NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 10.30 – 13:30 on Wednesday 5 September 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				
TB201/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence	**Chair**	**10**	**10.30**
TB202/18 (V)	**Declaration of Directors' Interests** To **review and update** declarations of interest relating to items on the agenda and/or any changes to the register of directors' declared interests	**Chair**		
TB203/18 (D)	**Minutes of the Meeting held on 4 July 2018** To **approve** the minutes of the Board of Directors	**Chair**		
TB204/18 (D)	**Matters Arising Action Log** To **review** the Action Log and receive relevant updates	**Chair**		
TB205/18 (P)	**Staff Story: The Menopause Clinic** To **receive** the presentation and **note** lessons learnt	**Dr Paula Briggs, Consultant in Sexual and Reproductive Health**	**15**	**10.40**
STRATEGIC CONTEXT				
TB206/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**10**	**10.55**
QUALITY & SAFETY				
TB207/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of Q&S**	**5**	**11.05**
TB208/18 (D)	**Quality Improvement Plan- Progress Update (In response to CQC Report – March 2018)** To **receive** the monthly report	**DoN**	**10**	**11.10**

Ref No.	Agenda Item	Lead	Duration	Time
TB209/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**IMD**	**10**	**11.20**
TB210/18 (D)	**Bi-Annual Safer Staffing Summary Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**10**	**11.30**
TB211/18 (D)	**Guardian of Safe Working** To **receive** the quarterly report	**IMD**	**10**	**11.40**
TB212/18 (D)	**Medical Appraisal & Revalidation Annual Report 2017-2018** To **approve** and **sign off** the report	**IMD**	**10**	**11.50**
TB213/18 (D)	**Update on Hospital Ulcer Sores Audit Findings** To **receive** the update	**DoN**	**10**	**12.00**
TB214/18 (D)	**Quarter 1 FTSU update and progress on NGO recommendations / action plan** To **receive** the report	**DoN**	**10**	**12.10**
PERFORMANCE				
TB215/18 (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**	**5**	**12.20**
TB216/18 (D)	**Audit Committee: Alert, Assure & Advise Report** To **receive** a highlight report including any escalated risks from the Committee	**Chair of Audit**	**5**	**12.25**
TB217/18 (D)	**Integrated Performance Report** To **receive** assurance from the current position in relation to national performance targets and integrated governance	**DoF/EXECs**	**10**	**12.30**
TB218/18 (D)	**Director of Finance Report** To **receive** the current financial position at Month 4 and progress on the Cost Improvement Programme / Internal Sustainability.	**DoF**	**10**	**12.40**

Ref No.	Agenda Item	Lead	Duration	Time
GOVERNANCE / WELL LED				
TB219/18 (D)	**Risk Management:** **Board Assurance Framework and Risk Register Mid-Year Review** To **receive** the mid-year review report on the BAF and the Corporate Risk Register.	**CoSec/DoN**	**10**	**12.50**
TB220/18 (D)	**Items for Approval / Ratification:** • **Approve** the updated Quality Visits Schedule and Methodology	**DoN**	**5**	**13.00**
TB221/18 (V)	**Questions from Members of the Public**	**Public**	**10**	**13.05**
CONCLUDING BUSINESS				
TB222/18 (V)	**Any Other Business** To **consider** any other matters of business • **Update on Open Day and AGM**	**Chair** **CoSec**	**5**	**13.15**
TB223/18 (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**		
TB224/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**		
TB225/18 (V)	**Date and time of next meetings:** **Wednesday 3 October 2018**, 11.00am Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**		**13.30 CLOSE**

Chair: Richard Fraser

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 4 July 2018

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 5 September 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
David Bricknell, Non-Executive Director
Juliette Cosgrove, Director of Nursing, Midwifery & Therapies
Julie Gorry, Non-Executive Director
Jugnu Mahajan, Interim Medical Director
Silas Nicholls, Chief Executive
Therese Patten, Director of Strategy
Jane Royds, Associate Director of HR*
Steve Shanahan, Director of Finance
Gurpreet Singh, Non-Executive Director

In Attendance

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

Apologies:

Steve Christian, Interim Chief Operating Officer*
Ged Clarke, Non-Executive Director
Pauline Gibson, Non-Executive Director Designate*

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB180/18	**Chairman's Welcome and Note of Apologies**	
	Mr Fraser, as Chair, opened the meeting by welcoming the Board members. He welcomed Ms Patten, in her new role as Director of Strategy. Apologies were received from Mr Christian, Mr Clarke and Mrs Gibson.	
TB181/18	**Declaration of Directors' Interests Concerning Agenda Items**	
	The Chair asked that members declare interests in relation to the	

	agenda items and asked that any changes or additions to the Register of Interests declared by the Board of Directors should be submitted to the Interim Company Secretary. Mr Christian's Declaration of Interests was added to the Register.	
TB182/18	**Minutes of the Meeting Held On 6 June 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 6 June 2018. **TB152/18 Any Other Business:** the new Public Board time may flex to accommodate the Private Board. **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendment.	
TB183/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **TB06718 IM&T Strategy:** The paper would be delivered at the September Board. **TB087/18 Monthly Safe Staffing Report:** a 6-month review would be delivered at the September Board. **TB142/18 Monthly Mortality Report:** The radar graph would be published in landscape format on the quarterly reports. **TB146/18 Emergency Care Performance Report:** This was assigned to the Interim COO for further update.	
TB184/18	**Patient /Staff Story: Experience of Being Admitted to Hospital when you have a Learning Disability**: Mrs Michelle Kitson	
	The Chair welcomed Mrs Kitson, Matron; Patient Experience who delivered the presentation. The Learning Disability Liaison Service organised support for adults who have a learning disability and may be vulnerable using the services of the Trust. This included identification and support, reasonable adjustments and facilitating referrals for other support. It also educated and supported staff to meet the needs of this patient group and worked in partnership with the Community learning Disability teams. Additionally it supported the NHS England Learning Disability Mortality Review. An Easy Read Patient Experience Questionnaire in September 2017 had shown 41% compliance in returned questionnaires: • 100% of patients/carers said that staff were friendly and helpful • 89% of patients/carers felt that they were listened to. • 89% of patients/carers said they were given time to ask	

questions.

Areas for development:

- Staff to always introduce themselves #hellomynameis
- Awareness of the health/hospital passport.
- Involvement in decision making and discharge planning.
- Explaining medications

Comments from this patient group had demonstrated the value of support.

Mrs Kitson shared the Trust-wide Learning Disability Alerts system which enabled sharing of information across specialities and also the Shared Health Passport, Easy Read versions of Patient Information, plus the chair-beds to accommodate carers staying with patients overnight on wards.

Mrs Kitson stated that the biggest challenge was the reliance on community nurses to deliver the training. There was a need to train medics and training sessions had been advertised at Ormskirk.

Mrs Gorry asked if Mrs Kitson was the sole resource and if there were any Champions or advocates on links to Volunteers.

Mrs Kitson replied the Learning Disability (LD) Steering Group was attended by multi-professionals, however it met quarterly and there was a need for passionate people to drive the commitment with enthusiasm. If a patient needed support, carers can be contacted and recurrent patients are known by ward staff which makes identifying their needs easier.

Mrs Gorry commented that Non-Executive Champions for LD/Dementia and other areas had been identified and would be shared shortly.

Mr Birrell thanked Mrs Kitson for her work in this area and added that hospitals are judged by the treatment of LD patients and these standards of care and shared information including Health Passports should be applied to everyone so every they receive the highest standards of care.

Mr Nicholls added that Health Passports were excellent as a sharing mechanism as constant repetition of needs becomes wearisome and frustrating.

	RESOLVED: The Board **received** the presentation.	
STRATEGIC CONTEXT		
TB185/18	**Chief Executive's Report**	
	Mr Nicholls presented the report. Thanks were recorded to the Accident & Emergency (A&E) Team for their hard work over the late May Bank Holiday and beginning of June in maintaining an upwards trajectory of activity which had continued. **RESOLVED:** The Board **received** the Report	
TB186/18	**Acute Sustainability Programme Progress Report**	
	Ms Patten as Chair of this Committee presented the report. It was widely acknowledged that the hospital needed to change and the Trust had embarked on a programme of work to transform the services it provided. With system partners and clinical colleagues, the Trust was working to develop a range of scenarios to describe how hospital care may look in future. The thinking was being shaped by what is best and safest for patients. There was no blueprint for change and clinical colleagues were working through a methodology which had a strong clinical evidence base and demonstrated positive benefit for patients. **The Acute Sustainability Programme** The Cheshire and Merseyside Health and Care Partnership (C&M HCP) had 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 had 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) 5. Acute sustainability of Southport and Ormskirk (S&O) NHS Trust	

(Sefton Place)

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

The first phase of the Acute Services redesign was the development of a service change proposal for Southport and Ormskirk hospitals. This work was led by Silas Nicholls (CEO) and supported by a Clinical Leaders Group (CLG). The CLG had clinical membership from across the health and social care system and provided clinical oversight and assurance for the acute sustainability work.

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. 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 gave 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.

Programme Scope

Dr Mahajan was leading on this at a very high level as the initial focus of the Southport and Ormskirk Acute Sustainability programme was to produce a Service Change Proposal which built on the work of the Northern England Clinical Senate. It linked with the care pathways re-design work stream to create the evidence base for clinically-supported service scenarios. The Service Change Proposal had two components which would be thoroughly

examined by the end of July 2018:

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 described the potential opportunities to deliver sustainable care in future

Early headlines from the Case for Change included:

- Workforce challenges (numbers and skills) exacerbated by the current service configuration
- A CQC rating of required 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 weren't always cared for in the most appropriate or efficient way
- Market share for elective services shrinking with significant efficiency challenges
- Financially do nothing was not an option
- Current estate was not fit for future purpose

The focus of the clinical scenarios would be to provide community-based, integrated care, instead of organisation-based care. This meant 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.

Mr Birrell welcomed the information now being in the public domain. The direction of travel was right and would improve care for the population as a whole. Much work had already taken place and would continue and it was a great foundation.

The Chair commented he was grateful Mr Nicholls open letter had removed unhealthy rumours and that the population would be better served and confirmed the commitment of Mr Nicholls as the substantive Chief Executive.

Dr Bricknell stated the Clinical Senate report was both helpful and supportive and asked if Clinicians had been involved from the outset as there may have been concern if the outcomes were imposed upon them, as it should have been developed with them.

Dr Mahajan responded that they were involved and the report was well received and supported by the Clinicians.

Ms Patten added that Appendix 2 demonstrated the Clinicians involved and the wealth of knowledge that group had in the 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.

The Chair noted that the Trust had specifically requested a Clinical Senate, which enabled clinically-led arguments of what was best for patients and staff and ensured no clinician was being 'done to'.

Mr Nicholls observed that he too was pleased that the discussion was in the public arena and commented that the Trust owned the agenda, having suffered and laboured previously and been 'done to'. There had been a vacuum which had been filled by rumours and the Trust now was setting out a different, positive future.

Whilst 50-60 senior clinical colleagues were consulted, the Trust recognised this was a comparatively small group amongst the 3000+ staff and meetings had been held to address this, with attendance in the hundreds.

This remained an early exploration of all the options available. A formal review of the thinking would be undertaken by NHS Improvement (NHSI) which would result in the creation of a pre-consultation business case, including clinical colleagues, Health Watch and the council. At present public consultation and discussion of the options would take place in early 2019.

He added that he would be pushing as hard as possible for the best possible deal for the people of Southport and Ormskirk. It would be hard work and tough decisions would need to be made however this was the chance of a lifetime to get it right.

Mr Birrell asked if any hold would be placed on the current development of services in the light of this, to which Mr Nicholls responded that plans to recruit staff and maintain safe staffing levels, plus the extension of the A&E Department would continue.

The Chair commented that potential plans could make the hospital more attractive to future staff.

Mr Nicholls concluded that he was mindful the Executive Team could be diverted from the day to day job by these plans, hence the appointment of a Director of Strategy. The challenge of safety, quality outcomes and patient experience would be focused upon by both the Director of Nursing and Medical Director.

RESOLVED:
The Board **received** the report.

QUALITY & SAFETY		
TB187/18	**Quality & Safety Committee - Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Birrell on behalf of the Chair of this Committee presented the report. Clinical Effectiveness and Mortality Operational Group meetings, which fed into the Committee, had been cancelled due to lack of quoracy, which would almost certainly result in delayed action. There was a potential problem with junior doctor cover at night. Options for resolving included the increased use of other healthcare professionals. On behalf of the Board, the Committee had approved the 2017/18 Quality Accounts which had been uploaded to the NHS Choices website. Approval had also been given to the Patient Experience Annual Report. The Pneumonia Clinical Evaluation had been completed and the results highlighted both the complexities of diagnosis and the importance of recording all co-morbidities. 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. **RESOLVED:** The Board **received** the report	
TB188/18	**Quality Improvement Plan Progress Update**	
	Ms Cosgrove presented the report. Previous reports had focused on the CQC inspections and going forward the report would extend to other areas. The 2017 CQC inspection had rated the Trust as 'Requires Improvement' and resulting from this, generic themes had emerged which would improve organisational standards. The Business Intelligence Team were developing a dashboard for assurance which would be shared as soon as it was complete. The new monthly Performance Review Board (PRB) would include	

	and deliver the function of Quality Improvement Development (QID) going forward and each Improvement Group would report into a committee or sub-committee of the Board. Older people as a specific group had not been a CQC focus, however cumulative incidents and complaints indicated these must be considered. Following discussion with CBUs, six improvement actions were identified to potentially move from amber to green (Action Completed). They currently await evidence review and Executive approval and will be presented to Quality & Safety Committee in July 2018 to support their status. Mrs Gorry asked if the lead for Clinical Care in Table 4 had been identified, to which Ms Cosgrove responded that this would be another Senior Nurse and all elements managed. Mr Birrell stated he agreed with what was being done, however it was confusing to have Quality & Improvement Strategy (QIS), this plan and the mortality plan, and it was agreed that the plan and the mortality plan would be combined for the September Board to establish if anything had been missed. QIS was an evolutionary and emerging process. Mr Nicholls commented that there were a variety of quality plans including CQC, Mortality and Older Patient care, all of which needed to be incorporated into the Trust's grand vision and plans. On the subject of what the organisation is doing about Quality and Safety, Ms Cosgrove stated that at present, the opportunity to understand what is happening and prioritise urgent requirements is taking place and Mr Nicholls confirmed that by September, a 'broad brush' of the vision and purpose would be available to the Board, potentially at a time out session and subsequently made available to regulators and the public. Mrs Gorry requested that a comprehensive approach be achieved. If a pause was to be made of QIS then an explanation would be required. Were QIP dates endorsed? The Board needed to have confidence in explaining the process if asked to do so. Mr Nicholls stated that actions from the Quality Strategy would continue and an over-arching vision would be available for September which would define if the Strategy continued or was revised. A pace for change was vital to achieve this.	**DoN**

	RESOLVED: The Board **received** the report	
TB189/18	**Monthly Mortality Report**	
	Dr Mahajan presented the report. There had been little change in the month. The Crude Mortality data showed a peak of deaths in January 2018, which could be attributed to seasonality and was now shown as a downward trend in April. The Learning Disabilities Mortality Review had met in May and integration of this and the Structured Judgement Review was scoped as part of the 'Learning Culture' project work stream. 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 would: • 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. Members of the Records and Management (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 on 30 May to discuss opportunities for support and improvement. The following offers of support, networking and benchmarking came out of the meeting: • The Trust had been invited to two AQuA workshops on 'Improving Outcomes for Frail Patients' in December 2018 and February 2019. • The Trust had been invited to join the upcoming AQuA Mortality	

	Collaborative. • Learnings on cultural engagement from Mersey Care were 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 had 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 will meet again in September, ahead of which, remote activity was coordinated via a shared action log. Dr Mahajan confirmed that the data within the graphs is crude data which is unarguable and that the coding issue identified at point 3.1.2 may be inaccurate however this had no significant impact on the clinical quality of care. Nationally there had been a 10% increase in mortality in January 2018, which may be attributable to the flu epidemic and the severe weather. **RESOLVED:** The Board **received** the report	
TB190/18	**Monthly Safe Staffing Report**	
	Ms 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 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. The recruitment and retention of nursing and midwifery staff	

	remained a priority for the Trust and is an on-going challenge. Trust workforce data showed 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 for the next 90 days. There will be an NHSI site visit at 60 days supporting finalisation of the Trust's improvement plan from August 2018. The Trust hosted a local recruitment event for registered nurses on 28 June 2018 to coincide with Armed Forces week. The Trust is out to advert for non-registered care staff and registered nurses and are considering flexible working, fixed night-working and a small bank for regular work, plus the Apprenticeship Steering Group was considering different levels of applicants. 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. Mr Birrell praised the Nursing Team for their work on recruitment and added this remained an ongoing concern to both the FP&I and Q&S Committees. At present the Trust was 90% below the fill rate but was spending £1.4m to cover the shortfall which was also a safety risk. It may be necessary to consider closing some wards to achieve a safe environment. Ms Cosgrove agreed this was an on-going area of concern and that the measures being undertaken with NHSI Retention could result in increased retention and make the Trust more attractive. Mrs Royds supported Ms Cosgrove and concurred that a meeting with NHSI Retention on 6 July would be positive and fruitful. Mr Nicholls questioned why the Trust struggled to retain and recruit staff, as the numbers did not lie. If the wider workforce was looked at, were Health Professionals any different? On wards, the balance of risk was examined daily in a huddle. It was acknowledged that the organisation had previously opened	

	up capacity with less than favourable staffing levels and this would not recur. Factors to improve included: • Good discharge • Length of stay reduction • Establishment of lines the Trust was and was not prepared to cross. Mr Singh requested that a knee-jerk reaction to staffing levels, i.e. closing wards/reducing beds etc did not occur without serious consideration so as not to impact on the morale of staff. Dr Mahajan highlighted that the skills of all staff, not just nurses, was paramount to patient safety. Mrs Gorry commented that safe staffing needed to meet patients' basis needs and asked how this was measured. If staff are not recruited, what would the impact be? The role of volunteers could make a significant difference and she urged that the forthcoming paper to the Board fulfilled this need. Dr Bricknell asked if the hospital was out of line in comparison to others in this matter or was staff churn inevitable given the nature of acquiring experience in specialities, to which Mrs Royds responded that the numbers were high and in smaller trusts the same trends were evident. Consideration was being given across Cheshire and Merseyside to provide rotational opportunities with Liverpool Heart & Chest so as not to lose staff. Mr Nicholls added that the vacancy rate in Southport and Ormskirk was very similar in Manchester. National training had impacted on this, as had Brexit and the recent visa issues. Whilst this may change in the medium term, work was required in the short-term. In response, Dr Bricknell suggested the Trust also takes reference from the emerging trends nationally and regionally to which Mr Birrell also highlighted the need for identifying any aspects of unsafe staffing. **RESOLVED:** The Board **received** the report	
PERFORMANCE		
TB191/18	**Finance, Performance & Investment Committee (FP&I): Alert, Advise and Assure (AAA) Report**	
	Mr Birrell as Chair of the Committee presented the report. The delivery of cancer waiting time targets continued to be a	

	challenge so the Committee had requested a report outlining the factors creating the problem and proposed remedial action. Mr Birrell was pleased to report that the financial position was not required to be included in the report, which was good news and evidence of improvement. **RESOLVED:** The Board **received** the report.	
TB192/18	**Integrated Performance Report (IPR)**	
	Mr Shanahan presented the report which was in two parts. **Part 1: Integrated Performance Report** The report will be part of the Performance Review Board going forward. Mr Nicholls was pleased to see continued A&E progress, which were all up on trajectories and reported that the performance against other organisations, both regionally and nationally was in the mid-table and sometimes close to the top. It was acknowledged this remained a fragile situation so care not to lose focus was required. Building work would continue in August at the front of A&E to provide a better ambulance handover point and give an improved environment for patients. It was recognised that length of stay reduced patient safety and quality and therefore increased adverse outcomes. Referrals had improved. Transient Ischemic Attack (TIA) performance was poor; Dr Mahajan reported that 60% of the TIAs suspected were not found to be TIAs. Delayed Transfer of Care data on an average per day required explanation. The Never Event lessons learned to be shared. Clarification whether there were one or two Grade 3 pressure ulcers in the month was required. It was queried whether texts were routinely sent to patients in advance of appointments to reduce *Did Not Attends* which was discussed in light of GDPR.	**DoF** **DoN** **DoF** **CoSec**

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 Trust's performance deteriorated towards the end of the month at Southport & Formby District General Hospital (SDGH) due to operational pressures experienced over the Spring Bank Holiday weekend. The recovery following the period was slow and not stabilised by month-end.

- From April 2018, the Trust had an improved rate of performance and was now reporting performance similar to the national average.

- The seasonal changes had supported performance improvement as per historical trends however the rate of improvement was 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 spent on average 100 minutes less in the department.

- The report also confirmed the next steps (phase) of the improvement work which was focused on reducing unnecessarily prolonged stays in hospital and reducing Length of Stay.

- The interventions being prioritised were primarily aimed at the Trust, but referred to how our system partners, social services, the voluntary/third sector, independent care providers and unpaid carers could play a supporting role.

Mr Birrell observed that progress has been good. There had been 54 people in E&D on 3 July when he called in, which was a high figure.
Mr Nicholls commented that attendance was high, possibly due to the hot weather, with the teams busy but coping. Primary care was giving advice to the population on coping with the weather. If the department had a bad day, the priorities were safety and recovery.

	RESOLVED The Board **received** the report	
TB193/18	**Director of Finance Report**	
	Mr Shanahan presented the report. **Current financial position at Month 2** The Trust had 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 would not receive PSF. For the first two months the Trust's financial performance to the end of May was a deficit of £5.407m against a deficit plan of £5.679m which is £273k better than plan. Income was currently performing to plan and the Trust had achieved the total income budget for May, resulting from a combination of improved CIP and collecting income. Total expenditure was within plan at month 2 YTD although some investments made in 2018/19 have not yet been appointed to substantively (e.g. 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 would be breached. This was recognised as a national trend. Capital expenditure is within the plan and is effectively managed through the Trust's Capital Investment Group (CIG) which was pleased to report a £127k award from NHS Digital to support the wi-fi project which must take place in-year and by December 2018. Standing Financial Instructions (SFIs) would be submitted to September Board. Mr Birrell requested that the value would not be reduced from the IT budget as a consequence of the awards. The Trust continued to require cash support as it was trading with a deficit each month and continued to provide a rolling 13-week cash forecast to NHS-I. There was a need to recruit more orthopaedic surgeons, which would reduce agency spend, and this was continuing.	

