 Postgraduate Clinical Tutor appointed to develop, implement and embed quality assurance framework thereby ensuring consistency of experience for all trainees Trustwide Undergraduate Year Lead appointed to support Clinical Sub-Dean in delivery of undergraduate medical education Trainee Doctors Forum (monthly) - trainees able to raise concerns directly with the GOSW GOSW presents a monthly exception report to Board Quarterly online healthcheck requesting trainee views- shared via summary report to specialty leads and trainees						**Gaps in Controls**	Approval for recruitment of dedicated Pharmacy Educator rescinded which impacts significantly on our ability to provide mandatory requirements to undergraduate teaching programme. This core requirement is the foundation stone of their training and is a significant risk borne out by monthly trainee SUI reports from risk which reflect primarily prescribing errors. Insufficient number of trainees to fill the rotas safely Impact of TUPE transfer of administrative team to StHK Trainees failing to complete ciritical incident forms as they do not like the Datix system Trainees report inconsistencies in ability to complete WBPA dependent upon specialty area Trainer disengagement - not responding to GMC Survey or completing/returning Specialty lead quarterly/annual reports Lack of evidence of effective supervision in clinics and constructive feedback Service pressures adversely impact on trainees experience and stop trainees attending local and regional teaching
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	13/06/2018	12/07/2018
Assurance	Medical Education Committee minutes of meetings Medical Education Governance Reports - CBU Governance Meetings (monthly) Regular meetings with the CEO and Executive MD to discuss progress on HENW Action Plan and organisational change The Job Planning Policy has been agreed with recognition of educational roles for Clinical/Educational						**Gaps in Assurance**		

	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 rotas use the correct nomenclature for each level of trainee to ensure clear differentiation between roles. The Trust should ensure that all trainees understand the process for submitting critical incident forms and the importance of doing so in respect of patient safety and lessons learned. The Trust should also ensure that trainees know how to seek feedback following submission of a critical incident form and that feedback enhances learning. The Trust should ensure that the system is not used by other healthcare professionals as a threat to manage the trainees. The Trust must ensure that trainees are appropriately supervised in clinics and that they receive constructive feedback on their work. ST3 paediatric trainees must not be left to run solo clinics without direct supervision. The Trust must ensure that trainees are able to complete the required Work-Place Based Assessments The Trust should respond to the issues highlighted in the Junior Doctors Advisory Team (JDAT) report to ensure safe and compliant rotas. The Trust must ensure that service pressures do not impact adversely on the training experience of medical trainees and that trainees are able to gain sufficient experience to meet the requirements of their curriculum. The Trust must ensure all trainees at both sites are able to access formal regional and local teaching. The Trust must continue to improve its internal quality control process including systematic collation of information from departments, to evidence that postgraduate medical education is being delivered effectively. This must include a process for ensuring that actions are taken to address negative outliers that may result from the GMC NTS with measures put in place to identify improvements. The Trust must ensure that all trainees at both sites are able to access formal regional and local teaching The Trust must presented HEE with comprehensive evidence of how trainees input into educational governance with examples of improvements being made, at the beginning of March 2018. The Trust must present HEE with comprehensive evidence of how the senior team has addressed a lack of trainer engagement by the beginning of March 2018 The Trust must review their governance structures to ensure they are fit for purpose in relation to education matters. The Trust must present HEE with comprehensive evidence of Board engagement and examples of how the structures are working by the beginning of March 2018. The Trust produce comprehensive evidence which shows how it has resolved the issue of the impact of the transfer of the education and training department on the administration of education by the beginning of March 2018. The Trust must present HEE with comprehensive evidence on how trainees are learning from critical incidents following its new process by the beginning of March 2018. The Trust must present HEE with comprehensive evidence that shows the job planning process is appropriately supporting educators to undertake their roles by the beginning of March 2018. The Trust must present HEE with comprehensive evidence of improvement in the trainee experience in the Paediatrics and O&G programmes by the beginning of March 2018.	**Action Plan Due Date**	31/03/2018 04/01/2018 16/05/2018 12/07/2018 12/07/2018 13/06/2018 12/07/2018 31/03/2018 12/07/2018 21/06/2018 13/06/2018 31/03/2018 04/05/2018 13/06/2018 12/07/2018 12/07/2018	**Action Plan Rating**	Completed Completed Completed Actions Almost Completed Actions Almost Completed Completed Completed Moderate Progress Made Completed Moderate Progress Made Completed Completed Completed Completed Completed Actions Almost Completed Actions Almost Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team						Link to BAF	BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).					
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, high turnover.								
Controls	Leadership Master Classes Annual Pride Awards Workforce Strategy Junior Doctors Survey Engagement and Culture Strategy Equality and Diversity Working Group New post created for support of records system, recruitment process is on going.						**Gaps in Controls**	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	19/06/2018	19/07/2018
Assurance	Quarterly HRD report to Trust Board Result of Staff Attitude Survey Coaching in the workplace Values based recruitment based on guidance from NHS England PDR Process which includes Trust values Charter for Staff and Managers Review of culture in the Trust, being carried out by external adviser. HR Director agreed extension of project, report is expected in February 2017.						**Gaps in Assurance**	Nil Identified	
Action Plan	Cultural Review as commissioned by the Board						**Action Plan Due Date**	02/02/2018	**Action Plan Rating** Completed