	RESOLVED: The Board **received** the report	
GOVERNANCE/WELL LED		
TB194/18	**Risk Management**	
	Board Assurance Framework Mr Charles presented the report. There was good news that for the first time since August 2017, Objectives 1 and 6 were proposed to be downgraded because of progress. Objective 1 would move from 15: *Extreme Risk* to 12: *High Risk* following significant work on strategic direction. Objective 6 would move from 12: *High Risk* to 9: *High Risk*, following the recruitment of the Director of Nursing, Director of Strategy and the Interim Chief Operating Officer. The proposal would go to the next Audit Committee on 11 July for approval. By September 2018, the Director of Nursing and the Company Secretary would undertake a review of both the Board Assurance Framework and the Risk Register to ensure that best practice was embedded, strategic objectives refreshed and agreed that a closer synergy of the two needed to be achieved in order to escalate risk effectively. Mr Birrell commented that key actions needed on the BAF were missing and would be writing to Mr Charles, copying in Mr Nicholls to this effect. Mr Singh congratulated the Executive Leadership Team, particularly Mr Charles, on the potential reductions, which infused a degree of confidence. **Risk Register** Ms Cosgrove presented the report. The Risk Register was unchanged from the previous month with work continuing to reduce and control risks. Ms Cosgrove reiterated that she and the Company Secretary would work closely to review both this and the BAF by September to further assure the	**CoSec** **CoSec/DoN** **CoSec**

	Board. **RESOLVED** The Board **approved** the reports.	
TB195/18	**Items for Approval/Ratification**	
	Uncommitted Revenue Support Loan Mr Shanahan presented the loan which had been approved under Emergency Powers by Mr Birrell and Mr Clarke on 19 June 2018 and this was approved by the Board. **Quality Accounts** The Board ratified the decision taken by the Quality and Safety Committee to approve the Quality Accounts.	
TB196/18	**Questions From Members of the Public**	
	Unidentified Member of the Public **Due to the financial pressures on the Trust, did the Board have specialists in economy?** Mr Nicholls responded that the whole Executive Team is responsible for ensuring the best use is made of the money available. **Will Marlow** **What was the strategy for the development of Information Technology, including data collection and ensuring systems are simple and easy to manage?** Dr Mahajan responded that this was a good question and the Clinical Information Management Technology (IMT) Strategy helped nurses and doctors. Some clinical systems were in the early stages of development however Order Communications had recently been implemented which was effective and VitalPac enabled real-time observation to be recorded. Plans included a Communications Hub to facilitate the recognition of the deteriorating patient. Mr Nicholls added there were many short-term IMT objectives in the coming two years, with significant re-development. At present there was no national technology strategy available for the future and 21st century demands were being delivered with 20th century solutions. If a new hospital were to be designed it would include telemedicine, remote monitoring and artificial intelligence systems. The Chair concurred that technology would be a significant	

	contributor to the NHS future. Mr Ryan added that there would be a number of PhD research projects which could provide mutual support and he would be happy to discuss these further with Mr Charles. He also recommended that Board members would be welcome at the Manchester IT meeting, which may prove advantageous.	
CONCLUDING BUSINESS		
TB197/18	**Any Other Business**	
	The Chair highlighted that the 5th of July would be the 70th birthday of the NHS and celebrations would take place on both hospital sites.	
TB198/18	**Items for the Risk Register/Changes to the BAF**	
	There were no items or changes.	
TB199/18	**Message from the Board**	
	There was no message from the Board.	
TB200/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 5 September, 10.30 **Seminar Room, Clinical Education Centre, Southport District General Hospital**	

There being no other business, the meeting was adjourned

Board Attendance 2018/19												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser	✓	✓	✓	✓								
Silas Nicholls	✓	✓	✓	✓								
Jim Birrell	✓	✓	✓	✓								
David Bricknell	✓	✓	✓	✓								
Audley Charles	✓	✓	✓	✓								
Steve Christian			A	A								
Ged Clarke	✓	✓	✓	A								
Juliette Cosgrove			✓	✓								
Pauline Gibson	✓	✓	A	A								
Julie Gorry	✓	✓	✓	✓								
Dr Jugnu Mahajan	✓	✓	✓	✓								
Therese Patten	✓	✓	✓	✓								
Jane Royds	✓	✓	A	✓								

Steve Shanahan	✓	✓	✓	✓								
Gurpreet Singh	✓	✓	✓	✓								
A = Apologies, ✓ = In attendance, - = No response ***** = Non-voting Member												

Public Board Matters Arising Action Log
as at 5th September 2018

NHS Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
	Jun 2017	**Human Resources Contractual Arrangement with St Helens & Knowsley (StHK)**	Board members to be apprised of the review's findings and implications	**ADHR**	Sep 2017	Sep 2018	**July 2018** **On-going process - not concluded**	**AMBER**
TB067/18	Mar 2018	**Information & Management Technology (IM&T) Strategy**	The IM&T Contract to be brought to the April Board. **Note: Contract needs to be signed by October 2018**.	**DoF**	Apr 2018	Oct 2018	July 2018 Next new Contract meeting has been arranged for 1 August **September 2018:** **On Agenda**	**GREEN**
TB087/18	Apr 2018	**Monthly Safe Staffing**	Outcome of review of hours worked by registered and non-registered staff on HealthRoster to be brought to the May Board.	**DoN**	May 2018	Sep 2018	July 2018**/September 2018** **Review continues to identify hours worked that are not captured centrally. DoN to update Board when full impact is identified**.	**AMBER**
TB146/18	Jun 2018	**Emergency Care Performance Report including 4-Hour Access Patient Flow**	COO agreed to look into 'First Responders' and Special Constables potentially undertaking some paramedic activity locally	**COO**	Jul 2018	Sep 2018	July 2018 Contact made with Robert Hussey, Community Resuscitation Manager to investigate. Update to be brought at October Board	**GREEN**
TB188/18	Jul 2018	**Quality Improvement Plan (QIP) Progress Update**	The QIP, QIS and Mortality Plans to be combined.	**DoN**	Sep 2018	Sep 2018	**September 2018** **Deferred to October Board.**	**AMBER**

Public Board Matters Arising Action Log
as at 5th September 2018

NHS Southport and Ormskirk Hospital NHS Trust

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Green	**Progressing on schedule**
Blue	**Completed**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Completion Date	Status Outcomes	BRAG STATUS
TB192/18	Jul 2018	**Integrated Performance Report**	Clarification whether there were one or two Grade 3 pressure ulcers in the month was required.	**DoF**	Sep 2018	Sep 2018	**September 2018 Originally two grade 3 pressure sores were identified in May 2018. After review informed that one of these was a reporting error and technically only a grade 1. IPR was updated to reflect this but the Nursing paper had already been published.**	**BLUE**
TB192/18	Jul 2018	**Integrated Performance Report**	Clarification if text messages are routinely sent to patients in advance of appointments to reduce Did Not Attends would still apply under GDPR	**CoSec**	Sep 2018	Sep 2018	**September 2018 Access to Health confirmed that text messages in advance of appointments are routinely sent to patients who have consented to receive them.**	**BLUE**
TB192/18	Jul 2018	**Integrated Performance Report**	Delayed Transfer of Care data on an average per day requires further explanation.	**DoF**	Sep 2018	Sep 2018	**September 2018 Metric has been reviewed and amended.**	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5th September 2018

Agenda Item	TB206/18	Report Title	Chief Executive's Report
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓To Receive

Executive Summary

- Investing patient services
- Transforming hospital services
- Improvements to car parking
- Board appointments
- National Guardian's Office visit

Strategic Objective(s) and Principal Risks(s)

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

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

Linked to Regulation & Governance *(the report supports …..)*	
CQC KLOEs ✓Caring ✓ Effective ✓Responsive ✓Safe ✓Well Led	**GOVERNANCE** ☐ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
☐ Compliance ✓ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ☐ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

CHIEF EXECUTIVE'S REPORT TO PUBLIC BOARD – SEPTEMBER 2018

Investing in staff and patient services

The Trust has continued to invest in staff and services for patients through the summer.

A £136,000 **patient discharge and transfer lounge** opened in July. It has three beds and a side-room for less able or infectious patients. There is also a seating area for up to eight other patients.

Patients move to the lounge on the day of their discharge if they are unable to go home directly – for example, where they are waiting for medicines to be dispensed. It also helps the hospital get ward beds ready for newly-admitted patients.

The Trust agreed investment of more than £300,000 to expand the **Critical Care Outreach Team** to a 24-hour-a-day, seven-day-a-week service. The team helps with the treatment of patients whose condition begins to deteriorate unexpectedly.

Work on a £350,000 contract to replace the ageing **CT scanner** at Southport gets under way this month. It is part of a wholescale review of the radiology estate which will see the Southport MRI scanner replaced in 2019 and the Ormskirk CT scanner in 2022.

We agreed the recruitment of a further three orthopaedic consultants, two more consultant radiologists and five additional senior doctors.

An expanded, brighter café, the 1652, has also opened at the entrance to Southport hospital.

Transforming hospital services

I published an open letter on 9 July outlining Care for You, our plans for transforming acute hospital services in Southport, Formby and West Lancashire.

Our senior doctors, nurses and other NHS professionals are looking at different ways in which we can improve our services and how we might run them in the future. No decisions have been made, beyond the fact we need to further invest in both our hospital sites at Southport and Ormskirk.

How services could be organised in the future range from keeping them as they are, redeveloping and improving the hospitals at both Southport and Ormskirk through to making the case for a new hospital.

I was pleased with the generally balanced and constructive feedback from stakeholders and the public.

The Trust's initial thoughts have been submitted to the Cheshire and Merseyside Health and Care Partnership in the form of a Service Change Proposal. The Trust and its partners will

move on to fleshing out clinical scenarios for a future hospital service once we have permission to proceed by NHS England and NHS Improvement.

Nothing has been decided and we will be asking people across our community and beyond for their views.

If a proposal is agreed, it must have a strong clinical evidence base and be further shaped through appropriate and timely public engagement and consultation.

Improvements to car parking

The Trust is taking steps to address difficulties some people had parking at Southport hospital earlier in the year.

Although the situation eased over the quieter summer months, I am sorry for the inconvenience this has caused.

However, we have now made progress to create more parking for staff, patients and visitors.

The first part is an agreement with KGV sixth form college across the road from Southport hospital for 50 parking spaces. These are being offered to staff to free up hospital parking for visitors.

The Estates team is also working on reconfiguring the layout of the car parks to create 64 more spaces. We plan to have this work completed by the end of September.

In the longer term, we want to replace the parking control system to further improve the experience of the visiting both Southport and Ormskirk hospitals.

Board appointment

Steve Christian has been appointed to the Board as Chief Operating Officer (COO).

He will be responsible for operational delivery of services and maintaining national and local performance targets and standards while retaining a clear focus on quality and safety.

Steve was on secondment as interim COO since May from his role as Regional Director of Improvement at NHS Improvement. He lives locally and is a former Trust operational manager, and will take up the post in October.

Three candidates have been shortlisted for the role of **Medical Director**. An assessment centre and interviews are scheduled for this month. Dr Jugnu Mahajan will continue as interim Medical Director for the time being.

National Guardian's Office visit

The Trust was delighted to welcome Dr Henrietta Hughes, the National Guardian for the NHS, in July. Her office provides leadership, training and advice for Freedom to Speak Up guardians based in all NHS trusts.

She met members of the Board and heard a presentation from Martin Abrams, the Trust's Freedom to Speak Up Guardian. She also met staff in A&E and critical care at Southport, and the children's A&E team at Ormskirk.

It was a very positive visit with Dr Hughes recognising the good progress the Trust has made and the challenges we face.

News in brief this month …

- **Unicef Baby Friendly celebration.** Congratulations to Ormskirk Maternity who celebrated their success at passing their Unicef UK Baby Friendly Initiative Stage 2 assessment. It measures the level of knowledge and skills of staff who provide breastfeeding support and care for pregnant women, mothers and babies. The unit is now working towards the final Stage 3 accreditation

- **Happy 70th birthday NHS.** We had a number of celebrations marking the 70th Birthday of the NHS in July. These were held at both hospitals, culminating in a celebratory march in from Southport town centre to the hospital to present a birthday card and cake for the Trust

- **North West NHS Leadership Academy.** I am delighted to have accepted the role of representing all NHS provider organisations in Cheshire and Merseyside on the Board on the North West NHS Leadership Academy. Through taking on this role, it will give the Trust greater insight into the work of the academy and how it may be able to help us on our own improvement journey

- **Hospital open day.** The Trust is holding an open day for the public on Saturday 8 September between 11-4pm at Southport hospital. Visitors will see how we deal with a major emergency, can ask experts about a range of health issues, visit the theatres and enjoy a range of complimentary therapies. Specialist stands, staffed by experts will cover dementia, cancer, alcohol misuse, emergency care, maternity, physiotherapy and much more.

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**28th AUGUST 2018**
LEAD:	**MR GUPREET SINGH**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Workforce and staffing levels are across all Clinical Business Units (CBUs) are low; Each CBU has their own individual action plans in response. There is however a mismatch between these numbers and those detailed in the FPI papers.
- Gaps in workforce need to be identified proactively and acted on to minimise delays.

ADVISE

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

- The Cancer Services Annual Plan 2017/18 was presented at the meeting. Due to the failure to meet the national 62-Day cancer waiting time standard, going forward, work will focus on changing the approach to cancer pathways within the Trust, in particular there is a proposed 7-day pathway to improve performance against the 62-day target and reduce the number of breaches.
- There has been no progress in last 6 month on a Regional Stroke pathway (Cheshire and Merseyside).
- Deputy Director for Nursing has been appointed with a focus on compliance and minimising risk.
- As reported via the Patient Experience Group AAA Report, under Pledge Group 3 'Getting the Basics Right', a new catering system pilot will commence on wards to improve nutrition.

ASSURE

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

- An update on Stroke and TIA was presented at the meeting. It was noted that Stoke is compliant with TIA targets but the data is not being correctly reported, as currently patients seen in ED are not included in the data. Dr McDonald, AMD for Urgent Care, will discuss the inclusion of those patients, with the Divisional Service Managers.
- Quality Improvement Plan Update – Progress is being made with 16 actions turning from 'Amber' to 'Green'.
- The Committee received the Research, Development and Innovation Department Annual Report 2017/18. The Committee were assured that the Department complies with all the research governance requirements and statutory obligations. They commended the report and noted the achievements and recommendations for 2018-19.

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

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)

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**23rd JULY 2018**
LEAD:	**MR JIM BIRRELL, Non-Executive Director**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Committee again expressed concern at stroke performance indicators and reiterated its request for a report and action plan to be brought to the next meeting.
- The external review of pneumonia deaths raised a number of concerns, including communication failures, over-reliance on junior medical staff, inability to meet escalation standards and delayed implementation of End of Life Care. The formal report is expected shortly.
- On a number of occasions the Committee identified quality/business continuity issues as a direct result of staffing gaps. The Executive Team was asked to consider ways of minimising this situation through improved workforce planning.
-

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)

- Due to annual leave and work pressures there was a very limited medical presence at the meeting, which restricted the Committee's ability to discuss items requiring a doctor's input
- The Quality Improvement Plan is being further refined with the aim of submitting an updated, cohesive and comprehensive plan to the September Quality Improvement Board.
- further information has been requested on fractured neck of femur breaches so the Committee can consider whether any remedial action is required.
- Concern was expressed that moving the e-discharge summaries into Medway may have stalled, potentially creating safety, reputation and commercial implications.
- The Trust has completed its first batch of Structured Judgement Reviews but nothing of significance has been identified as yet.
- A gap analysis is being undertaken on bereavement services with the output scheduled for consideration, at the September QSC.
-

ASSURE

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

- The Safety Hub, which is one of the key components of the Mortality Reduction Programme, has been established and is in the process of progressing the agreed plan. Oversight of medical handovers is the next action and the Hub aims to be fully operational by the end of September
-

New Risk identified at the meeting	None identified.

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

5 September 2018

Agenda Item	**TB208/18**	**Report Title**	**Quality Improvement Plan Progress Update**
Executive Lead	Juliette Cosgrove, Director 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 paper provides the Board of Directors with an update on the development of a 'single' Quality Improvement Action Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November / December 2017.

The Board of Directors is asked to receive the proposals for the development of a 'single' Quality Improvement Action Plan and note information within 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*
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✓**SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

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

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

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

New Themes	Number	Priority	Area for improvement	Measures	CQC No
Access & Flow	1	Bed rightsizing	(i) Ensure that any areas used for clinical care are suitable for this purpose. (ii) Identify all risks to patients safety specifically in relation to patients being accommodated in areas not designated for clinical care such as corridor areas. (iii) Treatment of patient outliers to ensure all patients have an identified consultant responsible for their review and are reviewed regularly (iv) 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.	**Implementation of High Impact Actions** **% reduction of outliers** **Audit of ED Bristol Checklist**	**65** **10** **13** **68** **14**
	2	SAFER	(i) Systematic Implementation of SAFER	**% Discharged before 12 noon from Inpatient Ward** **25% reduction in stranded and super stranded patient**	**N/A**
	3	Meeting Emergency Care Standard	(i) Ensure that patients can access emergency care and treatment in a timely way.	**Trust to reach 90% Sept 18 and 95% March 19 against 4 Hr standard**	**15**
	4	Escalation Policy	(i) Ensure that the Trust's internal escalation policies are followed appropriately.		**16**
Safe & Effective Staffing	1	Implement Safe Staffing Levels	(i) Improve governance of workforce indicators (ii) Review nursing and midwifery establishments and implement any recommendations (iii) Improve roster efficiencies (iv) Implement recruitment and retention plan for clinical workforce	**Safe Staffing Nursing - Standard 95%**	**N/A**
	2	Training	(i) Ensure that all staff have the up to date training they require to be able to safely care and treat patients. (ii) Improve the levels of staff that have completed mandatory training to meet trust targets. (iii) All theatre recovery staff completed immediate or advanced life support training	**Achieve 85% Target for mandatory training**	**4, 54, 20, 77** **21**
	3	Staff Sickness	(i) Implement new policy to support staff to return to work	**Achieve staff sickness rate of 4%**	
Safeguarding	1	Training & Documentation	(i) Monitor that all staff complete safeguarding training requirements. (ii) Records of consent for patients to be comprehensively reviewed to reflect any changes in patients' capacity. (iii) Ensure that all staff can complete documentation for Mental Capacity Act Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately (iv) Ensure that identification, assessment and documentation of the needs of patients who lack capacity is consistently implemented. (v) Ensure staff make use of the Trust capacity assessment documents when required and properly evidence that where a patient lacks capacity best interests have been adequately considered	**Achieve 90% Target for mandatory training**	**70** **51** **33** **52** **93**
Care of Older People	1	Reducing Falls	(i) Ensure that bed rails are only used when necessary. (ii) Ensure that risk assessments for moving and handling are undertaken, documented and reviewed. (iii) Ensure that individual care plans are in place for people who are at risk of falling	**Falls resulting in moderate harm, severe harm or death**	**28** **49**
	2	Improving care for people with delirium and dementia	(i) Undertake a review of the care of people with delirium and/or dementia and make recommendations for improvement and deliver the improvement plan		
	3	Nutrition	(i) Ensure that there are sufficient numbers of staff to assist with patients dietary needs. (ii) Ensure that all patients receive a Malnutrition Universal Screening Tool score where appropriate.		**32** **48**
Reducing Avoidable Mortality	1	Responding to the deteriorating patient	(i) The provider must ensure that Modified Early Warning Scores (MEWS) are completed and appropriately escalated in order to detect deterioration in condition (Maternity). (ii) Assess, monitor and act on sepsis management and improve the adherence to the use of and escalation resulting from the use of the Early Warning Score electronic system. Ensure all patients receive timely (particularly initial) observations whilst in the ED (iii) The paediatric ED should comply with the new protocol to standardise observations meets the expected standard.	**% overdue and breached observations for patients with EWS 5-6 (Standard 8)** **Timely identification and treatment of sepsis in ED and acute inpatient setting (CQUIN 2a/b) - Target 90%** **% #NOF operated on within 36 Hrs of admission - Target 90%** **VTE Risk Assessment all inpatients - Target 95%** **Proportion of stroke patients who have 90% of their hospital stay on dedicated stroke ward - Target 80%** **WHO Compliance - 100%** **Implementation of VitalPac in Paediatrics**	**38** **91**
	2	Learning from Deaths	(i) Improve the consistency and learning from mortality review processes	**% Deaths reviewed per month**	**92**

New Themes	Number	Priority	Area for improvement	Measures	CQC No
Documentation (Accuracy, Storage &	1	Accuracy	(i) The provider must ensure that patients' records are accurate, up to date and reflect the care the patient receives. (ii) All wards and departments should continue to audit and improve the standard of nursing and medical documentation	**Documentation Audits**	**11** **63**
	2	Document Availability	(i) Clinical records are readily available to staff, are comprehensive, contemporaneous and maintained as per best practice guidelines and local polices and procedures. Records must be kept secure at all times. (ii) All records relating to patients to be kept securely and computers are locked when left unattended to prevent breaches in data protection.		**36, 31, 58, 46** **06**
IPC, Environment & Cleanliness	1	IPC	(i) Ensure that isolation rooms have proper signage and the door is kept closed when necessary. (ii) Ensure that staff in clinical environments wear suitable personal protection to minimise the spread of infection. (iii) Ensure patients are protected from infections by completing the relevant local pathways and cleaning areas where patients receive care in line with their infection control policies and procedures in the emergency department. (iv) Ensure that all that any patients diagnosed with a transmittable infection is nursed appropriately. (v) Ensure that infection control risks are consistently and effectively managed at all times.		**44** **7** **12** **23** **43**
	2	Cleanliness	(i) Ensure that all wards and corridors are clean and well maintained. (ii) Ensure that all equipment in wards is clean and free from dust. (iii) Ensure consideration is given to the times of day to clean ward areas. (iv) Monitoring the cleanliness of privacy curtains in wards and theatres (v) Ensure all hazardous substances are securely stored in ward areas and dirty utility rooms.		**05** **22** **71** **72** **25, 34**
	3	Equipment Storage & Corridors	(i) Consider storage options for equipment in corridor areas.		**73**
Medicines Management	1	Expiry Date	(i) Ensure all medications are within their expiry dates.		**8**
	2	Storage	(i) Ensure all medicines are stored correctly in accordance with manufacturers recommendations and that room and fridge temperatures which fall outside the normal parameters are escalated and actioned.		**39**
	3	Prescribing & Administration	(i) Ensure all medication, including oxygen, is prescribed and recorded when administered. (ii) Ensure that all medication checks are completed appropriately	**Medication errors resulting in moderate harm or above**	**26** **29**
	4	Resus Trollies	(i) Resuscitation trolleys are to be checked effectively and ensure all medication and consumables are within date. (ii) Carry out regular checks of medical equipment included the anaesthetic machine and resuscitation equipment to ensure this safe for use (Maternity)		**35, 30** **40**
Improving Care from Patient Experience	1	Complaints	(i) Review complaints from adult inpatients to identify themes for improvement		**N/A**
	2	Patient Feedback	(i) Ensure systems that are in place to assess, monitor and improve the quality of services are robust and effective. (ii) Engage the public in relation to urgent and emergency services. (iii) Encourage patient feedback to drive improvement. (iv) Ensure feedback information is available including in multiple formats. (v) Conduct a review of complaints in adult services to identify opportunities for improvement		**41** **56** **78** **79**
Well Led / Governance	1	Fit and Proper Persons	(i) Ensure there is an effective system in place to meet legal obligations in relation to fit and proper persons employed at director level		**03 Reg 5**
	2	Risk Management	(i) Ensure the spirit of Duty of Candour is embraced particularly in relation to notifiable safety incident investigations. Consideration should be given to wider involvement with relevant persons in the investigation and sharing of outcomes. (ii) Ensure that duty of candour policies and processes are fully embedded across the service and that staff understand their responsibilities. (iii) Ensure that all risks identified in relation to all services are appropriately risk assessed and appropriate control measures are in place. (iv) Implement review of risk management to include a risk management policy	**Count of incidents and % low or no harm**	**02 Reg 2** **27** **17** **47**
	3	Freedom to Speak Up	(i) Continue to implement actions following the review by the National Guardians office		
	4	Good Governance	(i) Ensure effective trust-wide governance systems are in place.		**01 Reg 17**
	5	Well Led	(i) Ensure there is a clear vision and values set for staff to follow. (ii) Provide staff with a clear vision and strategy of the direction of the medical services and senior managers should be visible and approachable to all staff. (iii) Embed a strategy and plans for the future. (iv) Performance development reviews should be completed in line with trust policy.	**Achieve 85% Target for PDR**	**17** **67** **80** **69, 95**

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT ACTION PLAN

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on the development of a 'single' Quality Improvement Action Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November / December 2017.

2. BACKGROUND

The Quality Improvement Action Plan has been developed incorporating priorities from the Draft Quality Improvement Strategy, seen by the Board of Directors in May 2018, CQC Must and Should Do recommendations and the Trust's key quality priority themes emerging from complaints, incidents and patient feedback. The Quality Improvement Action Plan sets out our commitment to improving the quality of care for our patients and will enable us to monitor and measure progress and improvement against KPIs, metrics, audits and quality reviews (Appendix 1).

3. QUALITY IMPROVEMENT THEMES

The Quality Improvement Action Plan is divided into key themes, identified through the CQC Improvement Plan, national and local quality priorities including:

- Access & Flow – Continuing priority to ensure the Trust is 'safe and calm'. There is a focus to improving patient safety and experience by ending 12-hour waits in A&E and stopping patients receiving care in inappropriate environments and improve performance against national standards.
- Safe & Effective Staffing – Existing priority in relation to high vacancy rates in the clinical workforce. Mandatory training compliance and appraisal rates are also below trajectory and core competency development needs to improve.
- Safeguarding – Identified as an improvement area by CQC, we need to maintain training trajectory achieved in 2017/2018. Additionally we need to improve documentation across all areas related to safeguarding.
- Care of Older People – Theme identified through internal governance process (complaints and incidents), our patient demographic profile identifies a high frail elderly population, and therefore this is local priority.
- Reducing Avoidable Mortality – 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.
- Documentation (Accuracy & Storage) – Identified as improvement area by CQC, new nursing documentation launched in April 2018. However concerns

related to documentation feature in many incident and complaint investigations and also in clinical audits.

- Infection Protection Control, Environment & Cleanliness – Identified as improvement area by CQC, national PLACE survey and local HEAT surveys have identified areas for improvement. These relate to infection prevention and control measures, the cleanliness of the environment and governance.
- Medicines Management – Identified as improvement area by CQC, national priority drivers and CQUIN requirement. Improvement needed in the prescription, administration and storage of medicines.
- Improving Care from Patient Experience – Existing priority and Quality Account priority for 2017/2018. There is an opportunity to improve methods of gaining feedback and translate learning into improvement.
- Well Led / Governance – Identified as improvement area by CQC, we have and overall Inadequate rating for Well Led from 2017 Inspection.

4. CQC COMPLIANCE

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. A high level update on progress can be found below (Table 1). The evidence and assurance process has been refreshed focusing on impact and sustained improvement in each area. A formal assurance statement and approval process has been developed which includes the methodology for continued compliance. This will be reviewed by a Quality Assurance Panel and reported to Quality and Safety Committee and the Board of Directors for assurance. This will enable committees to challenge evidence of improvement and sustainability in the long term.

The Trust received the draft CQC 'Quality Report' following the unannounced safe & responsive inspection of Emergency Department in March 2018, factual accuracy checking is complete, we are now awaiting publication of final report, actions will be incorporated into the Quality Improvement Plan.

Following review and evaluation of supporting evidence, it is likely that 22 actions will be moved to Green (subject to sign off). Therefore, of the 97 improvement actions, 74 will be rated amber (on track to deliver), 22 Green (action completed) and one blue (delivered and sustained) based on current review and progress.

Table1. Current BRAG rating for CQC actions August 2018

Rating	Must Do	Should Do	Total
Delivered and Sustained	1	0	1
Action Completed	9	13	22
On track to deliver	49	25	74
No progress / Not progressing to Plan	0	0	0

5. QUALITY IMPROVEMENTS

To facilitate our improvement journey, the Quality Improvement Action Plan will be delivered through discreet single actions or larger improvement projects. Improvement groups have been established and terms of reference and governance arrangements have been agreed. The Trust will also retain focus on the domains and core services which the CQC found to be Inadequate or Require Improvement to ensure there is a clear trajectory for moving to good.

To support delivery of the action plan, a number of quality initiatives have been put in place including:

- Daily safety huddles to review all incidents reported in the previous 24 hrs.
- Daily staffing meetings.
- Monthly Mortality Operational Group meetings
- External support with learning from deaths.
- Roll out of RCP (Royal College of Physicians) Structured Judgement Review (SJR) training
- Weekly Serious Incident Review Group.
- Commencement of a three month Safer Programme launch with ECIST (Emergency Care Improvement Support Team) to focus on reducing length of stay.

We are also implementing the following:

- In-depth review of nursing care (Care of older people) on all adult wards to take place Q2-3 Review of complaints during past 3-5 years to gain further insights
- Roll out of VitalPac in Maternity and Paediatrics to monitor, identify and support the deteriorating patient.
- Implementing findings from the medical workforce engagement survey
- Establishment of a PMO (Programme Management Office) to support Quality Improvement programmes and projects
- Commencing in September/October 2018 Quality Improvement training programme for staff with AQuA.

To date the Trust has seen improvement in:

- Number of patients treated on corridor has decreased
- The process for the management and review of SIs has been strengthened
- The review and assessment of patients skin condition has improved at the point of attendance which in turn has identified several patients attending daily with poor skin integrity. A formal referral process to community services is now in place.

As part of the workforce quality agenda, progress is being made in the following areas:

- Triangulating all data sources including Model Hospital and Allocate System to understand establishment, deployment, spend and vacancies
- Working with NHSI to develop robust retention plan
- Recruitment underway, 22 Health Care Assistants recruited in August 2018, significant challenge in Registered Nurse recruitment, however there will recruitment event at the Trust Open Day 8th September 2018 and the Trust is attending a recruitment fair in Dublin in October 2018.
- Approval to recruit 5 SAS (specialty and associate specialist doctors) in Medicine, 4 Consultants in Trauma & Orthopaedics and 2 Consultants in Emergency Department
- Testing new roles including catering support and pharmacy technicians on wards
- Development of a Medical Workforce Plan.

6. RECOMMENDATIONS

The Board of Directors is asked to receive the proposals for the development of a 'single' Quality Improvement Action Plan and note information within this report.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

5th September 2018

Agenda Item	TB209/18	Report Title	Quarterly Learning from Deaths and Mortality Report (Qtr.4 2017/18)
Executive Lead	**Dr 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 Board is asked to receive the report for assurance of progress of Learning from Deaths activity driven by the Reducing Avoidable Mortality Project, supported by the roll out of the Structured Judgement Review and clarified with analysis of Trust mortality data.

Contents:

Learning from Deaths and Reducing Avoidable Mortality

- Strategic Context
- The Structured Judgement Review Method
- External Mortality Review
- Learning from Deaths, Quarter Four Data

Measuring Mortality

- Summary Hospital-level Mortality Indicator (SHMI) – 12 month rolling up to 31st December 2017
- Hospital Standardised Mortality Ratio (HSMR) – March 2018
- Disease-Specific Mortality – February 2018
- Mortality Dashboard Highlights – June 2018

Reducing Avoidable Mortality (RAM) Project

- 24/7 Critical Care Outreach Team Business Case
- Updates on the RAM project work streams, key risks and milestones.

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)*

Previously Presented at:

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

Quarterly Learning from Deaths and Mortality Report September 2018

1.0 Executive Summary

<table>
<tr><th colspan="2">Section</th><th>Summary</th></tr>
<tr><td>1.0</td><td>Background (Strategic Context)</td><td>The Trust is committed to delivering a reduction in mortality through the Reducing Avoidable Mortality Project. The roll out of the RCP's Structured Judgement Review and Learning from Deaths activity are key to embedding a sustainable learning culture to improve the quality of care and to progressively reduce mortality.</td></tr>
<tr><td>2.0</td><td>Learning from Deaths Activity</td><td>Updates are provided
The Structured Judgement Review
The External Mortality Review
Learning from Deaths Quarter Four 2017/18</td></tr>
<tr><td>3.0</td><td>Measuring Mortality - Mortality Ratios</td><td>The data reported herein appertains to the following timeframes. We provide the most up to date data available at the time of reporting.
<table><tr><th>Learning from Deaths (Trust Data)</th><th>SHMI (National - 12 month rolling ratio)</th><th>HSMR (National - 12 month rolling ratio)</th><th>Local Mortality Ratios</th><th>Mortality Dashboard (Trust Data)</th></tr><tr><td>Qtr. 4 2017/18</td><td>Qtr. 3 2017/18</td><td>March 2018</td><td>February 2018</td><td>June 2018</td></tr></table>Both the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain high and above expected levels.</td></tr>
<tr><td>4.0</td><td>Reducing Avoidable Mortality Project</td><td>An overview of the business case for the 24/7 Critical Care Outreach Team, approved by the Hospital Board in July is provided.
An update on the key activity against all six project work streams is reported alongside milestones and risks.</td></tr>
<tr><td colspan="3">Appendices</td></tr>
<tr><td></td><td>Appendix 1
Appendix 2</td><td>The Structured Judgement Review Process Version 3
Mortality Dashboard Highlights, June 2018</td></tr>
</table>

1.0 Strategic Context

The Trust is committed to improving mortality and in turn mortality ratios through the 'Reducing Avoidable Mortality' (RAM) Project which has the overriding aim of reducing avoidable mortality by April 2019.

The Trust is currently embedding the Royal College of Physicians Structured Judgement Review method to review in-hospital deaths, the findings from which will feed into the the Learning from Deaths processes and outputs in line with national guidance.

2.0 Learning from Deaths

2.1 Structured Judgement Review (SJR)

The Royal College of Physician's Structured Judgement Review (SJR) method went live in the Trust on Monday 2nd July 2018. An in-house screening tool has been developed for use by the junior doctors at the point that the death certificate is produced. The information input into the screening tool triggers the request for a Structured Judgement Review if required.

In the first month of the SJR method, 38.5% of in-hospital deaths were screened, 60% of which triggered a SJR review. The number of deaths screened was significantly lower than the number of mortality reviews usually undertaken each month (80% in March 2018). There is an expectation at the outset of a new process such as this that compliance will take time; however the target is for a minimum of 80% compliance by end of October 2018. Communications and briefings are ongoing to support this requirement while weekly compliance rates are being monitored.

The percentage of SJR reviews triggered by the screening tool is currently far higher than the nationally expected figure of between 10 and 20%. It has been agreed that the sensitivity of the screening tool will be reviewed (so that it is more in line with the expected national average), once the number of deaths being screened is at a significant level of 80% or higher. Once activity has stabilised at this level an additional random sample of 10% of deaths will also be reviewed each month.

No of In-Hospital Deaths - July 2018	No of Deaths Screened – July 2018	Percentage of Deaths Screened	No: Triggering for SJR Review	Percentage Triggering SJR Review
78	30	38.5%	18	60%

2.2 External Mortality Review

The final report for the external review 'Developing Trust Capacity & Approach to Learning from Deaths' into Pneumonia & Stroke Deaths is expected at the end of August and will be presented to the Trust Board in November 2018.

2.3 Learning from Deaths Quarter Four 2017/18 [1]

Mortality Review Headlines	Jan-18	Feb-18	Mar-18
Total Number of Deaths	121	89	106
Number of Learning Disability Deaths	0	0	1
Number of Mortalities Reviewed	123	81	107
Percentage of Mortalities Reviewed [2]	102%	91%	101%
Outcomes of Mortality Review	**Jan-18**	**Feb-18**	**Mar-18**
1) Not preventable death due to terminal illness or condition upon arrival at hospital	35	22	51
2) Not preventable death and occurred despite the health team taking preventative measures	88	59	56
3) Not preventable death BUT medical error of system issue was present	1	0	2
4) Possibly preventable death resulting from medical error or system issue	0	0	0
5) Likely preventable death resulting from medical error or system issue	0	0	0

There were no 'possibly preventable' or 'likely preventable' deaths reported in Quarter four.

There were however three deaths under the category 'not preventable but that there was a medical error of system issue present'; one in January and two in March 2018.

The death relating to a system issue in January was flagged due to concerns that the patient had been moved numerous times during a long stay. Of the two deaths in March: the first relates to a patient who died in hospital and not at their 'preferred place of home' while the second case is subject to coroner's review.

As part of the 'Reducing Avoidable Mortality' Project, a draft process has been developed to link mortality reviews, serious incidents or complaints (where relevant) with mortality data (Appendix 1). This process requires further development to be undertaken once the SJR process has been fully embedded and the detail of the required activity is fully understood. The overriding objective will be to identify thematic trends and areas requiring quality improvement.

[1] The data supplied is correct at the time of the submission of the report, however numbers can increase until all relevant reviews have been completed (those which have been subject to a prolonged investigation may require months to conclude).

[2] In some cases the percentage of mortalities reviewed exceeds 100%; this is because the data reports the number of deaths which have occurred in the calendar month against the number of deaths reviewed within the same time frame. The figures will therefore overlap, but they are not mutually exclusive and the data is therefore marginally out of sync.

Learning from Deaths data is available to the general public in the Quarterly Learning from Deaths Report to the Public Trust Board, the papers for which are published via the Trust website.

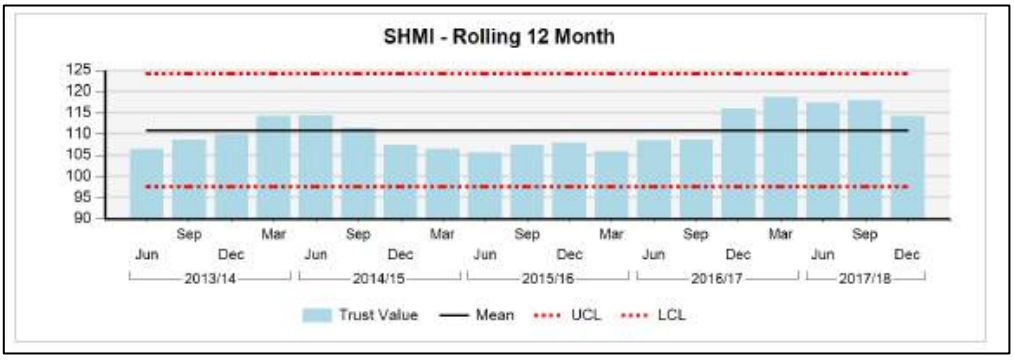
3 Measuring Mortality

3.1 SHMI & HSMR

3.1.1 Summary Hospital-level Mortality Indicator (SHMI)

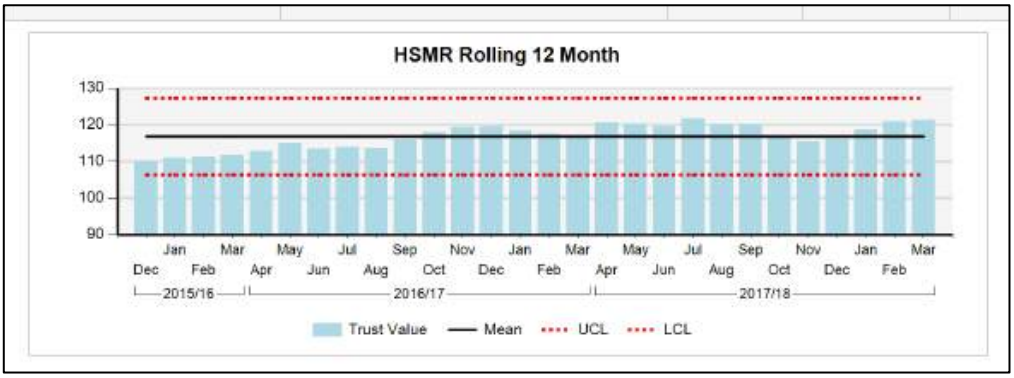
The SHMI ratio for Quarter 3 is 114.2 which is a slight improvement from 118.7 in Quarter 2. Although there is an improvement, the SHMI for the Trust remains high and above expected levels.

Qtr. 1 2017/18 (12 month rolling up to 30th June 2017)		**Qtr. 2 2017/18** (12 month rolling up to 30th September 2017)		**Qtr. 3 2017/18** (12 month rolling up to 31st December 2017)	
SHMI	**No. of Deaths**	**SHMI**	**No. of Deaths**	**SHMI**	**No. of Deaths**
117.3	1353 deaths over an expected figure of 1152	118.7	1392 deaths over an expected figure of 1172	114.2	1291 deaths over an expected figure of 1130



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 March 2018 was 119.1 which is a marginal improvement on February 2018 was 120.4.



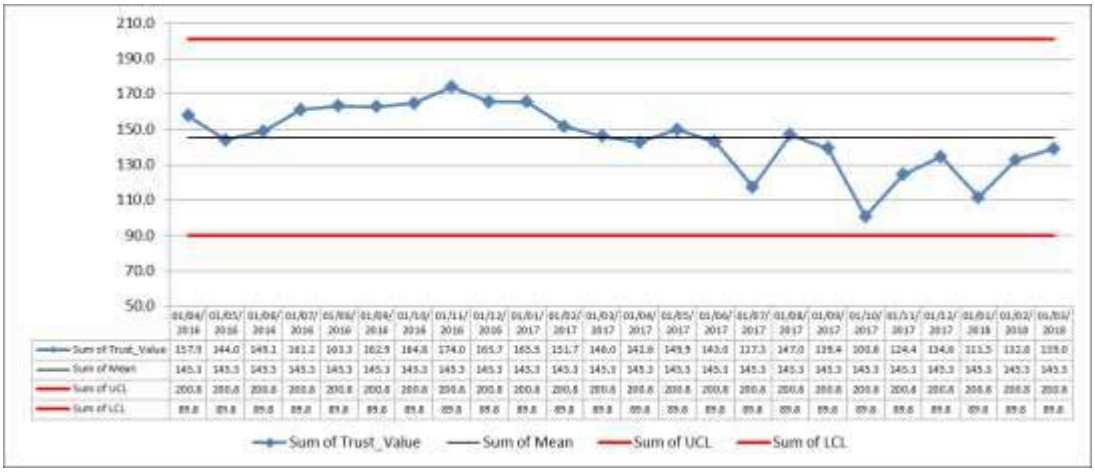
3.2 Disease-Specific Mortality – February 2018

3.2.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

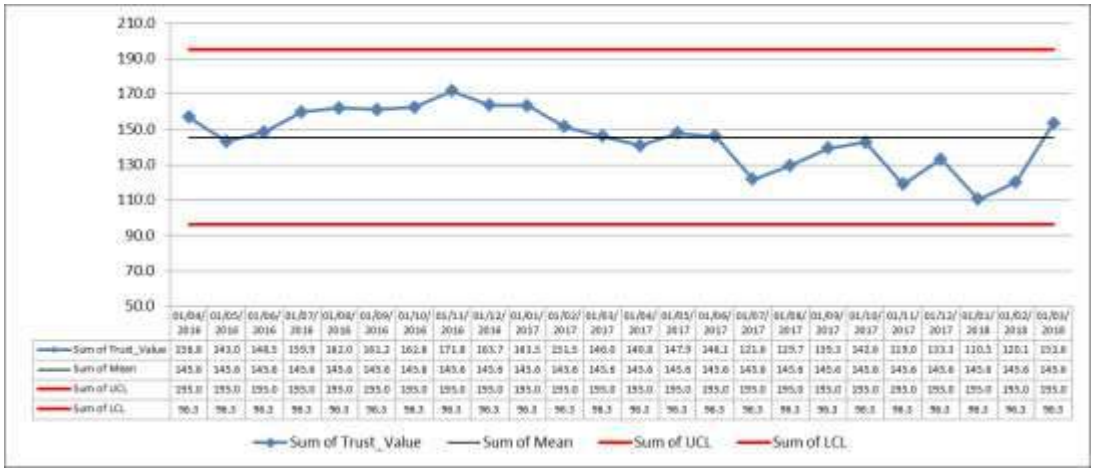
The rolling 12 month local Standardised Mortality Rate (SMR) for:

- Lower Respiratory Tract Infection (LRTI) increased significantly to 139.0 in January from 121.4 in February.
- Acute Bronchitis also increased to 153.6 in March from 120.4 in February.
- Pneumonia SMR dropped slightly to 138.8 in March from 140.5 in February.

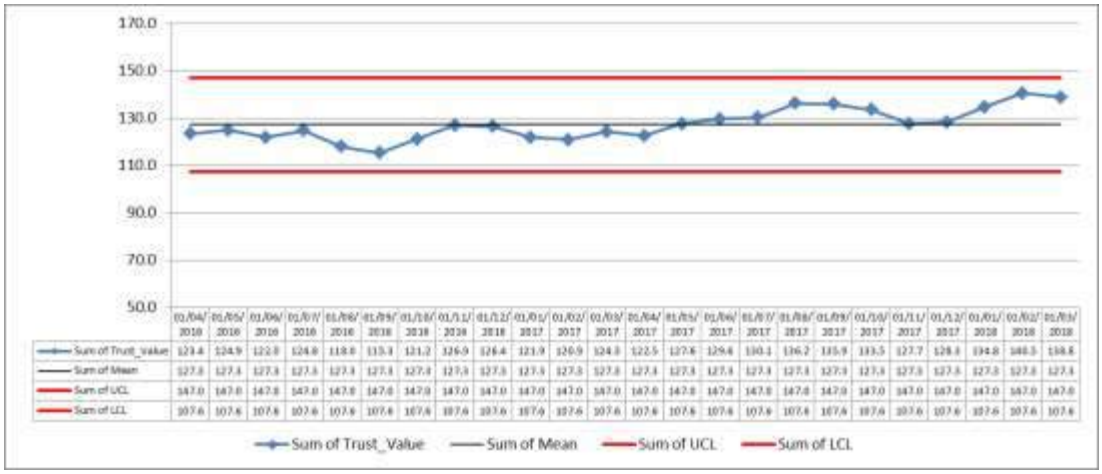
Accurate diagnosis of respiratory illness is needed for best treatment, but also to reflect the trusts targets for improvement. Work to improve diagnosis and aid best treatment is under way through the redesign of the Pneumonia Pathway. This work is being overseen by respiratory consultant Dr Chris McManus, Assistant Medical Director of Patient Safety, Chris Goddard, two new dedicated Respiratory Nurses and support from the Programme Office.



Lower Respiratory Tract Infection



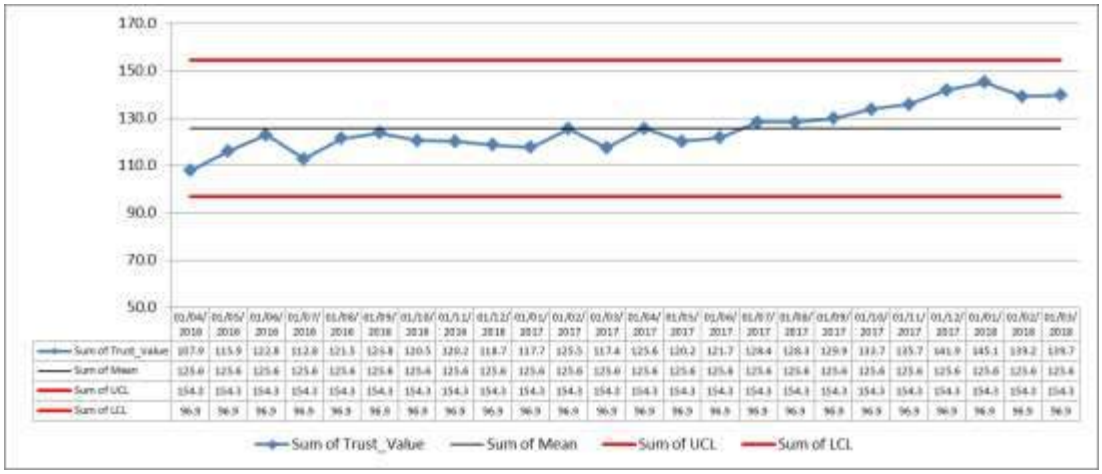
Acute Bronchitis



Pneumonia

3.2.2 Stroke

The rolling 12 month SMR for Stroke has increased marginally in March to 139.7 from 136.1 in February 2018.

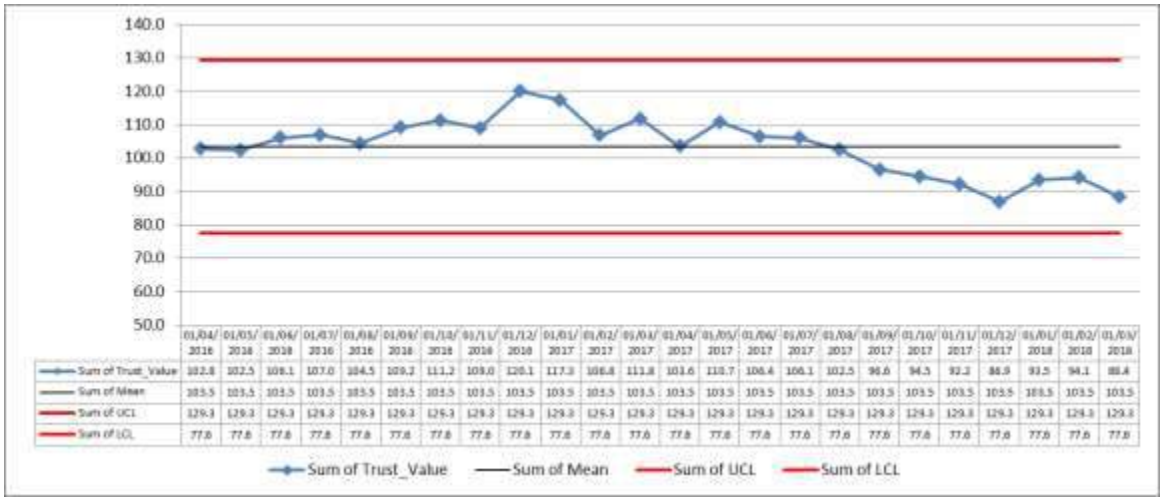


Stroke

3.2.3 Septicemia (Except in Labour)

The rolling 12 month SMR for septicemia dropped to 88.4 in March from 94.6 in February. As shown on the graph, the ratio remains below the target of 100 for the sixth consecutive month.

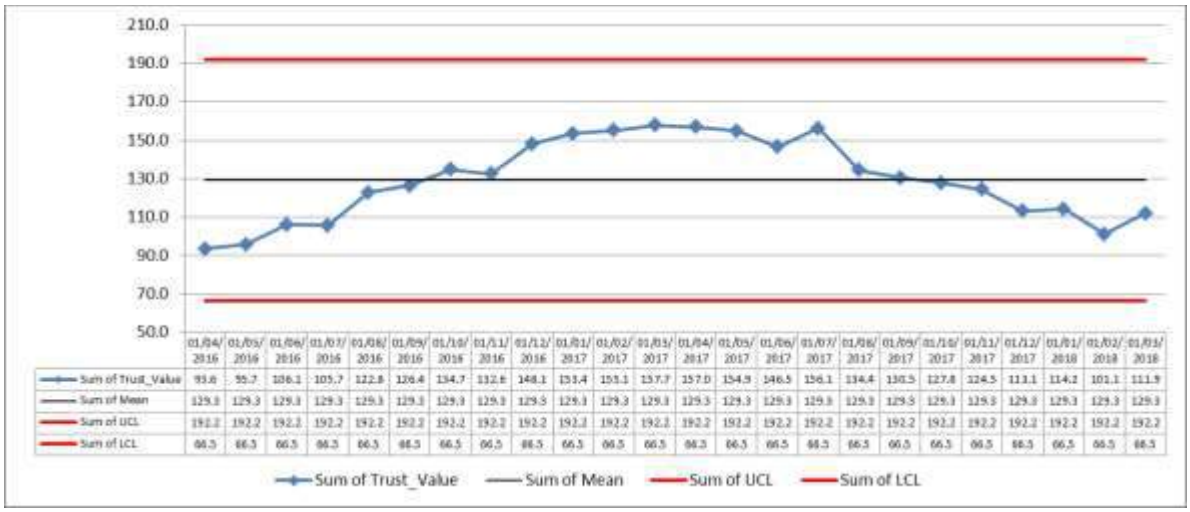
The Trust's Sepsis Pathway has been updated and new guidance is currently being rolled out across the Trust as part of the 14 new Deteriorating Patient Trolleys which have taken the place of the former Sepsis Trolleys.



Septicemia

3.2.4 Urinary Tract Infection

The rolling 12 month SMR for Urinary Tract Infection has remained below the mean .