Strategic Objective		SO3 - Provide care within agreed financial limit						Link to BAF	BAF007
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
10/05/2016	1329	Director of Finance	Steve Shanahan	Returning to financial balance by 2021					
Description	If we do not have a plan to return to financial balance by 2021, then potentially the organisation will not exist in it's current form.								
Controls	Long term financial model and an estate solution based on the sustainability report completed by the Deloitte in 2015. The Care for You programme built on the Deloitte findings. This has now been supported by the Northern Clinical Senate report. Trust is part of the Cheshire & Mersey Health & Social Care Partnership (STP); the Sefton Transformation Board provides oversight of the Care for You Programme Trust is working with KPMG (funded by STP) to develop costed clinical options based on Northern Clinical Senate report						**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	20/06/2018	23/07/2018
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

Strategic Objective		SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services					Link to BAF		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
24/07/2015	1132	Executive Medical Director	Kate Monaghan	AED Staffing					
Description	Insufficient medical staff to provide service within department. Number of medical gaps in the rotas not being filled, resulting in insufficient medical staff to run service in AED. National shortages of middle grade and Consultant level applicants for substantive vacancies. Continued shortfalls in SHO level establishment due to gaps in training programmes.This has lead to gaps in the rota reducing the level of medical cover, requiring consultants to work down at a lower level to maintain safety of patients. Position is unlikely to change until August.								
Controls	Identify alternative recruitment of junior and middle grade doctors in F3 or CESR rotations to generate interest Review rota and shifts to move rostered staff accordingly to reduce level of risk planned activities such as SPAs, teaching, training cancelled during periods of staffing shortfalls Identification of gaps in the rota identified and escalated to medical staffing to fill Tolerances for annual/ study leave allowances adhered to Regular locum doctors used wherever possible to enable continuity within the department Rostered shift times reviewed on a regular basis to ensure that shift times match periods of peak demand wherever possible to maximise utilisation of existing resources Identifying alternatives to support medical staffing such as ENP/ANP role and physician assistants						**Gaps in Controls**	Introduction of Agency Caps has reduced numbers of available locums within the system Occasions when there may still be shortfalls in cover due to national shortages of suitable AED locum doctors		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	4	Moderate risk	04/06/2018	30/06/2018
Assurance	weekly meeting held to check all locum coverage for the forthcoming weeks to ensure any potential gaps are targetted discussed monthly at Urgent Care Governance meeting rota reviewed on a monthly basis prior to being published with gaps highlighted to medical staffing Noted weekly at Patient Flow Improvement Board (chaired by COO) CV check by duty consultant to ensure locum has ability and training to undertake role in specialty						**Gaps in Assurance**	difficulties nationally in available AED locums		
Action Plan	Full staffing review required. Business case to be submitted. Review of ENP staffing levels. Contact Ambulance lead to explore potential of paramedics working within Dept Undertake bi annual workforce reviews- to be owned locally Proactive recruitment management						**Action Plan Due Date**	31/07/2017 30/06/2017 31/08/2017 28/06/2017	**Action Plan Rating**	Completed Completed Completed Completed