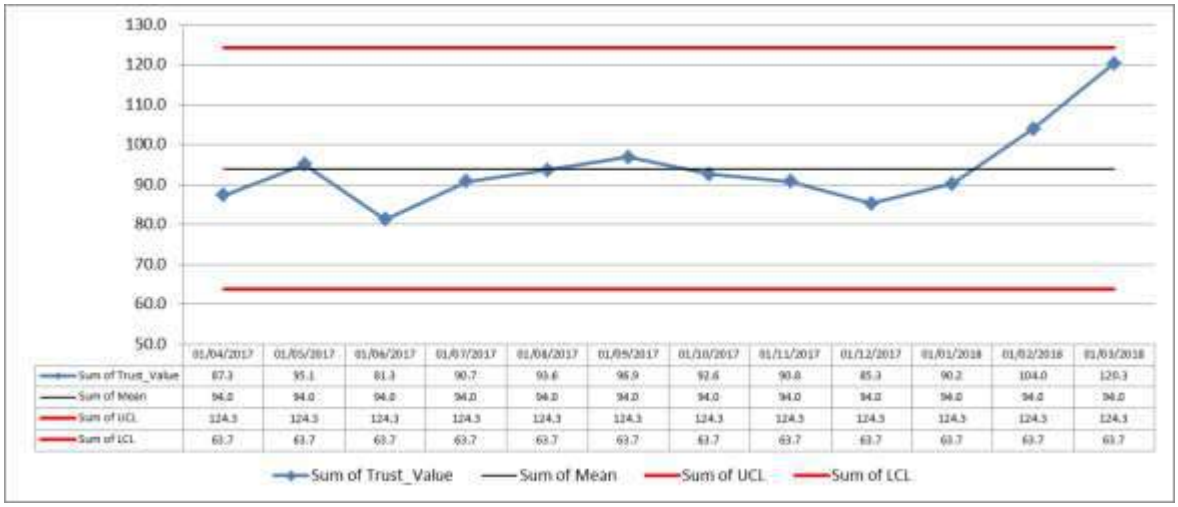


Urinary Tract Infection

3.2.5 Acute Kidney Injury

The 12 month rolling SMR for March jumped to 120.3 from 104.5 in February.

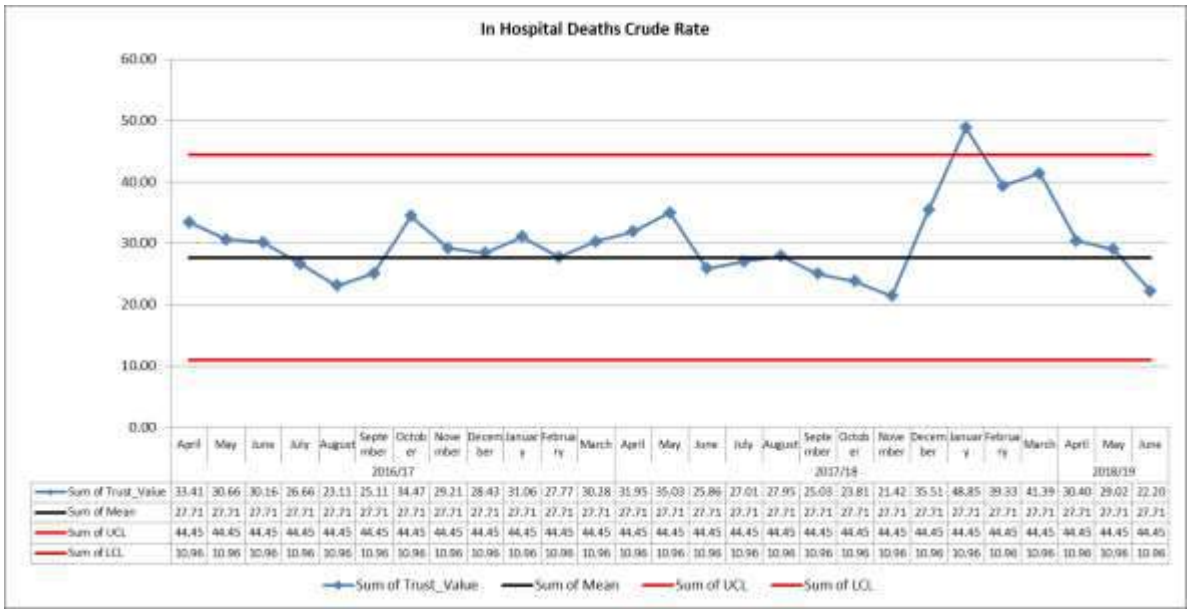
The new clinical pathway for Acute Kidney Injury, as with the new Sepsis Pathway is being rolled out across the Trust by the Critical Care Outreach Team on the Deteriorating Patient Trolleys. Communications about the changes are also being sent out centrally by the Trust Communications Team. How will the compliance to this pathway be monitored.



Acute Kidney Injury

3.3 Crude Mortality:

The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for June 2018 was 22.2 down from 29.09 in May.

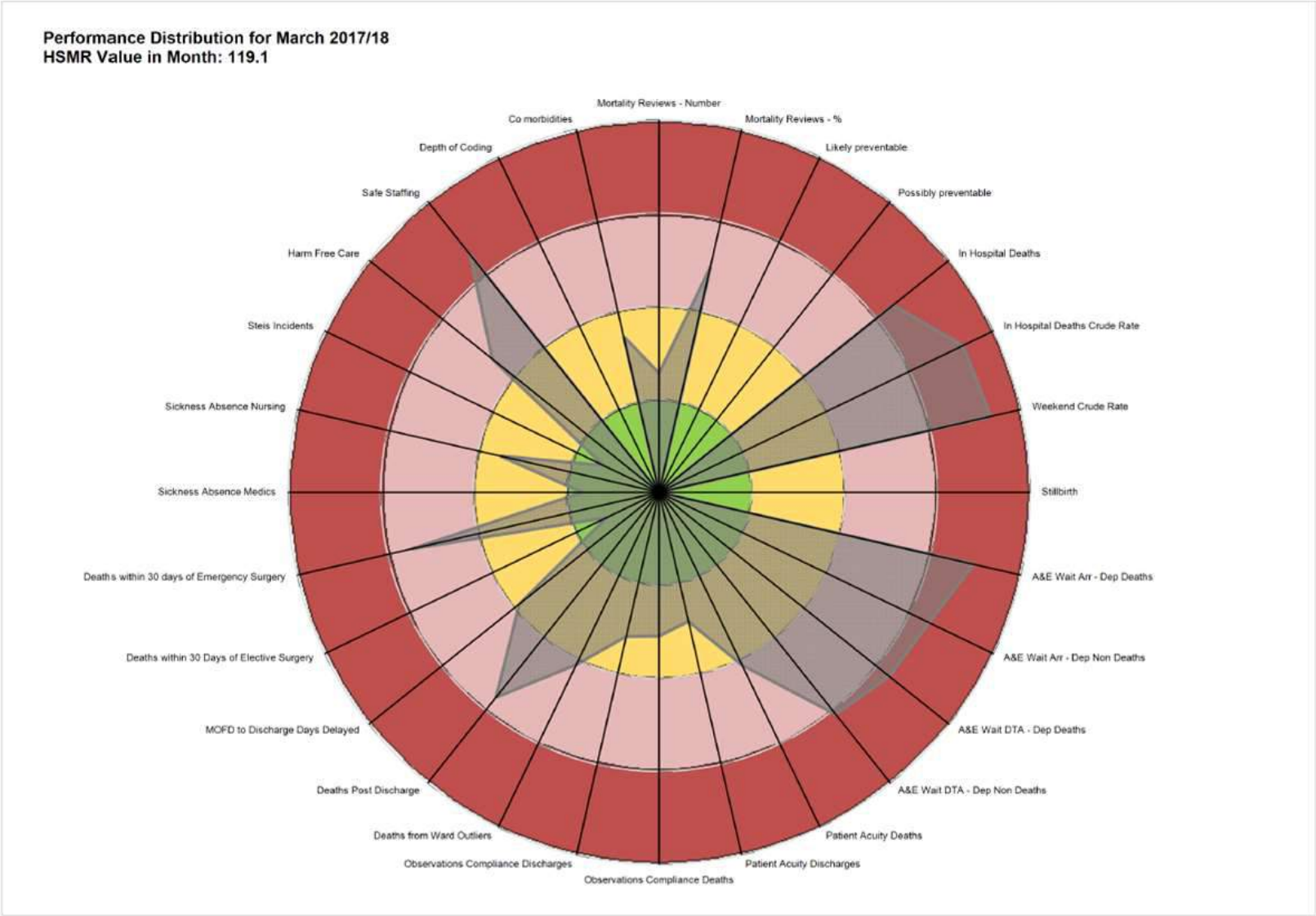


3.4 Performance Distribution – March 2018

The performance distribution radar graph below highlights the areas where performance is falling short against the targets set by the Trust. The main areas of concern (in the red) within this context for the month of March are:

- Safe Staffing
- In hospital deaths (the crude death rate for March was 41.39 deaths per 1,000 admissions).
- A&E waiting times

Performance Distribution for March 2018



4.0 Mortality Dashboard Highlights – June 2018

4.1 There were no preventable deaths reported for June 2018.

4.2 Seven patients whose deaths were recorded in June had been ward outliers during their inpatient stay; this is a significant reduction from the 17 which had been recorded in the month of May 2018.

4.3 Only one learning disability death was reported in June 2018, taking the total for the financial year to date to two. Activity to ensure the integration of the Learning Disabilities Mortality Reviews (as part of the Learning Disabilities Mortality Review programme – LeDeR) with the Structured Judgement Review will commence once the SJR method has been successfully embedded across the Trust.

4.4 95.19% of Urgent Care patients who stayed in the hospital in June received harm free care. (Harm free care is the term given to inpatients who who have not acquired an infection or pressure ulcer during their hospital stay; the data for which is collated against the safety thermometer). Data was not available at the time of reporting for Planned and Specialist Care Clinical Business Units.

4.5 There was only 57.8% compliance for observations recorded for patients who died in June; this has been flagged for investigation through the Mortality Operational Group. It is suspected that this figure is attributable in part to issues with the use of VitalPac Software.

There are two meetings planned with a RAM Project IT subgroup (29th August and 18th September) to discuss best practice use of VitalPac and to resolve this issue. Part of the solution already identified is a more rigid escalation process which will confirm the trigger points at which observations are to commence and the associated frequency at which they are to be checked.

4.6 There were only 0.17% of deaths occurring within 30 days of Elective Surgery and 7.74% Emergency Surgery. The age of those attending for emergency and elective surgery at the Trust is frequently in excess of average life expectancy, but despite this, mortality figures in this area consistently compare well nationally.

4.7 6.5% of deaths occurred in patients who had been in the hospital for less than one day. Further investigation is underway through the Mortality Operational Group to understand whether any of these patients were on the Gold Standard Framework. (The Gold Standard Framework is the scheme for those believed to be in the last year of their life. GFS patients have anticipatory clinical management plans which support their in their place of residence and minimise hospital admissions).

4.8 In June, 50 deaths occurred to patients within 30 days post discharge; of these 14 had been on the Gold Standard Framework at the time of admission with an increase to 27 patients on the GSF at the time of discharge. It is of benefit to the patient, primary and acute health care providers to be placed on the GSF when it is appropriate, in order to ensure the most appropriate care planning and again, to avoid unnecessary hospital admission.

4.9 In June, GSF patients who were discharged from hospital but who subsequently died within 30 days had spent a combined total of 178 days between being confirmed as being Medically Optimised for Discharge (MOFD) to the point of discharge.

4.10 The percentage of episodes of Z515 Palliative Care Coding has increased significantly for a third consecutive month to 23.08%. This improvement is attributable to a greater understanding by the coding team of the variable ways that palliative care is currently recorded and a request to the Specialist Palliative Care Team to adhere to the correct templates and documentation within patient case notes.

5.0 Reducing Avoidable Mortality Project (RAM) – July 2018 Update

5.1 The 24/7 Critical Care Outreach Team

5.1.1 Overview

The current Critical Care Outreach Team provides cover during core hours only; there has long been a need for additional, out of hours cover, in order to provide consistent quality care to deteriorating patients at all times. A business case for an extended team to provide the additionally required cover was approved by the Hospital Board in July.

5.1.2 The Requirement

There has been a proven inconsistency in the management of the deteriorating patient within the Trust, dependent upon the Critical Care Outreach (CCOT) service available at the time of the patient's admission or the time of noted deterioration (the point at which they are noted to have a high Early Warning Score [EWS]). This discrepancy is impacting negatively on the time to recover, length of stay and outcome for those patients who deteriorate out of hours.

There is a clear case for a 24/7 Critical Care Outreach Team to provide consistent care and give assurance that all deteriorating patients are appropriately identified and looked after, regardless of the time of admission or time that they are noted with a high EWS.

A 24/7 CCOT will reduce mortality, ensure the timely identification and appropriate escalation of the deteriorating patient, improve patient flow and length of stay and as a result use of bed capacity and resources.

Serious Incidents and mortality reviews have shown that the existing configuration and staffing levels are not adequate enough to consistently identify and manage the deteriorating patient in a timely and responsive way, leaving the patients and the Trust at risk

5.1.3 The Model

After extensive research and consultation, the proposed 24/7 Critical Care Outreach Team (CCOT) model has been designed to provide the best solution to mitigate this risk and close the existing gaps identified around:

- The timely management of the deteriorating patient 24/7
- The lack of escalation of Early Warning Scores 24/7
- The inadequate capture of patient information onto VitalPac (Electronic Patient Safety System)
- The absence of a culture of proactive escalation
- Management of AKI and sepsis
- Training
- Meeting safe and effective standards of care

The Trust has invested in VitalPAC technology; the system however is not currently being optimised. This is due to both time and workforce constraints which are currently limiting the amount of information that is being input into the system, thereby restricting the effectiveness of reporting and ability to deliver quality improvement. The extended service provision of the CCOT will be support the engagement and utilisation of the system to maximise its use to deliver patient safety.

The expanded team CCOT service will cover the following:

- Management of sepsis ensuring the sepsis pathway is commenced for all patients that fit the initial criteria for sepsis.
- Identification of the deteriorating patient ensuring plan of care decided and documented in medical records.
- Support clinical teams in the management of the 'at risk' / 'deteriorating patient'.
- Management of the patient with AKI.
- Management of tracheostomy patients.
- Follow up of critical care patients following step down to ward.
- Follow up clinic for critical care patients following discharge home at 8 weeks, 6 months and 12 months.
- Attend cardiac arrests.
- Support the use of VitalPAC.
- Training : resuscitation (BLS, ILS, ALS, PLS, APLS), trust induction, RN rolling programme, AIMS, Drs training, SIM, SCITT, tracheostomy, track and trigger (VitalPAC).

The expansion of the CCOT will directly improve compliance for the Trust around the following NICE Guidance:

CG50: Acutely ill adults in hospital: recognising and responding to deterioration.
CG176: Head Injury: assessment and early management.
CG174: Intravenous fluid therapy in adults in hospital.
NG51: Sepsis: recognition, diagnosis and early management.
CG169: Acute Kidney Injury: prevention, detection and management.

The Critical Care Outreach Team is part of Critical Care and as such the routes for medical escalation will follow the same process out of hours as they do within core hours.

5.1.4 Conclusion

The benefits of the service over time will reduce the number of Serious Incidents, STEISs (externally reportable incidents), complaints and litigation which the Trust is currently handling. The implementation of the team will reduce the cost associated with the management of incidents and the expense of clinical negligence claims. Furthermore the service will improve patient flow and reduce the impact of extended length of stay on bed capacity/availability and therefore the Trust's potential to generate income from elective planed admissions.

5.2 Reducing Avoidable Mortality Project – Update by Workstream:

Work Stream	Progress Status
1. Care Pathways To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care & produce evidence to assure quality of delivery by October 2018.	• New Sepsis and AKI pathways have been rewritten and are now available across the Trust in clear, coloured, one sheet guides. They are being rolled out across the Trust the wards by the Critical Care Outreach Team as part of the relaunch of the 'Deteriorating Patient' Trolleys. • The scoping of a new Pneumonia pathway commenced on 13th August with the aim of roll out across the Trust ahead of the winter. • An External Mortality Review of pneumonia and stroke deaths (May 2017- April 2018) was undertaken in June. The final report is to be with the Trust in August 2018 from which an action plan will be created and reported to the November Trust Board.
2. Communication To establish & develop a Communications Hub with ICT infrastructure which supports clear pathways for escalation and staff support to encourage ownership & leadership by December 2018.	• The Safety Hub opened on the Southport Hospital site in June 2018, housing the Critical Care Outreach and Resuscitation Teams. • The ICT enablement of the Hub has been consolidated with multiple reporting modes: 'Bed Meeting', 'Discharge Planning' have been completed, 'Clinical Mode' is under development. • Escalation, Bed and Operational meetings are now taking place in the Hub; the effectiveness of the meetings is to be further developed through QI methodology. • Improved collaborative working between the Transform (palliative care team) and the Critical Care outreach team has been established.
3. Learning Culture To implement the screening of all deaths within 30 days to identify those which require a structured judgement review (within 14 days). Themes of issues in care to be identified & disseminated as learnings for improvement throughout the Trust by August 2018.	• The Trust has worked in collaboration with DATIX to implement the full Structured Judgement Review tool. • In-hospital deaths are now screened with a bespoke Trust 'screening tool' which triggers the requirement for a Structured Judgement Review (July 2018). • A draft process has been mapped to triangulate the findings of the SJR, serious incidents and mortality data for quality improvement. • The project sub-group are working with the Advanced Quality Alliance (AQUA) to implement best practice communication of Learning from Deaths and Learning from Excellence.

Work Stream	Progress Status
4. Future Care Planning To ensure that all patients who are identified as approaching End of Life (Gold Standard Framework) have a plan for appropriate levels of intervention which involves clear communication with the patient, family and all relevant health professionals across boundaries by April 2019.	• Training has been rolled out to doctors to support conversations with families about resuscitation decisions. E-learning module, 'Unified DNACPR Policy' is universally available to staff. • Anticipatory Clinical Management Planning: benchmarking has been linked to findings of ACMP audit which is to be created into a training sessions once documentation has been revised. • Advance Care Planning: training days (provided in collaboration with the North West Coast Learning Collaborative) are now running at Queenscourt Hospice. • Rapid End of Life Transfer: portable oxygen cylinders are now available to be taken home with patients to enable rapid transfer back to the place of residence.
5. Information To prevent robust and clear information to inform both leaders and clinicians across the pathway of consistent morality rates & processes of care by October 2018.	• Mortality data and quarterly Learning from Deaths reports are published to the public through Public Board papers on the Trust website. • A dedicated Mortality webpage provides a link to the papers alongside a brief on mortality and bereavement services. • The Information Team are working in collaboration with both AQUA and Dr Foster to look for opportunities for improvement to increase effective and insightful reporting. • The Mortality reports to the Mortality Operational Group, the Quality and Safety Committee and the Trust Board have been revised twice this year to this end. • SJR data is to be incorporated into reporting into the standard national Learning from Deaths Dashboard.
6. Workforce To establish the proposed workforce to include a tangible 24/7 outreach team to deliver clinical services.	• The business case for the 24/7 Critical Care Outreach Team was successfully approved in July 2018. (The current team covers core hours only). • The full 24/7 team is to be in place as soon as possible, however it is anticipated that the recruitment cycle will take four months from its commencement in the third week of August. • The establishment of a 24/7 service is expected to improve the management of the deteriorating patient, reduce length of stay in turn improve patient flow.

Reducing Mortality Project - Milestones and Risks

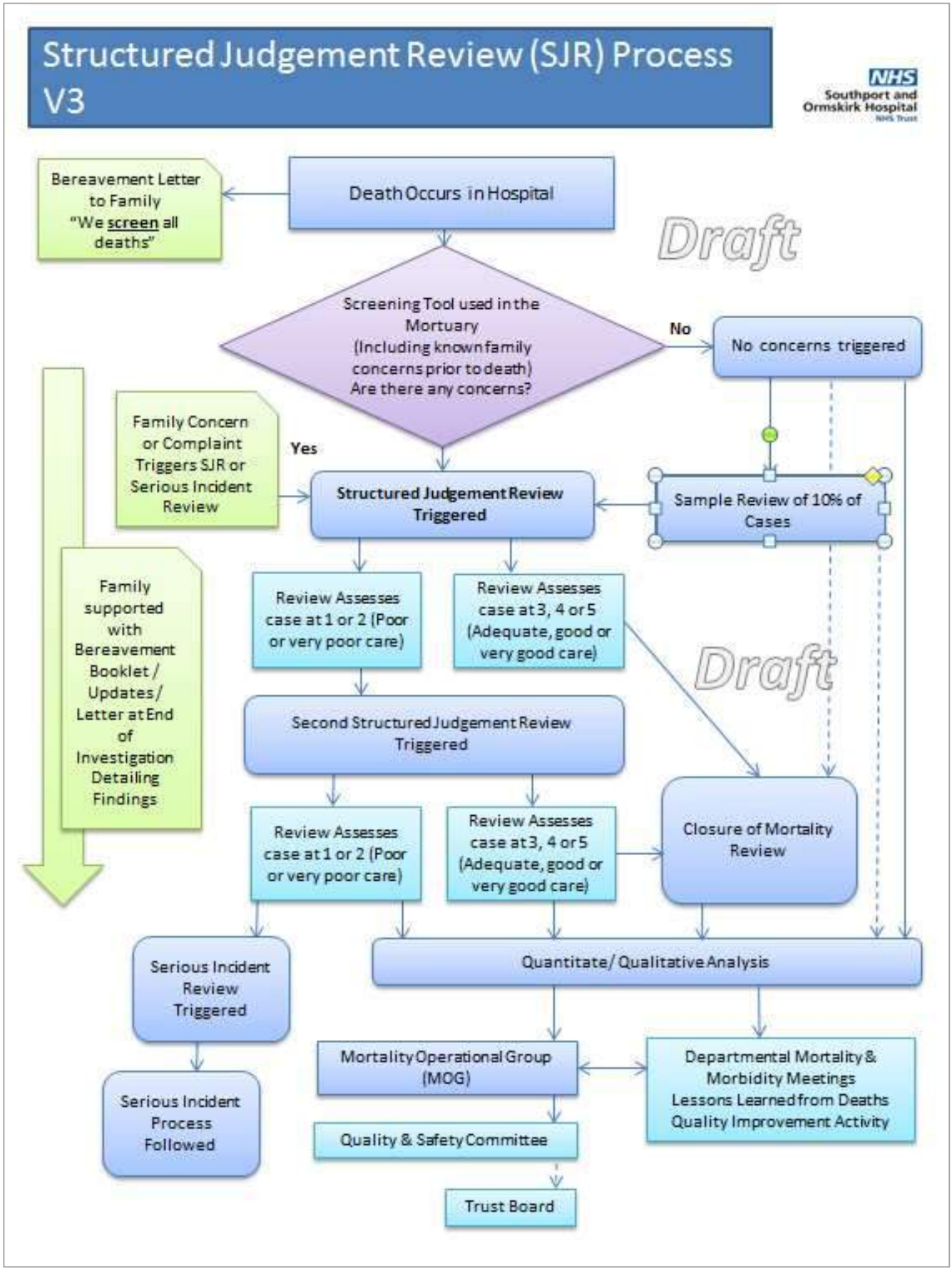
Key Milestones

Key Milestones	Start date	End date	BRAG	Comments
Safety Hub Set Up	10th March 2018	10th March 2018	B	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	30th June 2018	B	Escalation Nursing Meetings, Medical Handover and Bed Meetings are now running in the Hub.
Surgical Assessment Unit Opens (SAAT Project)	14th July 2018	14th July 2018	R	Part of the Safe At All Times Project. The opening has been pushed back from the middle of July to the middle of September.
Go Live of Structured Judgement Review Method	3rd July 2018	3rd July 2018	B	The SJR Method went live a day early on 2nd July.
100% compliant use of SJR Method	3rd July 2018	15th October 2018	A	Current levels of compliance are 38% - communi cation to be sent to medical staff 8th August 2018 requesting adherence to new process
Triangulation of Serious Incident, SJR Outputs & Mortality Data	1st June 2018	30th August 2018	A	The initial processes have been written on the back of the roll out of the SJR method. This is to be picked up as part of the new 'RAM Project Promotions' meetings starting w/c 13th August 2018.
Go Live Lessons Learned and Learning from Excellence	1st June 2018	29th September 2018	A	Liaising with AQUA to use best practice. The requirement for LfD communication is being scoped into the existing process planning. A PDSA approach and Comms Plan are now required. This is to be picked up as part of the new 'RAM Project Promotions' meetings starting w/c 13th August 2018. Contact with AQUA required for next meeting.
Joint Working Transform Palliative Care and Outreach Team	2nd July 2018	30th August 2018	B	This is nowbusiness as usual
24/7 Outreach Team	1st March 2018	30th September 2018	G	The Business Case has been approved. The recruitment process for November start dates has commenced.

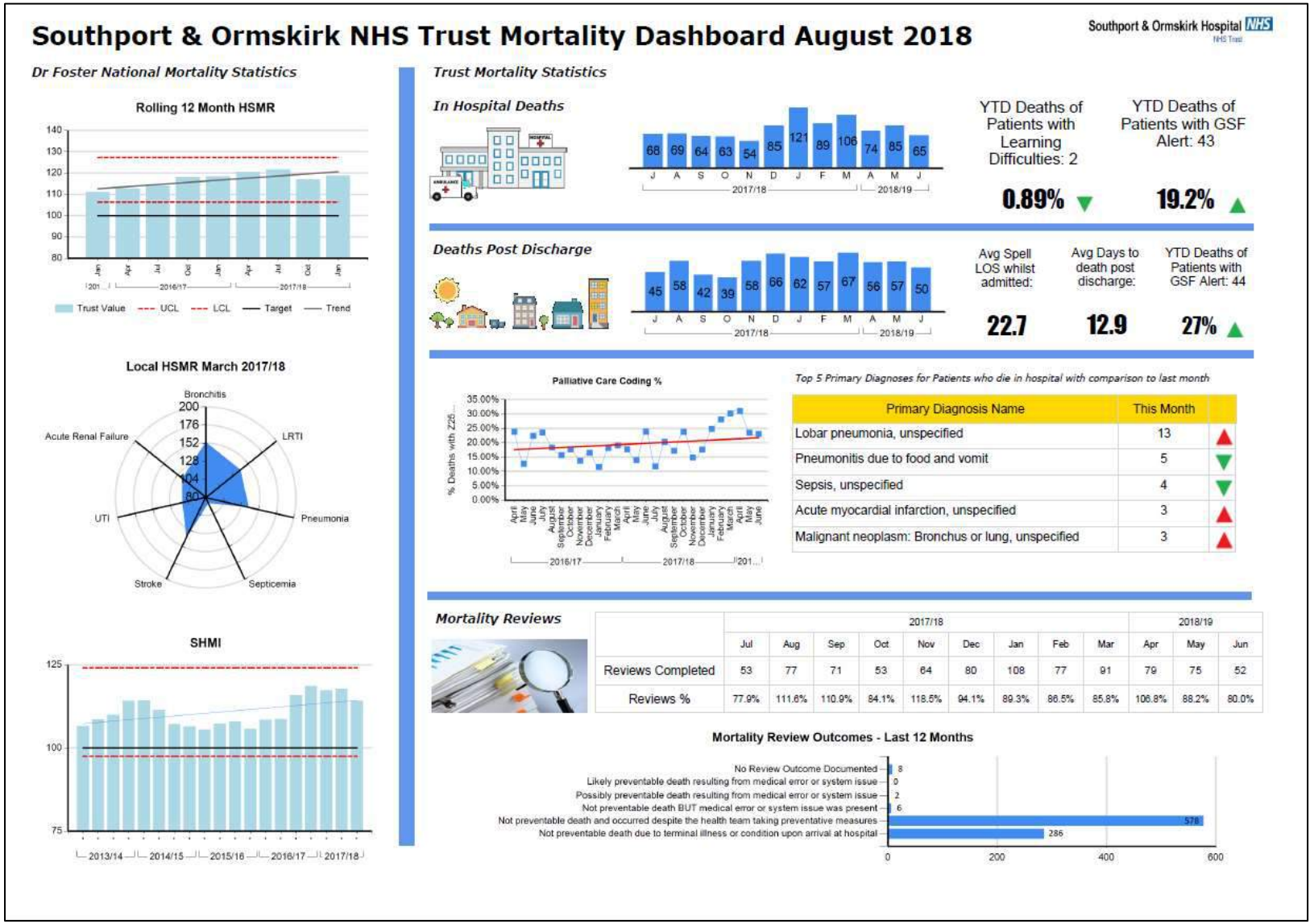
Top Risks and issues to achieving programme objectives

Risk	RAG	Mitigation Activity	RAG After Mitigation	Comments
The timely recruitment of the full 24/7 Critical Care Outreach Team	R	Joyce Jordan to consult Carol Fowler (Workforce) and the relevant HR Manager to expedite requirements and navigate any systemic blockages encountered.	A	Issues impacting on ability to recruit to be escalated immediately as the timeframe for November (start date) is already tight.
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.	A	This has been added to the agenda for the Communications/IT workstream meeting September 2018. There is a pre-meet on 8th August 2018 with Information Governance. Embedding activity is to be incorporated into the new "RAM Project Promotions" subgroup, meeting w/c 13th August 2018.	G	Since originally raised as a risk, work has been ongoing to look at improved reporting; this along with the Hub meetings is driving a culture to use Medway. Further support will come as processes are rolled out. .
If clinical staff cannot be released for training then pathway education will not be embedded and objectives will not be achieved.	A	The key to this issue is staffing levels and doctor's rotas which are being dealt with outside of the RAM project.	G	Training funding is also an issue which is to be addressed in the same forum.
Funding resource for the CareFlow System	G	On IM&T Annual Funding Plan	G	The roll out of VitalPac versions 3.5 and 3.6 are currently being delivered on time which will also deliver NEWS2 and the modules for AKI and Sepsis.

Appendix 1 – Structured Judgement Review Process

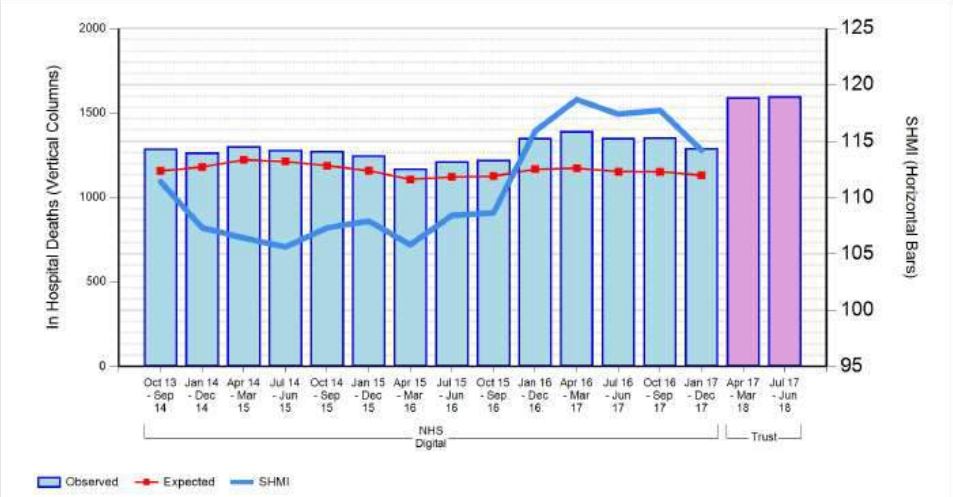


Appendix 2 – Highlights from the Trust Mortality Dashboard August 2018



SHMI Breakdown

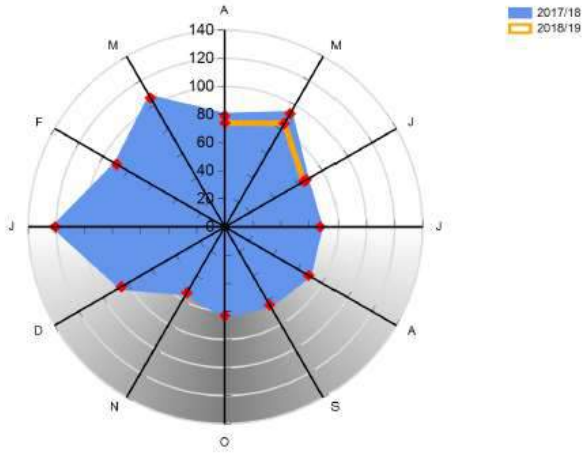
Southport & Ormskirk Hospital NHS



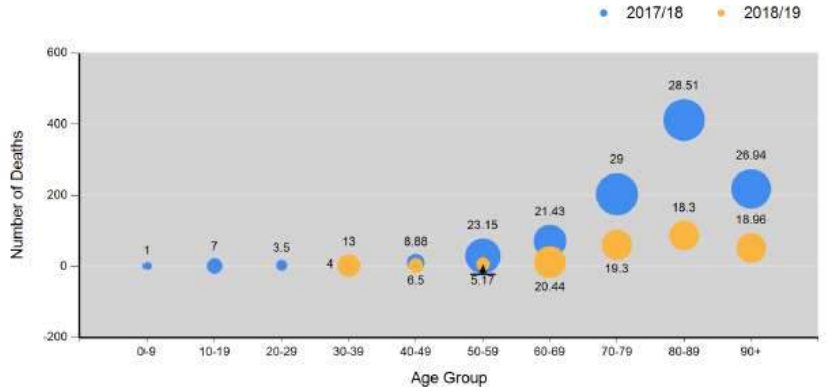
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

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

In Hospital Deaths Seasonality Distribution



In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



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

5 September 2018

Agenda Item	**TB210/18**	**Report Title**	**Nurse Safe Staffing**
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 X To Receive	

Executive Summary

The purpose of this report is to provide the Trust Board with the current position of nursing staffing in line with National Quality Board and National Institute of Health & Care Excellence guidance.

This report advises on the future work to confirm a baseline establishment through Safe Nursing Care Tool audit and professional judgement.

The board is advised the current nurse staffing risk reports as High (12) via the risk register (ID1368). Following the aforementioned activities this risk will be further reviewed.

For the month of July 2018 the trust reports safe staffing against the national average at 90:43%. This is the first time national average has been reported since November 2017.

Strategic Objective(s) and Principal Risks(s)

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

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

Linked to Regulation & Governance *(the report supports …..)*	
CQC KLOEs ☐ Caring ☐ Effective ☐ Responsive ☐ Safe ☐ Well Led	**GOVERNANCE** X Statutory Requirement • Annual Business Plan Priority ☐ Best Practice ☐ Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
☐ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal X Quality & Safety X Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
To receive this report as assurance and support its presentation to BOD	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

1.0 Introduction

The purpose of this report is to provide a summary of the current nurse staffing in line with National Quality Board (NQB) and National Institute of Health & Care Excellence (NICE) guidance.

2.0 Background

In 2013 The National Quality Board[1] (NQB) issued guidance relating to the optimisation of staffing capacity and capability for Registered Nurses and Nursing Assistants. The Care Quality Commission and NHS England have subsequently produced additional guidance on the delivery of publishing staffing data as part of a 'Hard Truths Commitments' paper[2] (March 2014)

In addition, the Department of Health and NHS England commissioned the National Institute of Health and Care Excellence (NICE) to develop evidence based guidelines on safe staffing, with a particular focus on nurse staffing[3]. The guidance was published in July 2014 and makes recommendations for safe staffing for nursing in adult inpatient wards in acute hospitals. The guideline identifies the organisational and managerial factors that are required to support safe staffing for nursing

It is clear from these papers that Trust Boards are expected to take full responsibility for the quality of care provided to patients and, as a key determinant of quality; take full responsibility for nurse/midwife staffing capacity and capability.

In July 2016 the National Quality Board[4] (NQB) published guidance that led on from the Carter report[5] promoting an improvement in workforce efficiency that beneficial for patient care. The NQB report[4] focuses on 'right care, doing the right thing, first time; Minimising avoidable harm, a relentless focus on quality; and maximising the value of available resources, providing high quality care to everyone who uses the healthcare'. The NQB framework provides guidance on delivering the right staff, with the right skill, in the right place at the right time.

In light of national guidance Trust Boards should be:

- Managing nurse staffing capacity and capability by agreeing staffing establishments
- Considering the impact of wider initiatives (such as cost improvement plans) on staffing
- Monitoring staffing (nurse) capacity and capability through regular and frequent reports on the actual staff on duty on a shift by shift basis versus planned staffing levels
- Examining trends in the context of key quality and outcome measures
- Asking about the recruitment, training, skills and experience, and management of nurses, and giving authority to the Director of Nursing & Director of Organisational Development to oversee and report on this at Trust Board level

3.0 Historical Nurse Staffing Establishment Reviews

To support the recommended establishment reviews Southport and Ormskirk Hospital NHS Trust have historically undertaken bi-annual patient acuity and dependency studies. Previous establishment reviews have taken place in October 2015 and October 2017. Therefore a comprehensive staffing review will commence in October 2018 which will, in accordance to NQB guidance[4], include systematic review of all inpatient ward areas using formalised methodologies and professional judgement. The methodology used will be Safer Nursing Care Tool (SNCT) which determines nurse staff requirements based on the acuity and dependency of patients. As the Trust has already implemented 'SafeCare' the SNCT will triangulate with SafeCare to provide an over-arching establishment review.

3.1 Allowances for planned and unplanned leave

Key to establishing safe staffing levels is a comprehensive understanding of all ward establishments and allowances for planned and unplanned leave. The current position with regard to establishment uplift is as follows:

- There is an overall 22.5% uplift. This is added to the budget of every ward/department covering the base establishment and including cover for annual, sick and study leave
- Of this, 15 % is allocated for Annual Leave, 7.5% is allocated for sickness and study leave.

4.0 Safe Nurse Staffing

Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts[6] (NHS Improvement, June, 2018) :This publication by NHS Improvement clarifies that from September 2018 the Trust monthly CHPPD data will be published at a trust and ward level on 'My NHS & NHS Choices'. This will replace the current data submission process on Unify. The publication of this data is in line with leading Change, Adding value (NHS England 2016) to 'have the right staff in the right places and at the right time' to achieve the triple aim of better outcomes, better patient and staff experiences and better use of resources.

The Board is advised that the Trust continues to comply with the requirements to upload and publish the aggregated monthly average nursing and care assistant staffing data for inpatient areas. Average shift fill rates identify the actual staffing levels in place against what was planned. Currently the Trust is using healthroster when submitting the national nurse staffing return. In the future the data will be generated from healthroster and all of the NHSP data which currently is not consistently being captured.

- **Trust overall % fill rate July 2018= 90.40%**
- 83.61% Registered Nurses on days
- 87.89% Registered Nurses on nights
- 97.07% Care staff on days
- 102.97% Care staff on nights

4.1 Red flagged incidents:

In line with NQB report[4] the nurse staffing red flags are currently reported via the Datix system. With the implementation of the daily Incident Review & daily Safe Staffing Meeting the incidents will be reviewed. This change in methodology is designed to support the nurse in charge of a shift to assess systematically that the available nursing staff for each shift, or at least each 24hour period, is adequate to meet the actual nursing needs of patients on that ward. This change would then support an immediate response by the registered nurse in charge of the ward to take the required and appropriate actions to the allocation or redeployment of additional nursing staff to the wards. These issues would then be reviewed and action logged by the matron and Head of Nursing at the daily nurse staffing safety briefs.

Red flag indicators are currently being reviewed in safecare to support this change and ensure timely response. Training plans and a role out milestone trajectory will support this. All ward areas will commence reporting red flags alongside patient acuity data during September 2018.

In addition the Trust keeps records of the on-the-day assessments of actual nursing staffing requirements so that these can be used to inform future planning of ward nursing establishment levels.

5.0 External support to review Safe Nurse Staffing

5.1 NHS Improvement Support

Earlier this year the Trust invited the Clinical Workforce Lead from NHS Improvement to assist in the diagnostic work to understand the challenges facing the trust. Verbal feedback from NHSI advised that the ward staff were not accurately interpreting the tool during this census period and strongly recommended training and assessment be provided for the staff supported by NHSI in the first instance but which the Trust would then take on to roll out across the whole Trust. This work is in progress and will be linked to the Establishment Review process.

5.2 Insight report (Allocate- Healthroster)

Allocate have also undertaken a recent baseline assessment of the Trust roster performance and identified areas for further improvement.

- Full functionality of Healthroster not being utilised by ward staff
- Proactively managing the 'net hours'
- High vacancy factor in comparison to our peers

6.0 Current Nurse Vacancy Position

Currently the Trust has a vacancy of 12.28% (104.02 wte) for registered nurses at band 5 and above and 10.32% (38.47wte) for healthcare assistants, based on July 2018 funded establishment versus contracted. Therefore, the development of a workforce plan for the next 2 years is fundamental to maintain and improvement the standard of care for our patients and the experience of our nursing workforce working at the Trust. This will be in two parts focusing on recruitment & retention of staff.

6.1 Recruitment Position

Domestic recruitment has not been as effective as other organisations in the regional therefore is a priority for the Trust. Recruitment fairs have been hosted on the Southport site and a recent event took place at the end of July 2018, which was well attended. These events will take place on a monthly. The Trust plans to visit Ireland in October 2018 and March 2019 to support nurse recruitment. As part of the recruitment campaign the Trust has increased its engagement of social media feeds to support recruitment and raising awareness of opportunities the trust has to offer. External events are being utilised to support every opportunity and the trust recently engaged with the armed forces week and the Southport Flower Show. The Trust is also supporting a recruitment stand at the Trust Open Day in September 2018 which will allow staff to be recruited through a 'one-stop-shop' principle.

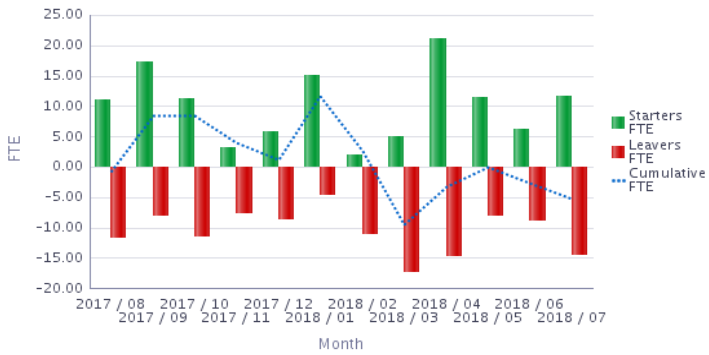
The Trust currently has no overseas recruitment activity planned. As part of the recruitment strategies and plan to reduce vacancy and the use of temporary workforce the Trust nursing workforce lead is seeking out overseas recruitment opportunities and costings via the Trusts HR recruitment leads inclusive of opportunities with NHS Professionals. These opportunities will be for consideration to Trust Board in the future.

The Trust continues to work closely with University of Central Lancashire (UCLAN) and Edgehill University to review placement uptake and the Trusts capacity to host pre-registration nursing students. The Trust has pro-actively increased its placement capacity for undergraduate nurses with UCLAN to enable the number of local graduating nurses to be recruited by the Trust.

The community engagement lead role remains funded for 2018-19 via Health Education England with this role giving further exposure to the Trust for engaging with new employees, pre-employment programmes and attending multiple regional careers fairs.

6.2 Retention Progress

Recruitment and retention of staff are closely linked. The graph below demonstrates that the organisation has successfully recruited 138wte staff into band 2-5 roles however, over the same period 147wte have left the Trust.



The Trust has recently contributed to NHS Improvement national retention programme. This focused programme assists organisations with the development and implementation of improvement measures to support nurse retention, through the application of guidance and good practice. Areas of focus for the Trusts are:

- Understanding the reasons for staff leaving the Trust

- Further work on the retention of experienced and long service staff
- Career progression opportunities for the Band 5 workforce
- Development of competency frameworks/matrix for all nursing roles
- Develop mechanisms to support transfers between departments

The draft plan was delivered to NHSI on 4th August 2018 for feedback and final 'sign-off' of the retention plan is planned 27th September 2018 at the Service Improvement Board with NHSI and CCG's.

7.0 Modernising the Workforce

The organisation continues to consider to development the workforce in line with national guidance and service improvements.

Nursing Associates:

Southport and Ormskirk Hospital NHS Trust remains part of Health Education England's (HEE) National Nursing Associate (NAs) pilot scheme. The Trust is currently supporting its 3rd cohort and is to upscale its current project and train an additional 6 Nursing Associates from July 2018.

Apprenticeship Levy:

The Trusts vacancy control panel fully supports the consideration of apprenticeship opportunities and has adapted its paperwork to support this. Alignment to the apprenticeship levy via nursing routes is becoming embedded within the organisation and monitored going forward. Band 2, 3 and 4 healthcare assistant job descriptions have been reviewed and support apprenticeship opportunities at the point of advert. The band 5 job description is planned to follow this process.

Acorn Students: This is a 2 year Health & Social Care extended diploma at Southport College with placements provided within the Trust. The Trust continues to celebrate the successes of the program.

Advanced Clinical Practitioner: The Trust has also increased the number of Advanced Clinical Practitioners (ACP) roles to support innovations and modernisation of the clinical workforce.

8.0 Quality Metrics:

The following table summarises the Safety Thermometer of achievement for harm free care delivered by the Trust per clinical business unit April – July 2018. This data will be used as part of the triangulation of nursing metrics within the Nurse Staffing Establishment review.

Division	Apr-18	May-18	Jun-18	
Planned Care	98.48%	99.26%	93.53%	93.3%
Urgent Care	97.93%	97.88%	96.17%	96.2%
Trust	**98.12%**	**98.38%**	**95.18%**	**95.1%**

9.0 Financial position:

The current financial position of nurse expenditure is projecting a year end forecast that is higher than planned (£691,000) appendix 1. Agency demand for Registered Nurses needs to continually reduce; both from a patient safety and variable pay spend perspective. However, the Trust has observed a decrease within the substantive nursing workforce, therefore continued to utilise agency nurses to support safe staffing levels in the absence of sufficient substantive supply.

Anecdotally it is believed that due to the changes of patient acuity & dependency in many of the wards the current staffing establishment does not reflect patient clinical needs of nursing care. However, to maintain minimal safe staffing additional staff are utilized on a daily basis to meet these needs. Therefore, the current budgets need to be revised as part of the future nurse staffing establishment review.

There are also additional beds opened to support the escalation of capacity that are currently not funded within the staffing establishment.

10.0 Conclusion:

The Trust has not undertaken a nurse staffing review in line with various NQB and NICE guidance for a number of years therefore the Trust Board is asked to support the commencement of this review in October 2018. The review will align the current establishments, the healthroster data and the SNCT acuity & dependency data to provide an overview of the nurse staffing reuqirements for the Trust.

The Trust Board is asked to support the on-going recruitment & retention programmes that will promote the Trust as an employer of choice across the region and enable the Trust to reduce the use of agency staff.

References:

1. The National Quality Board (2013) - How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time http://www.england.nhs.uk/.pdf
2. Hard Truths Commitments Regarding the Publishing of Staffing Data (2014) http://www.england.nhs.uk.pdf
3. National Institute for Health and Care Excellence (NICE 2014) - Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals http://www.nice.org.uk/guidance/sg1
4. National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – July 2016
5. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (Carter report) – 2016
6. NHS Improvement - Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts, June, 2018

Appendix 1
Nursing Expenditure April 2018 to July 2018

Nursing, Midwifery & HCA Pay Expenditure	2018/19 Actual Expenditure				2018/19 Forecast expenditure								
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	F'cast Year End
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Substantive Pay	3445	3480	3527	3536	3933	3532	3532	3532	3532	3594	3532	3,532	42,707
Bank	482	522	496	494	494	580	500	500	500	500	500	500	6,068
Agency	137	181	156	191	220	200	220	200	200	250	250	250	2,455
Additional Basic Pay	34	19	18	23	23	23	23	23	23	23	23	23	278
Overtime	51	30	22	29	33	33	33	33	33	33	33	33	396
Total Nursing Expenditure	4,149	4,232	4,219	4,273	4,703	4,368	4,308	4,288	4,288	4,400	4,338	4,338	51,904
Planned v Expenditure	4164	4199	4120	4262	4636	4315	4297	4196	4197	4371	4251	4205	51,213
Variance	15	(33)	(99)	(11)	(67)	(53)	(11)	(92)	(91)	(29)	(87)	(133)	(691)

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

5th September 2018

Agenda Item (Ref):	**TB211/18**	**Report Title:**	**Guardian of Safe Working Report to Board 22/04/18-21/08/18**
Executive Lead	Dr Jugnu Mahajan, Interim Medical Director		
Lead Officer	Dr Ruth Chapman, Guardian of Safe Working,		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Key Messages of this Report & Recommendations:

Need for Clinical Fellows in Medicine to provide stable ward based workforce

Implementation of New F2/CT Rota in Surgery and T & O to significantly reduce unfilled shifts

Significant Reduction in Exception Reports for the last quarter

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

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

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

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

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

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

Southport and Ormskirk Hospital NHS Trust

THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT 22nd April – 22st August 2018

Introduction

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

1. EXCEPTION REPORT OVERVIEW (22nd April – 31st July 2018)

	26/07-19/10/17	20/10/17 - 22/01/18	23/01-22/04/18	22/04-31/07/18
Exception Reports ERs	19	95	74	13+2*
Completed ERs	17/19	65/95	32/74	1/15
Trainees	9	15	14	7
Episodes	27	103	104	19
Review Interview Held	19/19	95/95	64/74	12/15
A&E	0	0	0	0
Medicine	15	88	65	9+2*
Surgery	2	3	2	2
Orthopaedics	2	2	0	0
Anaesthetics	0	0	0	0
Ophthalmology	0	0	0	0
Paediatrics	0	2	7	0
Obs & Gynae	0	0	0	0
GP	0	0	0	2

2* Not Exception Reports

See Appendix A for Exception Report Breakdown

Each Assistant Medical Director and Clinical Director receives a monthly overview report. At Workforce Sub–Committee in July, it was suggested departmental managers would also benefit from these reports.

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

There are significant numbers of Exception Reports not signed off as completed by the trainees. I consider the important element of the process is the Review Meeting and agreed outcome between the trainee and supervisor. This has occurred for the majority of Exception Reports. Changes involving rostering monitoring and payment should improve trainee completion rate.

Action: Add Departmental Managers to Exception Report Overview distribution list.

Action: Trainees are still being given payment in most instances. From 1st August TOIL will be considered as first option.

Action: Monitor new arrangements for improvement in completion rates

2. MEDICINE

Deputy Medical Director, GOSW, Assistant Medical Director and Clinical Director for Medicine have drawn up a staffing template for all Medical Wards. 5 SAS doctors have been offered posts and are awaiting full documentation before a commencement date is agreed.

It was decided that until Physician Associates were licenced to prescribe, this role would have limited usefulness on Medical wards. The Clinical Director in Medicine has written a Business Case for 12 Clinical Fellows who will work on the Medical wards alongside F1, F2 and CT doctors. New trainees in Medicine have already reported dissatisfaction with ward support. In particular changeover day saw a number of F1s working without close supervision.

Clinical Fellows would provide stable and experienced ward based staff during changeover. On a day to day basis they will ensure greater support of trainees, quicker patient review by more experienced staff, on call coverage and also allow trainees more time to attend education opportunities.

Phlebotomy are recruiting staff to cover unfilled posts and have re-organised phlebotomy cover. However there is a need to significantly increase the workforce to match demand. Pathology managers from Whiston are preparing a Briefing Paper to address this shortfall of at least 20%.

3. PAYMENT AND FINES

Payment for TOIL generated from Exception Reports from 1st August 2017 to 30th June 2018 is £1,723.80.

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

Action: ***GOSW to present Exception and Fine costs quarterly***

4. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

The GOSW is keen to stabilise the medical workforce by employing more substantive doctors. This means SOHT are less reliant on trainees for service provision. This is advantageous in that SOHT do not have control over the number of trainees allocated and there are often last minute changes. It will also ensure a better working environment and educational opportunities for trainees.

A SOP Covering Unfilled Trainee Doctor Shifts has been written and is with Workforce Committee.

5. DOCTORS NOT ON THE NEW CONTRACT

Medical Staffing identified the 10 doctors not on 2016 contract in the last quarter. No concerns about safe working from non-trainee doctors have been escalated to the GOSW.
Medical HR will identify any trainees not on 2016 contract quarterly and GOSW will continue to monitor these trainees

6. DOUBLE/TRIPLE BLEEP CARRYING

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

Unfilled shifts in Surgery have led to Double Bleep carrying on 5 partial shifts. There was also a night shift when an F1 in Medicine carried the Bleeps for both Medicine and Surgery. See 10.2. However on occasions the same shift has been refilled 4 times because locums have taken shifts elsewhere citing the reason as higher pay at other hospitals.

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

7. VACANCIES (as of 1st August 2018)

See Appendix B

8. MIAA REPORT

The Mersey Internal Audit Agency Report on Junior Doctors Contracts was positively rated as Significant Assurance. A SOP for the Exception Reports dealing with safety issues, processing overtime payments resulting from exception reports and training has been written.
Terms of Reference for the Trainee Doctors' Forum have been written. They are awaiting ratification by Workforce Committee.

9. TRAINEE CONCERNS

The Trainee Doctor Forum continues to meet monthly. Trainee attendance remains low, but trainee representatives raise concerns forwarded to them. Clinical pressures are still given as the main cause of non-attendance. Although TDF time is protected there is no one else to do the trainees' work whilst they are away from their clinical duties. From August a change of day is being trialled to see if this improves attendance. A Skype link to Ormskirk has also been organised.

Trainees continue to email their concerns to the GOSW.

Datix Reports involving trainees are sent to GOSW and relevant ones are discussed at TDF.

10.1 Medicine

Bank holiday staffing for the 2 May bank holidays was the same as week end staffing. Changes have been made to ensure Bank holiday staffing is the same as week-ends going forward.

F1s have highlighted lack of support on some Medical wards at August changeover. See 2

Concerns continue to be raised by trainees about opportunities to attend clinics as part of training.

ACTION*: Monitor employment of more staff and effect on excessive workloads*
ACTION: *Medical Education Department to monitor training clinic attendance*
ACTION*: DME and AMD to look at how attendance at teaching and clinics could be protected such as looking at taking doctors out of clinical activity during dedicated training time*

10.2 Surgery

Staffing levels in Surgery and Trauma and Orthopedics are a significant cause for concern. F1 rota had to be changed after schedules had been sent out, because Two Psychiatry F1s were taken off the 11 doctor F1 surgery on call rota, by the Deanery, at short notice resulting in unfilled shifts over the last 3 months. From 20th August the F1 rota will run as a 9 doctor rota.

There have also been gaps in the F2/CT and Registrar rotas. This has resulted in episodes of Double Bleep carrying see 6.

ACTION: *GOSW and EMD will continue to monitor Surgery and T & O shifts closely.*
ACTION: *GOSW and Assistant Medical Director are looking at re-organisation at F2/CT level to provide a service which is not locum dependant*

10.3 GP

One of the trainees had been working outside their schedule at a GP practice. This occurred because a satellite clinic finishes an hour later than the trainee finishing time. Apparently this had been happening all year but an ER was not submitted until July. The GP practice was immediately contacted and the GOSW has received assurance the trainees starting in August will not be expected to stay after scheduled hours.

ACTION: *Medical HR to contact 2 GP trainees at this practice from August and ensure hours reflect their schedule*

10.4 Facilities

Longstanding concerns have been raised by trainees about inadequate mess facilities in Southport. A review of space and accommodation usage has identified an extension to

enlarge the mess. The whole mess will then be refurbished with improved computer facilities. Work should start the 17th September and take 3 weeks.

Ormskirk Mess facilities do not have a working microwave or fridge and the room can be accessed by the public. Urgent upgrade needs to occur.

Poor wifi necessitates trainees occasionally using their own phones for clinical tasks which looks unprofessional. IT systems upgrade would be necessary.

ACTION *GOSW to monitor Southport mess extension and refurbishment*
ACTION: *GOSW to investigate upgrade of Ormskirk Mess*
ACTION IT to upgrade wifi

10. ADDITIONAL GOSW CONCERNS

GMC training survey showed an overall reduction in satisfaction. There was a significant decline in satisfaction in A & E trainees despite receiving no Exception Reports from trainees. Trauma and Orthopaedics and Paediatrics are also National outliers. However in Paediatrics there has been almost a doubling of satisfaction compared to 2017. DME is meeting each department and will feed back to the EMD and GOSW.

Medical HR encouraged trainees to apply for holidays in advance of starting to try and spread leave allocation more evenly, however decision on leave requests are not being actioned.

ACTION: EMD will use Medical Survey results to further target resources to areas identified.
ACTION: *GOSW will contact Operational Service Managers about timely response to leave requests*

11. DOCTORS REQUIRING ADDITIONAL SUPPORT

These trainees left at the end of July having successfully completed the year.

12. ID BADGES

Despite regular meetings with the Task and finish group there was no Smart card support available at August Induction. However further investigation has shown many trainees do not require Smart cards. IT support is required prior to Induction day lectures.

ACTION: *GOSW to identify who requires smart cards and Medical HR will rationalise production for future induction*
ACTION: *IT support from 8am on future Induction Days*

13. GOSW ROLE

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

Additional work supporting implementation of a more stable and resilient workforce particularly in Medicine, Surgery and T & O has been agreed by the CEO and EMD.

GOSW does not have the facility to make changes to the GOSW Dashboard. All actions have to be facilitated by Healthmedics team in addition to their significant workload.

Action: ***EMD to review extra hours on a monthly basis.***
ACTION: ***GOSW to explore administration permission which would allow direct alteration of the GOSW Dashboard***

Dr Ruth Chapman
Guardian of Safe Working
22nd August 2018

Appendix A

EXCEPTION REPORT OVERVIEW (22nd April – 31st July 2018)

Exception Reports

13 +2* by 7 trainees
9 + 2* Medicine
2 Surgery
2 GP
3/15 Completed on system
17 + 2* Episodes

*Not Exception Reports

Exception Episodes

Medicine

9 Episodes
9 Extra Hours Episodes
0 Training Episodes
0 Service Support

Extra Hours

0/9 Episodes Completed
6/9 Episode interviews have taken place
3/9 Episode Interviews within 7 days*
6/6 Awaiting trainee sign off
9.50 Extra hours worked
1.00 hours TOIL agreed
8.50 hours Overtime pay agreed
3 Episodes overdue
0-21 days overdue

Training 0

Service Support 0

Surgery

2 Episodes
2 Service Support

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

GP

5 Episodes
5 Extra Hours

Extra hours

5/5 Episodes completed
5/5 Episode interviews have taken place
1/5 Episode Interviews within 7 days
5/5 Awaiting trainee sign off

4.50 Extra hours worked
0.00 hours TOIL agreed
4.00 hours Overtime pay agreed
0.00
0 Episodes overdue

Appendix B

VACANCIES AS OF 1st AUGUST 2018

AED

Consultant	6 vacancies in 11 posts (3 locums in post) (1 SAS acting up)
SAS	3.5 vacancies in 10 posts
>ST3	0 vacancies in 2 posts
FY2 – ST2	0 vacancies in 9 posts
Clinical fellow	1 vacancy in 4 posts
FY1	0 vacancies in 2 posts

Anaesthetics

Consultant	4 vacancies in 20 posts (1 locum in post)
SAS	2 vacancy in 16 posts
ST3	1 vacancies in 3 posts
FY2 – ST2	1 vacancy in 8 posts (X2 CT not on on-call rota)

Dermatology

Consultant	0 vacancies in 2 posts (2 locums in post)
SAS	2 vacancies in 4 posts

GP Practice

FY2 – ST2	1 vacancy in 9 posts

Haematology

SAS	0 vacancies in 1 post

MFU Medical Staff

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

Medicine

Consultant	6.6 vacancies in 20 posts (4 locums in post) 2 vacancies in 11 person rota (2 locums in post)
SAS	1 vacancy in 5 posts (1 locum in post) Further 5 SAS doctors being appointed for rotation across medical wards
ST3 and above	1 vacancy in 10 posts (1 on Parental leave) (1 locum in post)
FY2 – ST2	2.4 vacancies in 16 posts (1 on Parental leave) (2 part-time)
FY1	0 vacancies in 16 posts

Obstetrics and Gynaecology

Consultant	1 vacancies in 13 posts (2 locums in post)
>ST3	4 vacancy in 8 posts (1 on parental leave)
FY2 – ST2	0 vacancies in 8 posts

Ophthalmology

Consultant	0.4 vacancies in 3 posts (1 locum in post)
SAS	0 vacancies in 5.7 posts
ST1-7	0 vacancies in 1 posts

Orthopaedics

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

Paediatrics A&E

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

Paediatrics

Consultant	0 vacancies in 8 posts
SAS	0 vacancies in 3 posts
ST3	0 vacancies in 4 posts
FY2 – ST2	0 vacancies in 8 posts
FY1	0 vacancies in 1 post

Psychiatry

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

Sexual Health

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

Spinal Injuries

Consultant	0 vacancies in 3 posts
SAS	0 vacancies in 3 posts
ST3	0 vacancies in 2 posts
FY2 – ST2	0 vacancies in 2 posts

General Surgery

Consultant	0 vacancies in 7 posts
SAS	2 vacancies in 6 posts
ST3	2 vacancies in 5 posts (2 Locum in post)
FY2 – ST2	3 vacancies in 9 posts (1Locum in post)
FY1*	0 vacancies in 5 posts

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

Urology

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

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

NHS
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GOSW February 18 Trust Board Report Action Log

Matters Arising Action Log

May, 2018

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Owner	Original Deadline	Forecast Completion	Status Outcomes	Status
GOSW Nov Tr	Nov-17	Exception Report training	GOSW to ensure more user-friendly e-Exception reporting training as part of Induction August 2018. Education department have arranged more user friendly Exception Report training as part of induction and an extended time slot for GOSW	GOSW	Aug-18	Aug-18	Feedback from February and August Induction was positive Extended Exception Reporting Presentation to be given as part of F1 teaching programme in September	BLUE
GOSW Nov Trust Board Report	Nov-17	Exception Report Completion	Changes to ER process to ensure TOIL and payment only occur if trainee signs off report.	GOSW	Feb-18	ongoing	Over the last 12 months 188/204 Exception Epiode Review meeting occurred, however only 115/204 have been signed off as completed	AMBER
GOSW Nov Trust Board Report	Nov-17	Payment System for Exception Reports and Fines	GOSW, HR and Finance to organise a suitable system. GOSW to present Exception and Fine costs at the May Board	Fianance, GOSW	Dec-18	Aug-18	All payment requests submitted before 5th July paid to trainees in July pay. 1 trainee submitted request in early August will receive pay by end of September	BLUE
GOSW Nov Trust Board Report	Nov-17	Rota Compliance and In-house Locum Arrangements policy	GOSW, Interim EMD and HR to agree in-house locum arrangements and write a policy. EMD to formalise a SOP	GOSW/EMD	Dec-18	Jun-18	Agreement has been reached for when payment of breaks is appropriate. SOP for Internal Locums written. Agreed at May TDF. Awaiting Workforce committee ratification.	GREEN
GOSW Nov Trust Board Report	Nov-17	Double/Triple Bleep Carrying	GOSW has and will continue to forward all instances of double bleep carrying to EMD.	EMD/GOSW	Nov-18	ongoing	All episodes of Double Bleep carrying reported to GOSW. All escalated to EMD	RED
GOSW Nov Trust Board Report	Nov-17	Doctors in Difficulties	Monitoring and support have been given. GOSW, EMD and DME to monitor situation.	GOSW/EMD/ DME	N0v-17	Jan-18	Both trainees completed their year and have left SOHT	BLUE
GOSW Nov Trust Board Report	Nov-17	ID Badges	Task and finish group to ensure ID badges will be available and working. GOSW to check whether there were any issues for new starters in February	EMD/HR	Jan-18	Ongoing	No issues with new trainees start in Feb 18. ID badges available for August trainees	BLUE
GOSW Nov Trust Board Report	Nov-17	GOSW extra hours reviewed by interim EMDs and payment made	Extra hours reviewed by interim EMDs and actioned for payment. EMD to review extra hours on a monthly basis.	EMD/Finance	Feb-18	Aug-18	GOSW supporting service development in Surgery and Medicine. Extra hours sanctionned by CEO	GREEN
GOSW Nov Trust Board Report	Feb-18	Exeception Report Overview	GOSW has advised TOIL as default from 1st August.	GOSW/EMD	Aug-18	ongoing	Continued monitoring	AMBER
GOSW Nov Trust Board Report	Feb-18	Southport Doctors' Mess	Extension of Southport Mess Area agreed and refurbishment	GOSW/HR	Feb-18	Oct-18	Work due to start 17th September	AMBER
GOSW Nov Trust Board Report	Feb-18	Medicine Workload	EMD and AMD for medicine to determine safe medical staffing levels for each ward following the principles of safe nurse staffing.	EMD/AMD Medicine/G OSW	Aug-18	Aug-18	5 SAS doctors employed - awaiting visas and start dates. Business Case for 12 Clinical Fellows awaiting E	RED
GOSW Feb Trust Board Report	May-18	Surgery unfilled shifts - 2 Psychiatry F1s removed from on call rota at short notice.	F1 Surgery rota reduced from 1 in 11 to 1 in 9	EMD/GOSW	Aug-18	Aug-18	New F1 rota to start 20th August so that rota has no planned unfilled shifts.	BLUE
GOSW May Trust Board Report	May-18	Surgery unfilled shifts Gaps in F2/CT rota have led to further issues with unfilled shifts in surgery. Combined Surgery an T & O night rota	Combined F2/CT rota for Surgery and T & O agreed by AMD and CDs	EMD/GOSW/ AMD Surgery	Aug-18	Dec-18	New roster not yet on system. Needs consultation with trainees. Implementation date Dec-18	RED
GOSW May Trust Board Report	May-18	MIAA identified SOP for Exception report required	GOSW to write a SOP for the exception reporting dealing with exception reporting for safety issues and processing overtime payments resulting from exception reports	GOSW	Jun-18	Jun-18	SOP written and awaiting ratification by Workforce	GREEN
GOSW May Trust Board Report	May-18	MIAA identified Terms of Reference for TDF required	GOSW to write Terms of Reference for Trainee Doctors Forum by June 2018	GOSW	Jun-18	Jun-18	ToR written and awaiting agreement by Workforce Committee	GREEN
GOSW May Trust Board Report	May-18	Inadequate Bank holiday staffing levels identified	Week end staffing levels put in place and GOSW and EM	GOSW/EMD	Jun-18	Sep-18	Week end staffing in place for both May Bank holidays. Monitor August Bank holiday	GREEN
GOSW May Trust Board Report	May-18	Accomodation Concerns	ACTION GOSW to monitor accommodation concerns	GOSW	Aug-18	Aug-18	All trainees emailed about new accomodation arrangements after 6 weeks - no concerns raised	BLUE

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5th September 2018

Agenda Item	**TB212/18**	**Report Title**	**Medical Appraisal and Revalidation Annual Report 2017 - 2018**
Executive Lead	Dr Jugnu Mahajan - Interim Executive Medical Director		
Lead Officer	Mr Kevin Thomas - Deputy Medical Director/Clinical Appraisal Lead		
Action Required *(Definitions below)*	✓ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The Board is asked to approve the contents of the report and be assured that the Trust has appropriate processes in place to ensure that doctors have high quality annual appraisals and that the Responsible Officer's revalidation recommendations are based on robust information about each doctor.

The paper provides assurance that:

- Medical staff are engaged with the revalidation process;
- Appraisals and appraisers are appropriately quality assured;
- The Trust complies with its legal obligations in relation to medical revalidation.

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 is asked to approve the report and sign off the 'Statement of Compliance' for submission to NHSE.

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

MEDICAL APPRAISAL & REVALIDATION

Annual Report

2017 - 2018

C O N T E N T S

SECTION ONE: INTRODUCTION

1.1 Medical revalidation, which began in December 2012, is the process by which doctors who wish to continue to practise as a doctor maintain their status as a licensed medical practitioner. It aims to improve the safety and quality of care provided to patients and to increase public trust and confidence in the medical profession as well as supporting doctors in their professional development.

1.2 All registered medical practitioners with a licence to practise must participate in revalidation and must demonstrate to the General Medical Council (GMC) that they comply with professional standards and abide by the principles of clinical governance.

1.3 All licensed doctors have a '*prescribed connection'* to a '*Designated Body' (*usually their employing organisation), which is responsible for ensuring that they remain fit to practise and for organising their annual appraisals and revalidation recommendations. Each Designated Body must have a *Responsible Officer* (RO) to oversee these processes. The RO's role is governed by "The Medical Profession (Responsible Officers) Regulations 2010" (amended in 2013).

1.4 Revalidation is supported by a number of processes, based around completion of an annual medical appraisal which requires each doctor to collect and reflect upon specified data about their performance and to submit evidence of good practice. On the basis of this evidence, a revalidation recommendation is provided to the GMC every five years by the doctor's RO.

1.5 By recommending a doctor for revalidation, their RO is confirming that the doctor has collected all the supporting information that the GMC require, that they have completed an annual appraisal based on the standards set out in the GMC's "*Good Medical Practice"* document and that there are no outstanding concerns about their fitness to practise.

SECTION TWO: PURPOSE OF THIS PAPER

2.1 The purpose of this paper is to assure the Board that the appropriate processes are in place to ensure that the Trust is compliant with legislation, as well as notifying the Board of any future developments required to ensure the Trust continues to meet its legal obligations and to provide a robust appraisal and revalidation system.

2.2 The Board is asked to accept the contents of the report and to approve the 'Statement of Compliance' confirming that the Trust, as a Designated Body, is compliant with the relevant regulations **(**appendix 1).

2.3 This statement, along with the Annual Organisational Audit (AOA), will be submitted to the higher level Responsible Officer (HLRO, the Responsible Officer's RO) at NHS England.

SECTION THREE: BACKGROUND

3.1 In April 2014, NHS England published a 'Framework of Quality Assurance for Responsible Officers and Revalidation', to provide assurance that Designated Bodies are discharging their statutory duties. It also provides the basis on which Designated Bodies are required to demonstrate that the appropriate resource and systems are in place, that they work effectively and that they meet the agreed national standards.

3.2 The Responsible Officer Regulations include the statutory obligation on the part of Designated Bodies to provide support to the Responsible Officer. In demonstrating this support, the Chair of the Trust is asked to sign a statement of the organisation's compliance with the Responsible Officer Regulations (appendix 1).

SECTION FOUR: GOVERNANCE ARRANGEMENTS

RESPONSIBLE OFFICER

4.1 Following the resignation of Dr Paul Mansour from the role of Responsible Officer and Deputy Medical Director on 31st January 2018, Dr Jugnu Mahajan, Intermin Executive Medical Director was appointed to the positon of Responsible Officer on 1st February 2018. Mr Kevin Thomas, Deputy Medical Director was appointed Clincal Lead for Appraisal and undertook Responsible Officer training in March 2018.

4.2 In some organisations the role of the EMD and RO is split, in other organisations the EMD is the RO. The rationale for separating the roles of EMD and RO previously was to remove any potential conflict of interest arising from the EMD being both the line manager and professional lead of doctors employed by the Trust, and also their RO, making revalidation recommendations to the GMC. It also aimed to mitigate any potential criticism that the process of medical revalidation could be used as a punitive tool. Originally within the Trust, the two roles were held by the EMD and then in 2015 were separated. However, on the appointment of Dr Jugnu Mahajan, Interim Executive Medical Director in February 2018, these two roles have again merged and it is likely that this will continue when the substantive EMD is appointed.

4.3 The current RO Dr Mahajan, received a positive revalidation decision from the GMC in March 2018. She has undertaken the required RO training programme and has an annual appraisal undertaken by an external appraiser appointed by NHS England.

4.4 Disciplinary cases and doctors in difficulty are discussed at regular meetings between the EMD, Deputy Medical Director and HR. The RO and Revalidation team also meets regularly with the GMC Employment Liaison Adviser (ELA) to discuss any relevant issues and receive updates from the GMC.

4.5 All ROs or their deputies are required to attend at least 75% of NHSE's quarterly Responsible Officer Network Group meetings, to ensure that their thresholds, decisions and recommendations are calibrated against and consistent with those of their peers.

REVALIDATION AND APPRAISAL TEAM

4.6 The current revalidation and appraisal team comprises the Interim Executive Medical Director/RO (Dr Jugnu Mahajan), the Clinical Appraisal Lead (Mr Kevin Thomas) and the Appraisal & Revalidation Support Manager (Ann Higgin) who meet regularly to monitor the progress of doctors' appraisals and revalidation recommendations, address operational issues and quality control the appraisal process.

4.7 Most organisations have a Clinical Lead for appraisal and revalidation to assist the RO (particularly in the quality assurance of the appraisal process) and to provide clinical and professional support for doctors. At the Trust, this role has not been filled since 2014, as the sessional commitment was then transferred to the Deputy Medical Director role. However, it was clear that this role needed to be reinstated to assist the RO in identifying and disseminating good practice and to maintain and improve the quality of appraisals within the organisation and Mr Kevin Thomas was therefore appointed to this role in February 2018.

ANNUAL ORGANISATIONAL AUDIT

4.8 The Trust is required to complete and submit an Annual Organisational Audit (AOA) to NHS England. This end-of-year questionnaire provides an overview of the elements defined in the Responsible Officer Regulations, to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.

QUARTERLY REPORT TO NHS ENGLAND

4.9 In addition to the AOA, NHS England also may require a quarterly submission to demonstrate the Trust's progress against the anticipated rate of completed medical appraisals within the reporting period and the reasons for any delay. The Trust is currently exempt from this requirement as it has met the necessary performance criteria as detailed below:

- The DB has achieved greater than 90% appraisal uptake in the previous year as stated in the 2017/18 AOA
- The DB has fewer than 1% non-managed incomplete or missed appraisals
- The DB engages with the RO and appraisal networks
- No concerns have been evidenced from a Higher Lever Responsible Officer Quality Review visit or any other source.

MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT

4.10 An annual report is presented to the Trust each year. From 2014 it has been a requirement by NHS England for the Board of each Designated Body to sign off a Statement of Compliance (appendix 1), to be returned to the higher level RO at NHS England.

POLICY AND GUIDANCE

4.11 The Trust's appraisal and revalidation policy was approved and published in 2014 (MED STAFF-17: Medical Appraisal & Revalidation Policy). NHS England regularly publishes updates and newsletters and also arranges quarterly networking groups and an annual conference for both ROs and support teams. This assists in sharing best practice and any guidance issued is implemented as appropriate. This policy is currently being updated.

EXTERNAL REVIEW

4.12 In August 2014, Mersey Internal Audit Agency (MIAA) reviewed the Trust's medical appraisal process. Their report was very positive about the Trust's appraisal and revalidation processes. All of their recommendations have since been implemented.

4.13 Following a minor decrease in the Trust's appraisal rate from 86% in 2014/15 to 85% in 2015/16, due to a large number of overseas and new doctors starting employment with the Trust, the Trust underwent a Higher Level Responsible Officer Quality Review (HLROQR) in November 2016 by representatives from NHS England. Following this review we have since changed our procedures, and all new doctors who have not had an appraisal in the last cycle, wherever possible, now undertake one within the current appraisal cycle, even if they have not accumulated all the necessary supporting information. This has since increased our annual appraisal rate to over 90%.

BACKGROUND RECRUITMENT CHECKS

4.14 The Trust has an appropriate procedure in place, operated by the medical staffing department, for obtaining relevant information when entering into a contract of employment with doctors for the provision of services

QUEENSCOURT HOSPICE

4.15 Since the introduction of medical revalidation, the Trust has historically acted as the Designated Body and provided an RO for Queenscourt Hospice. This was seen as a sensible arrangement given the small number of doctors (four) employed by the hospice and the close working relationship between the organisations. Following discussions with the GMC, Queenscourt became a Designated Body in its own right in December 2016 and is provided with a separate board report and AOA. Dr Mahajan acts as Queenscourt's RO and the Trust provides appraisal support for the hospice doctors, under a formal SLA. Two doctors at Queenscourt have been trained as appraisers and act as appraisers for the Trust.

SECTION FIVE: MEDICAL APPRAISAL

MAINTAINING THE LIST OF PRESCRIBED CONNECTIONS

5.1 Revalidation dates are issued to individual doctors by the GMC. It is a legal requirement that an accurate record of all licenced medical practitioners with a prescribed connection to the trust is maintained. The Appraisal & Revalidation Support Manager receives a list of new starters and leavers from the HR department each month, cross references this list with the GMC electronic system 'GMC Connect' and makes any necessary changes. It has however, recently become apparent that the information flow concerning bank doctors recruited through the Trusts internal bank system TempRE needs some improvement to ensure that the RO is aware of any bank doctors for whom the Trust may be their designated body. Work is currently being undertaken to address this by the Medical Staffing Team.

5.2 The Appraisal & Revalidation Support Manager contacts all new starters to obtain details of their previous appraisals, and to train them on the systems which they are required to use for their appraisals at this Trust.

5.3 The Trust is not necessarily the Designated Body for all doctors working here. Trainees are employed by the lead employer, St Helens & Knowsley Trust, and their Designated Body is Health Education England. Locums not employed by the Trust have a prescribed connection to their employing agency, and visiting consultants maintain a connection with their primary employing Trust. There are also four doctors who are not subject to revalidation as they are governed by the General Dental Council (GDC) which does not yet have a revalidation process in place. These doctors still undergo the same annual appraisal and are required to provide the same supporting information as all other doctors.

5.4 For the purposes of the AOA the numbers are collated using the number of doctors in post on 31st March each year. On 31st March 2018 the Trust was the Designated Body for 178 doctors.

DOCTORS WITH PRESCRIBED CONNECTIONS TO THE TRUST	2016-17	2017-18
Consultants	87	85
Staff grade, Associate Specialist & Specialty (SAS) Doctors	65	63
Short-term contract holders	27	30
TOTAL:	**179**	**178**

APPRAISAL AND REVALIDATION PERFORMANCE DATA

5.5 All doctors are required to have an annual appraisal and include in it specified supporting information as required by the GMC.

5.6 The Trust allocates each doctor an 'appraisal birthday' which is the month (between June and February) by which they must complete their appraisal. This should be the same month each year, unless a change is approved by the Responsible Officer. To be considered valid and complete (NHSE category 1a), the appraisal meeting must be held by the end of the 'appraisal birthday' month and be signed off within 28 days. If the appraisal is late but held before 31st March it is still considered complete but recorded separately as delayed (NHSE category 1b). Of the 164 completed appraisals during the year, 77 were on time and 87 were delayed by this definition.

Any appraisals held after 31st March or which are incomplete or missed entirely are classed as late or missed appraisals; these may be approved (late or missed for valid reasons, category 2) or unapproved (category 3).

5.7 92% of doctors completed an appraisal during the appraisal year. This is a slight decrease of 5% on the period 2016 -17 when 97% were completed. This was due to doctors who joined in the last three months of the appraisal year who had not had an appraisal elsewhere and it was not practical for them to complete one within the Trust by the end of the appraisal year.

There was one unapproved late appraisal. The RO has taken the appropriate action in this case to avoid it happening again.

5.8 The progress of appraisals is monitored by the Appraisal & Revalidation Support Manager who escalates any delays to the RO and Clinical Lead as necessary. The RO or Clinical Lead meets with doctors who have not completed their appraisals on time without good reason and takes appropriate action if the situation is repeated.

APPRAISALS COMPLETED	2016-17	2017-18
Appraisals completed - on time (category 1a)	93 (52%)	77 (44%)
Appraisals completed - delayed (category 1b)	80 (45%)	87 (49%)
Total appraisals completed (categories 1a & 1b)	**173 (97%)**	**164 (92%)**
Approved missed or late appraisals (category 2)	6 (3%)	13 (7%)
Unapproved missed or late appraisals (category 3)	0 (0%)	1 (0.5%)
TOTAL:	**179**	**178**

5.9 This year's figures compare favourably overall with those of our comparator group in the same sector (55 acute non-foundation trusts) nationally:

	2017-18	2017-18
APPRAISALS COMPLETED 2017-18: COMPARATOR TABLE	**SOHT %**	**SECTOR %**
Total appraisals completed (categories 1a & 1b)	97	92
Approved missed or late appraisals (category 2)	7	5
Unapproved missed or late appraisals (category 3)	0	4

5.10 An annual audit of reasons for missed or non-completed appraisals has been undertaken:

REASONS FOR APPROVED MISSED OR LATE APPRAISALS	**2016-17**	**2017-18**
New starters	1	9
Maternity or sick leave	5	4
Exclusion	0	0
TOTAL:	**6**	**13**

REASONS FOR UNAPPROVED MISSED OR LATE APPRAISALS	**2016-17**	**2017-18**
Appraisee poor time management	0	1
TOTAL:	**0**	**1**

APPRAISERS

5.11 45 consultants and SAS doctors within the Trust have been trained as appraisers. Further appraisers are trained as necessary to ensure that there is always a sufficient number to allow for leavers or those who no longer wish to undertake the role.

5.12 To ensure a fresh perspective and avoid any suggestion of collusion, it is recommended that doctors should have at least two different appraisers within each five-year revalidation period. The aim of the trust is for a doctor to change appraisers every three years if possible.

5.13 Appraisers are required to participate in relevant continuous professional development to maintain their appraisal skills. The Trust provides support to appraisers through the Appraiser Support Group, a closed meeting held at least once (and usually twice) in each appraisal cycle to provide an opportunity to discuss best practice, share reflections on the challenges faced as an appraiser and promote their continuous professional development as an appraiser. Sometimes the GMC are invited to attend to update on any relevant topics. Appraisers also complete a 'self-assessment questionnaire' every three years to identify any areas for development to be addressed at their own appraisal.

QUALITY ASSURANCE

5.14 Quality assurance of appraisals and the appraisal process is monitored using the following processes:

5.14.1 Appraisal Portfolios

The RO or Clinical Lead for Appraisal reviews the portfolios of all doctors before making a revalidation recommendation to the GMC, to provide assurance that the appraisal inputs, outputs, declarations and supporting information provided meet the necessary requirements, using a recognised quality template. The RO also aims to review a sample of other appraisal folders each year. Feedback on the quality of the appraisal documentation is given to both the doctor and the appraiser. This information, together with feedback from appraisees, forms the basis of an annual review for each appraiser, which in turn will feed into their own appraisals. This should drive up the quality of appraisals and give the RO more assurance that their recommendations for revalidation are based on reliable, high-quality evidence.

5.14.2 Individual appraisers

Appraisers complete a self-assessment exercise about their continuing professional development needs once every three years and include this as supporting information for discussion at their own appraisal**.** Appraisers receive individual feedback on appraisals that they have carried out and an annual record of their participation in appraisal events such as the Appraisal Support Group meetings. This information is used at the appraisers' own appraisals to direct future learning and development. The RO or Clinical Lead for Appraisal aims to meet with each appraiser at least once every three years to discuss the results of their appraisal review, agree with them any actions that may be appropriate, and include such actions in the appraiser's PDP for the subsequent year.

5.14.3 Doctors

Feedback in the form of a short questionnaire is requested from each doctor following their appraisal. The questionnaires are then anonymised and a report collated to give feedback in three areas: the Trust's organisational approach to appraisal; the appraiser's skills; and the administration of the appraisal process. Feedback from doctors is generally positive; the main issue raised from an organisational perspective is a preference for an appraisal toolkit which is accessible from outside the trust through the internet. The current appraisal system is based on Sharepoint, which works well but is only accessible within the trust.

5.14.4 Clinical lead for appraisal and revalidation

It had become apparent that the RO alone cannot review sufficient appraisal folders to provide optimum quality assurance, or hold three-yearly meetings with appraisers, and therefore Mr Kevin Thomas was appointed Clinical Lead for Appraisal in February 2018 to assist the RO in her RO duties.

ACCESS, SECURITY AND CONFIDENTIALITY

5.15 In the absence of any standard national electronic system for appraisal and revalidation in England, each Trust is required to acquire or develop their own appraisal systems based on GMC guidance. The Trust continues to use the SharePoint system. While it does not have some of the advantages of a web-based system, such as access from outside the Trust and ease of compiling reports, it is free, flexible, robust and secure and allows us to amend our appraisal forms as we wish in a timely manner. Commercial alternatives used by some other organisations are less flexible and carry a financial cost.

5.16 Doctors' appraisal portfolios can only be viewed by the RO, Clinical Lead for Appraisal, the Appraisal & Revalidation Support Manager, the appraiser, the doctor themselves and their Clinical and Associate Medical Directors. Following sign off, the appraisal file is then locked so it cannot be amended but can still be viewed.

CLINICAL GOVERNANCE

5.17 Processes are now in place to provide the following information to individual doctors by pre-populating their appraisal forms so they may reflect on any issues arising during the year, in line with GMC revalidation requirements:

- Complaints;
- Claims;
- Serious unexpected events;
- Never events;
- Dr Foster clinical outcome benchmarking data;

SECTION SIX: REVALIDATION RECOMMENDATIONS

6.1 There are three options available to the RO once the GMC has served notice on a doctor informing them that a recommendation about their revalidation is due:

a) A recommendation that the doctor is up to date and fit to practise and should therefore be revalidated;

b) A request to defer the date of recommendation for between four and twelve months. This may be because the doctor has been on sick or maternity leave or has been working abroad, and therefore has not yet had time to collect the necessary supporting information, or because the doctor is subject to an on-going disciplinary process. If the RO decides to defer a recommendation because of a lack of supporting information, the RO agrees a timetable with the doctor to ensure that the required information will be available by the deferred date;

c) Notification of the doctor's non-engagement in the appraisal and revalidation process. This can be actioned at any time in the revalidation cycle by the RO in situations where a doctor has been given the opportunity, support and guidance by the Trust to complete their annual appraisal but do not engage in the process. Since the beginning of the revalidation process, no doctors within the Trust have had to be reported under this category.

6.2 The RO has provided all relevant notifications to the GMC within the required timescale, as follows:

REVALIDATION RECOMMENDATIONS MADE	2016-17	2017-18
Recommendations completed on time	30	24
Late recommendations	0	0
Missed recommendations	0	0
TOTAL:	**30**	**24**

REVALIDATION RECOMMENDATION CATEGORIES	2016-17	2017-18
Recommendation for revalidation	16	20
Deferred for lack of supporting information	13	4
Deferred as subject to investigation	1	0
Non-engagement	0	0
TOTAL:	30	24

6.3 2017 saw the end of the first revalidation cycle and during 2018/19 there will be aproximateley 48% of our current doctors due for revalidation.

SECTION SEVEN: MONITORING DOCTORS' PERFORMANCE

REVIEW OF COMPLAINTS, CLAIMS, SUIS, NEVER EVENTS AND INCIDENTS

7.1 Doctors who have been involved in any complaints, claims, SUIs, never events or incidents are required to include reflections on these in their annual appraisal portfolio. This information is provided to the Appraisal & Revalidation Support Manager by the risk department and is entered into the doctor's portfolio to ensure that all such events are reflected upon at appraisal.

CLINICAL OUTCOME DATA

7.2 Clinicians are required to provide, and reflect on, data describing their clinical activity and outcomes. This information is available through the Dr Foster tool, although it is not applicable to all specialties. In the past it has not provided any data for Staff Grade and Associate Specialist (SAS) doctors; these doctors were able to share their consultants' data, but otherwise need to keep their own records. However, this is changing as more activity is appropriately recorded against the names of individual SAS doctors, including those who are granted autonomous working as part of the Trust's commitment to the SAS Charter. It is the professional responsibility of consultants to review their data regularly in order to identify trends and any potential recording errors in a timely manner rather than just at their appraisal.

MULTI-SOURCE FEEDBACK

7.3 All doctors participate in a multi-source feedback (MSF) exercise at least once in every five-year revalidation cycle, thereby obtaining feedback from colleagues and patients. The Trust has a rolling programme for doctors to participate in MSF every three to four years, or earlier if any developmental issues are identified; this is organised for doctors by the Appraisal & Revalidation Support Manager, using an external company to administer the process with relevant validated questionnaires.

7.4 In addition, from 2017-18, those doctors who also have a managerial role (including Clinical Directors, Associate and Deputy Medical Directors and the Director of Medical Education) will also undergo a further MSF exercise directed at feedback on their leadership and people management.

SECTION EIGHT: RESPONDING TO CONCERNS AND REMEDIATION

GMC

8.1 Quarterly meetings are held between the RO and the Trust's GMC's Employment Liaison Advisor to discuss any performance or revalidation issues relating to doctors. The Deputy Medical Director and the Appraisal & Revalidation Support Manager are also invited to attend these meetings.

FORMAL INVESTIGATION PROCESS

8.2 During the period April 2017 to March 2018, the cases of two doctors employed by the Trust were opened under Trust policy MED STAFF 01 "Maintaining High Professional Standards in the Modern NHS" (MHPS). In addition, the cases of two doctors continues from the previous year, one of whom has retired from practice and one who no longer works for the Trust.

NATIONAL CLINICAL ASSESSMENT SERVICE (NCAS) CASE MANAGER & INVESTIGATOR TRAINING

8.3 Seven clinicians attended the NCAS case investigator training held in the Trust in February 2016.

SECTION NINE: PROVISION OF RESOURCES TO SUPPORT THE RESPONSIBLE OFFICER ROLE

9.1 Under 'The Medical Profession (Responsible Officers) Regulations 2010' (amended 2013), each Designated Body is required to provide their Responsible Officer with sufficient funding and other resources necessary to enable them to discharge their responsibilities.

9.2 As well as allocating appropriate time to the Deputy Medical Director in his role as RO, the Trust has provided funding for:

- administrative support in the form of a part time Appraisal & Revalidation Support Manager;
- multi-source feedback for doctors (360° appraisal for colleague and patient feedback and for managerial skills);
- appraiser training in medical appraisal skills;
- training for case investigators and case managers.

9.3 As revalidation and medical appraisal are still developing it is likely that further costs will emerge. For example, we will ensure that appropriate support is in place for appraisers, recognising the vital role they play in revalidation.

9.4 In addition, because the need for remediation of medical staff is so sporadic and unpredictable, no specific budget exists for such purposes and any remediation will therefore continue to be provided from the Medical Director's existing budget.

SECTION TEN: RISKS TO THE ORGANISATION

10.1 If a doctor does not participate and engage in annual appraisal and revalidation, the GMC has the power to remove their licence to practise. In such an event, the Designated Body must be able to supply evidence that they have provided the doctor with all the necessary opportunity, support and guidance to enable them to complete their appraisal and that the doctor has not taken up such opportunities. To date, no doctor has approached the threshold of non-engagement, and the processes in place to support doctors make this unlikely in the future. The risk to the organisation of losing the services of doctors in this way is therefore considered to be low.

SECTION ELEVEN: CORRECTIVE ACTIONS, IMPROVEMENT PLAN AND NEXT STEPS

11.1 Whilst the appraisal process within the trust is now well developed and mature, there are areas where improvements can be made.

11.2 From quality assurance checks, it is apparent that some appraisals, whilst containing the relevant supporting information, still lack challenge, and some fail to produce an appropriate 'SMART' personal development plan (PDP). Attempts to improve this have included workshops in these particular areas. This will continue to be addressed as part of the appraiser support group programme.

11.3 Whilst we achieved a 92% appraisal completion rate this year, there is still a high proportion of doctors fail to complete their appraisal by the end of their appraisal birthday month. This is being addressed by a more rigorous system of reminders and, where necessary, meetings with individual doctors. However it is recognized that there will always be delays caused by unforeseen clinical demands and hence the necessity to sometimes reschedule appraisal meetings.

THE PEARSON REVIEW

11.4 2017 saw the end of the first revalidation cycle. Several reviews are taking place concerning the impact of revalidation and the appropriate way forward.

Sir Keith Pearson has produced a report '*Taking Revalidation Forward* ' as a clear account of what has been achieved in establishing revalidation, where we are now and what needs to happen next.

11.5 NHS England have communicated that they are committed to work with the GMC in delivering the report's recommendations and the five key priorities identified:

- Making revalidation more accessible to patients and the public;
- Reducing unnecessary burdens and bureaucracy for doctors;
- Increasing oversight of, and support for, doctors in short-term locum positions;
- Extending the RO model to all doctors who need a UK licence to practise;
- Measuring and evaluating the impact of revalidation.

Any relevant recommendations will be reviewed and implemented by the RO as appropriate.

SECTION TWELVE: RECOMMENDATIONS

12.1 The Board is asked to accept the contents of the report and be assured by it that the Trust has appropriate processes in place to ensure that doctors have annual high quality appraisals, and that the Responsible Officer's revalidation recommendations are based on robust information about each doctor.

12.2 The Board is therefore asked to approve the Statement of Compliance confirming that the organisation, as a Designated Body, is in compliance with the Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013) and the GMC (Licence to Practice and Revalidation) Regulations 2012.

Dr Jugnu Mahajan, Responsible Officer
Mr Kevin Thomas, Appraisal Clinical Lead

September 2018

APPENDIX 1: Designated Body Statement of Compliance

The board of Southport and Ormskirk NHS Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes - Transfer of the role of Responsible Officer from Dr Paul Mansour to Dr Jugnu Mahajan with effect from 1st February 2018.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Comments: Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Comments: Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

   Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

   Comments: Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Comments: Yes

Signed on behalf of the designated body

Official name of designated body: **Southport and Ormskirk NHS Trust**

Name: **Richard Fraser** Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Role: **Trust Chair**

Date:

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Southport and Ormskirk Hospital NHS Trust

PUBLIC BOARD

5th September 2018

Agenda Item	**TB213/18**	**Report Title**	Report into the Prevention, Identification Review and Treatment of **Pressure Ulcers**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery and Therapies		
Lead Officer	Gill Murphy. Deputy Director of Nursing Midwifery and Therapies Dominic Williams Tissue Viability Nurse		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve ✓ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

The report is a detailed review of the incidence of Hospital Acquired Pressure Ulcers (HAPU) across the organisation reviewing data from

- Incidents
- Root cause Analysis (RCA)
- Complaints
- Monthly harm free care (safety thermometer)
- National Reporting and Learning System (NLRS)

The report has identified that the recognition and assessment of skin integrity in A&E was not in place and since focused awareness training and the introduction of new nursing documentation in May 2018, the number of patients being assessed as having tissue damage on admission has increased. Since the introduction of daily incident meetings in July 2018, no HAPU incidents have been identified in A&E.

The report concludes that having reviewed all the data available and the improved recognition, assessment and reporting of patients who attend A&E it is unlikely that we have concerns in the care given to patients which would result in a HAPU incident in A&E. This will also have a positive effect on patients admitted to our wards, as plans will already be in place for patients deemed at risk.

A quality improvement plan is in place (appendix 1) which will be monitored through the Nursing and Midwifery board, together with the revised quality dashboard and performance framework and a quarterly assurance report from the Tissue Viability Nurse (TVN).

The board are asked to receive this report as assurance that systems and processes are in place, together with a quality improvement plan, to ensure we give good care to our patients and reduce and ultimately eliminate hospital acquired pressure ulcers.

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

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

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

- ☐ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref:

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

  _____

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

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

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

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

To support the report as assurance to the board that policies and procedures are robust and in place for the identification, management and subsequent elimination of hospital acquired pressure ulcers.

Previously Presented at:

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

Report into the Prevention, Identification Review and Treatment of Pressure Ulcers

Definition

A pressure ulcer is “localised damage to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure (including pressure associated with shear). The damage can present as intact skin or an open ulcer and may be painful.” Previously they have been referred to as pressure sores or bed sores.

The causes of pressure ulcers are mainly mechanical forces to the skin/tissues; however there are multiple risk factors that make people more vulnerable to developing them. These include factors such as poor mobility, reduced sensation, poor nutrition and hydration, acute and chronic illness. In some clinical scenarios, development of a pressure ulcer increases mortality, for example in critical care.

Background

Southport and Ormskirk Hospital Trust (SOHT) has an overall Pressure Ulcer Prevention Plan that includes the following

- Pressure Ulcer Prevention Policy in line with NICE guidelines since 2001 (Current V3)
- Pressure Ulcer Risk Assessment tool (Waterlow) within 6 hours of admission
- Care plan for patients assessed as at risk, with further guidance for those at high risk
- SSKIN bundle for all patients. This records 5 major factors thought to be associated with pressure ulcer risk (Skin inspection, Support surface, Keep moving, Incontinence, Nutrition = SSKIN)
- Pressure Ulcer Prevention training delivered by Tissue Viability Service throughout the year, also delivered at Induction to clinical staff.
- Rapid access to appropriate pressure relieving equipment (Medical Equipment Library)

The Trust has been an active member of the Cheshire and Mersey Pressure Ulcer Steering Group since its inception. The aim of the group is to standardise approaches to reporting, prevention, documentation and management of pressure ulcers in line with national and international guidelines. Currently the Root Cause Analysis tool developed by SOHT and modified with two other organisations, is being tested across the region.

Guidelines

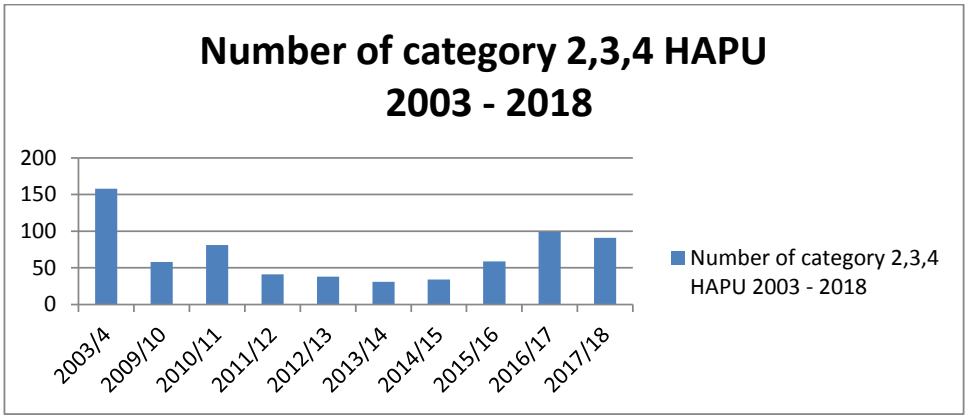
There are several different organisations that have developed Pressure Ulcer Guidelines including NICE, European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel, Pan Pacific Pressure Injury Alliance. Very recently, NHSI produced guidance for definition and reporting of pressure ulcers, and a gap analysis has been developed to ensure local amendments are made effectively. SOHT will be compliant to these guidelines by end August 2018. We are however awaiting further information as to how NHSI expect healthcare organisations to report as they plan to implement an audit tool during Autumn 2018.

Reporting of Hospital Acquired Pressure Ulcers

All category 2 and above pressure ulcer incidents are reported via Datix reporting system. All these incidents are reviewed by direct report to the Tissue Viability nurse (TVN) and through

the daily incident reporting meeting. Pressure ulcers are categorised according to the depth of tissue damage. Category 1 is unbroken skin, with Category 2, 3 and 4 being increasingly deeper injuries. Often the categorisation is seen as a severity index, when in fact some Category 3 ulcers can be very small in size, but considered severe, and conversely, a large category 2 ulcer may equate to more harm. Debate is on-going within guideline groups as to whether we change the category system to something more clinically accurate.

Table 1 : Hospital Acquired Pressure Ulcer (HAPU) incidence



The Pressure Ulcer Prevention Plan and associated policy has brought about historical reductions in pressure ulcers that had been identified and reported across the organisation since 2003. However over the last 3 years, there has been an increase in the number of HAPU incidents reported, all of which are reviewed as described below. All incidents reported are uploaded to the National Reporting and Learning System (NRLS) and as an organisation we have seen an increase in reporting of all categories of incidents as seen in table 2.

Table 2 : NRLS data – SOHT incident reporting

Time Period	No of Incidents Occurring	Median Days to Report	Rate per 1,000 bed days	% No Harm	% Low Harm	% Moderate Harm	% Severe Harm	% Death	Position based on rate per 1,000 bed days - all Acute Trusts
April - Sept 2014	1,989	67	27.16	80.2	9.8	9.5	0.5	0.1	119/140
Oct 2014 - Mar 2015	2,470	38	33.43	81.3	7.9	10.2	0.3	0.2	87/137
April 2015 - Sept 2015	2,748	18	37.75	79.1	14.2	5.9	0.5	0.2	73/136
Oct 2015 - Mar 2016	2,804	16	41.49	77.7	18.1	3.9	0.3	0.04	52/136
April 2016 - Sept 2016	3,001	31	44.92	79.1	18.7	1.7	0.3	0.1	33/136
Oct 2016 - Mar 2017	2,922	36	44.76	82.6	15.7	1.5	0.1	0.0	43/136
April 2017 - Sept 2017	2,585	21	39.07	83.1	15.0	1.5	0.2	0.1	82/135

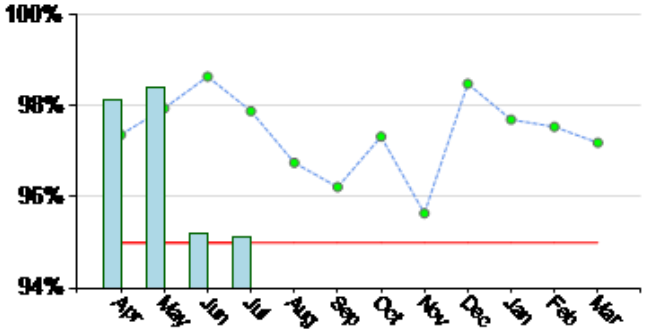
It is a requirement that we investigate all category 3 and 4 incidents, however this organisation also investigates all category 2 incidents as we believe that this encourages

faster learning (there are more category 2's than 3 or 4's), and the enhanced vigilance will lead to overall reduction of more severe ulcers. Reporting of category 2 ulcers has now been recommended in the NHSI guidance on reporting and definitions.

Harm Free Care (Safety Thermometer)

The Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: **pressure ulcers**, falls, urinary tract infections (in patients with a catheter) and Venous Thromboembolism.

Data is collected through a point of care survey on a single day each month on 100% of patients. This enables wards, teams and organisations to: understand the burden of particular harms at their organisation, measure improvement over time and connect frontline teams to the issues of harm, enabling immediate improvements to patient care.



Safety Thermometer - Percentage of Patients With Harm Free Care.

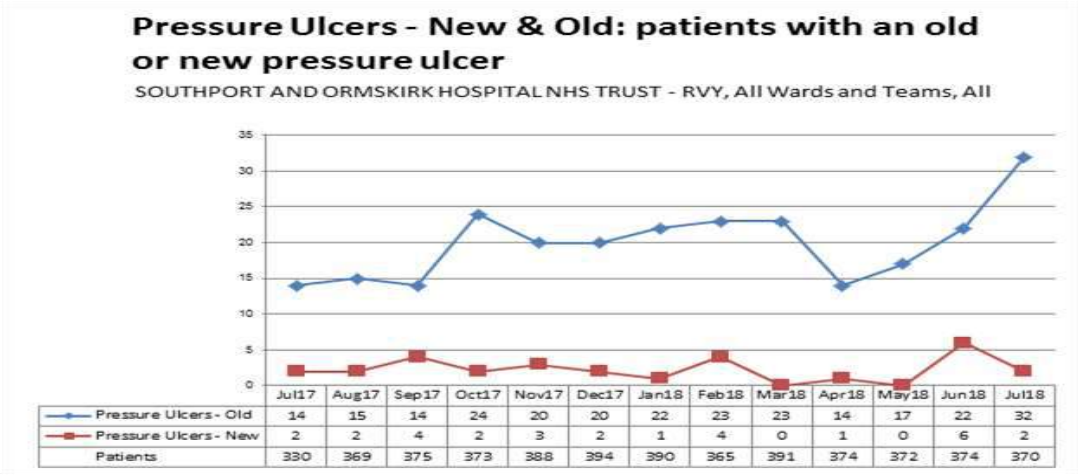
Threshold 95%. Higher is better.

Line = Last Financial Year, Bar = This Financial Year.

SOHT has consistently achieved the 95% harm free care rate and continue to monitor monthly, reporting to wards and boards. It was recently identified that this monthly review was not being completed across all areas on the same day, leading to a potential risk of double counting patients. This has now been rectified and from August all data is being collected on the same day in all acute clinical adult wards.

From the safety thermometer data we are able to determine what pressure ulcers are recorded as new or old. Table 3 below identifies the prevalence over the last 12 months.

Table 3 : Pressure Ulcers – new and Old



	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18	Apr18	May18	Jun18	Jul18
Pressure Ulcers - Old	14	15	14	24	20	20	22	23	23	14	17	22	32
Pressure Ulcers - New	2	2	4	2	3	2	1	4	0	1	0	6	2
Patients	330	369	375	373	388	394	390	365	391	374	372	374	370

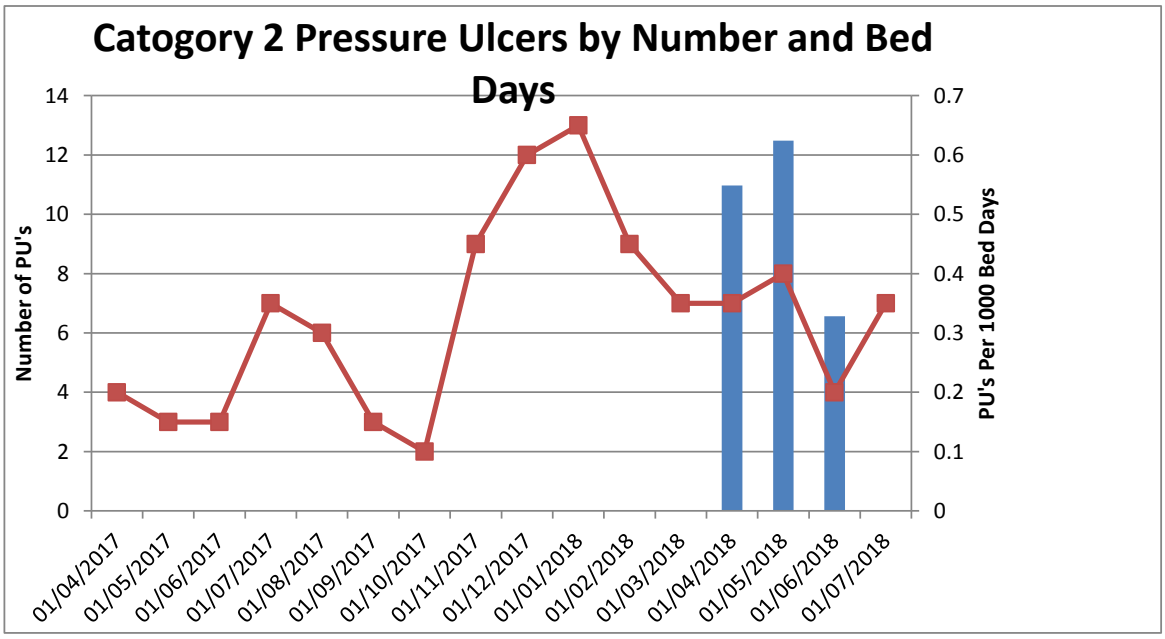
The safety thermometer website identifies all acute trusts and for the month of April 18 (latest data available) the % range of pressure ulcers identified across acute trusts was from 0% - 10.6%. Details of SOHT and local providers is described below.

Table 4 : Percentage pressure ulcers April 18 (safety thermometer data)

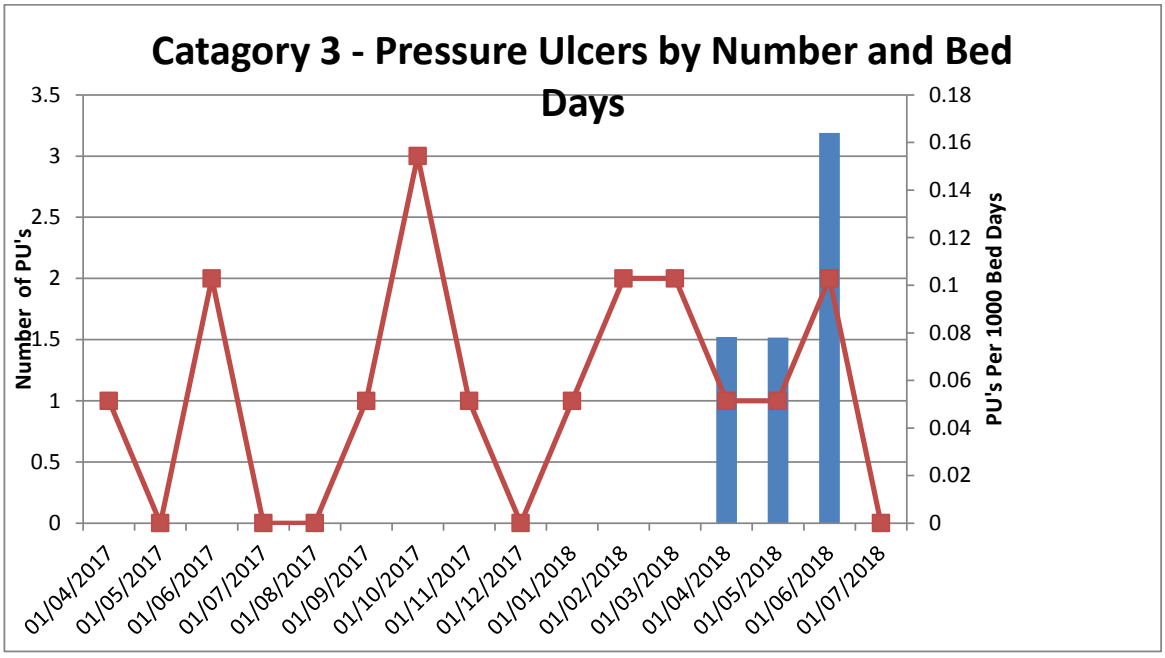
Trust	Percentage Pressure Ulcer (April 18)
Southport and Ormskirk Hospital NHS Trust	4.1
Royal Liverpool & Broadgreen Hospital	2.97
Blackpool Hospital	4.83
Aintree Hospital	5.9
Lancashire Teaching Hospital	4.7

Monthly incidence monitoring of HAPU is in place, but, Business Intelligence have been asked to report the number of patients who develop pressure ulcers per 1000 bed days. This will support trend analysis and give us the opportunity to review our long term performance as historical data is available, back several years, and benchmark against our peers.

Table 5 & 6 – HAPU incidence by number and per 1000 bed days.



The above table identifies a spike in winter 17/18 at a time when there were increased admissions of frail elderly patients, lack of access to TVN, which resulted in potential mis-reporting as the TVN was unavailable for approx. 5 weeks, and the overwhelming numbers of patients being cared for across the trust. Further analysis in being undertaken to determine how many of these category 2 incidents deteriorated. However the table below clearly identifies there were few category 3 HAPUs reported during the same time, which suggests the positive identification and reporting of the category 2 resulting in appropriate care being delivered.

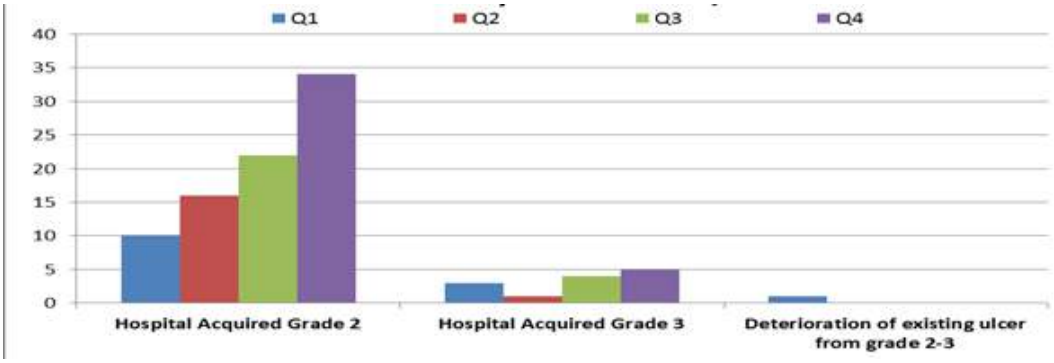


Tables 5 & 6 now identify incidence per 1000 bed days. The TVN through the Cheshire and Merseyside steering group is liaising to benchmark against other organisations across C&M.it is expected that this data will be available in the September 18 meeting.

Investigation of Hospital Acquired Pressure Ulcers (HAPU)

All HAPU incidents are investigated and the graphs below identify the reporting trend of HAPU 17/18 and the location of incidents reported.

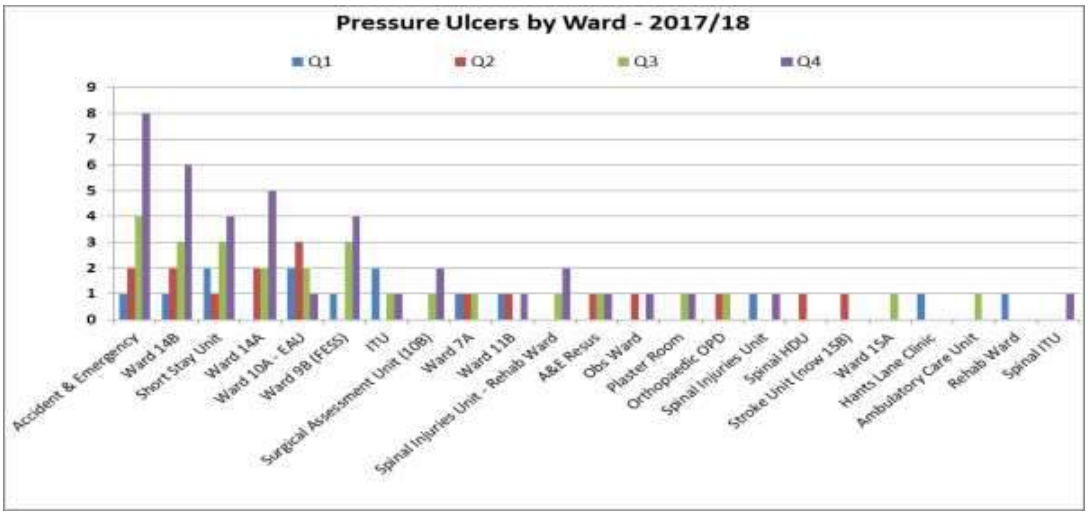
Table 7 : HAPU incidents reported 17/18



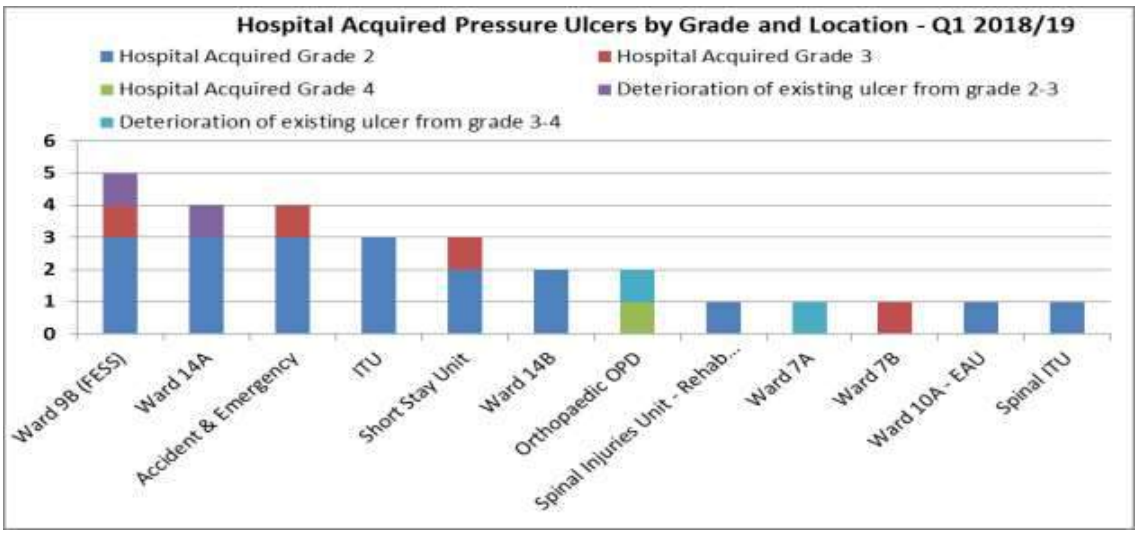
The increase in numbers reported in quarter 4 may be attributed to the Trust being at capacity during this quarter. There were many days in Q4 when the A&E had been required to evoke the 'full to capacity' protocol with in excess of 70 patients in the department. Escalation beds were opened and patients were often waiting within A&E. This caused difficulties in delivering appropriate pressure relieving care as the trolley surface is not designed for this purpose and it is almost impossible to reposition patients on a trolley,

particularly within a corridor setting. The renovation plans for A&E, have helped alleviate some of these issues and a decrease in reported incidents in Quarter 1 2018/19 has been seen. The plans to improve patient flow and the new safety hub will also help with pressure ulcer prevention. In addition, the new nursing documentation has an integrated body map to enable earlier identification of tissue damage.

Table 8 : Pressure ulcers reported 17/18 by ward / department.



During quarter 1 - 18/19, 28 HAPUs were reported, a decrease of 11 on the previous quarter. The breakdown by grade and location is shown in the graph below.



Currently the incidence of category 2 and 3 skin damage of patients cared for in A&E is under review. There has been specific awareness training across A&E to ensure a full assessment is made on attendance. This is supported with the implementation of new nursing documentation which ensures we identify skin damage prior to admission and treat / take action as required. Going forward incidents identified in A&E would not be a HAPU. The introduction of the daily incident call, the increased awareness in A&E on how to assess

patients skin integrity on arrival has identified no hospital acquired pressure ulcers only patients arriving with pressure ulcers of category 2,3 and 4. This has resulted in a proactive approach and the development of a referral pathway into community services to manage these patients who are then not admitted but discharged home, which in some cases is a nursing home.

Complaints/Claims/Inquests related to Pressure Ulcers

There were no claims or Inquests opened in Q4 17/18. relating to pressure ulcers. One complaint was received which raised concerns about the appropriateness of the patient positioning due to risk of pressure damage. This complaint related to ward 7A who have reported three grade 2 pressure ulcers in 2017/18, but none in Q4.

One complaint was received in Q1 18/19 relating to a patient who sustained pressure ulcers whilst an inpatient on ward 14A during March 2018. No claims or inquests opened in Q1 relating to pressure ulcers.

Lessons learned

Identifying the real root cause(s) of an incident is hampered by the time scale between an incident occurring and the investigation process, particularly in planned care. There is often a delay of several weeks and the local intelligence of the time period is lost. Plans are in place to combine both CBU weekly meetings, (which reviews in detail all reported incidents) into one meeting. This is due to commence in September 2018. This will further enhance shared learning across the organisation and support efficient and effective use of specialist knowledge and skills.

Investigation outcomes and recommendations are incorporated into action plans for clinical staff and also included in on-going Pressure Ulcer training sessions.

Theme	Action
Poor re-assessment of risk	Compliance to this was identified as being an issue in the 2017 HAPU audit. The 2018 HAPU audit is in progress and out of the 5 reviewed to date all had had a re-assessment. The audit (25 cases) continues.
Gaps in recorded repositioning	The intentional rounding form, (which is the form completed every hour for every patient whereby the clinical staff assess the patients physical and health needs) has been revised to include reference to SSKIN bundle. Compliance will be determined through the HAPU audit.
Lack of timely referral to TV team	Incidents logged on Datix, with daily incident review meetings now in place to raise awareness across senior leaders and expedite referrals. This has had a positive impact as incidents are actioned immediately and appropriate care in place, not now reliant on one individual to action.

Poor attendance at Pressure Ulcer Training	Training continues to be provided by TV team, which will increase when substantive staff in post in October. Training has resulted in an increase in recognition of tissue damage by staff in A&E, and identified an increasing number of patients who attend with tissue damage. A referral pathway to community teams in in place with monthly review meetings planned.

Current Position

Over the last 12 months since June 2017, there are **17 reported incidents of Category 3** pressure ulcers. Tables 5 & 6 above, identify this incidence from April 2018 per 1000 bed days. This will be the method of reporting HAPU going forward, to also reflect bed occupancy per month.

There are **no** confirmed category 4 incidents.

All category 3 and 4 ulcers are validated by TVN, and if found to be incorrectly recorded (incorrect category or present on admission) the incident report is updated. This cleansed data can then be re-reported on a quarterly basis to take any changes in to account and reflect more accurate performance.

The Tissue Viability service and leg ulcer service are currently provided by a single practitioner (with ad hoc assistance from NHSP Band 5) as the post has been vacant since August 2017. This vacant post has now been filled, with expected date of commencement October 2018. The team are working more closely with the Infection Prevention and Control team as basic clinical support is very similar and allows shared skills, knowledge and experience across 2 small and specialist teams. The demand on both teams to provide effective support is being monitored to ensure patient safety and experience is maintained. The Tissue Viability team of 2wte staff, is small, but having benchmarked with RLUBH the team there have ratio 1wte per 228 beds, SOHT have 1wte per 235 beds.

Since 2016,185 clinical staff have attended training sessions and 339 have had training through clinical induction. A full training needs analysis is being developed to support the training plan to commence in October 18 when the additional TVN's commence in post to capture the additional staff (351).

2015	37
2016	33
2017	62
2018	53
Total	**185 +339 = 524**

Conclusion

Having reviewed all the data available and the improved recognition, assessment and reporting of patients who attend A&E it is unlikely that we have concerns in the care given to patients which would result in a HAPU incident in A&E. This will also have a positive effect on patients admitted to our wards, as plans will already be in place for patients deemed at risk .

A quality improvement plan is in place (appendix 1) which will be monitored through the Nursing and Midwifery board, together with the revised quality dashboard and performance framework and a quarterly assurance report from the TVN.

The board are asked to receive this report as assurance that systems and processes are in place, together with a quality improvement plan to ensure we give good care to our patients and reduce and ultimately eliminate hospital acquired pressure ulcers.

APPENDIX 1 - Quality Improvement Plan

Objective	Action	lead	Progress update	Completion date	BRAG
Monthly incidence monitoring by 1000 bed days	BI to report incidence by number and by 1000 bed days.	TVN	In development, still awaiting data for bed occupancy to be analysed with incidence number and by 1000 bed days.		
	Revised reporting to be part of new performance dashboard and framework	DDON	Clinical KPIs in development to be part of performance dashboard and framework from ward to board.		
Training of all clinical staff in Pressure ulcer prevention, identification and management, with appropriate use of equipment	Training to be delivered to all clinical staff at induction	PEFs		In place	
	Review possibility of E-learning package	TVN	Contacted training and development dept to review possible e-learning packages to support training		
	Training to be delivered to clinical areas to all clinical staff (875)	TVN team	Training sessions in place, will be increased once new staff commence in post October 18		
Need to focus on strategies to prevent heel pressure ulcers, as poor mobility and lower limb swelling are high risk factors that affect many of our older, frailer population.	TVN will liaise with Older Persons Lead to ensure appropriate care and care plans are in place for this cohort of patients.	TVN	Older person lead not yet in post, but TVN had liaised with them to look at requirements going forward.		

Formal reporting through a national audit tool	Formal reporting through national audit tool expected to be implemented by NHSI Autumn 2018.	TVN	Awaiting audit tool from NHSI		
Formal reporting to community providers of patients who present to A&E	Meet with community providers to implement reporting structure of patients presenting to A&E with skin damage	DDON	Met with community providers, agreed process of referral, awaiting secure email addresses to share incident details.	16/08/18	
	All incidents to be reviewed on daily basis with agreement of which incidents to share with community providers	DDON	Process in place	20/08/18	
	Monthly update / feedback meetings with community providers until process embedded	DDON	Meetings planned	20/08/18	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 September 2018

Agenda Item	**TB214/18**	**Report Title**	**Freedom To Speak Up Quarterly Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Martin Abrams, Freedom To Speak Up Guardian *(FTSU)*		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓ To Note ☐ To Receive	

Executive Summary

This report provides an update of the concerns raised to the FTSU during Quarter 1 2018/19 and will be uploaded to National Guardian Office (NGO), once their database is back up and running.

There were 9 issues in total, all managed appropriately.

There were no themes to note.

The NGO action plan is attached for information with 1o actions currently off plan, all being managed by the appropriate executive lead to bring back on plan and manage as identified.

The board recently spent time out and completed the Freedom to Speak Up self-review tool for NHS trusts and foundation trusts, for submission by the end of July 18. An action plan to meet the issues not yet implemented is in plan to be submitted to NHSI 31 August 2018.

Strategic Objective(s) and Principal Risks(s)

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

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

☐ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
✓ **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)*

To accept this report as progress against the NGO action plan and compliance to quarterly FTSU return

Previously Presented at:

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

National Guardian
Freedom to Speak Up

NHS
Southport and
Ormskirk Hospital
NHS Trust

Freedom to Speak Up Guardian Quarterly Update

1. Report on Quarterly Submission to Nation Guardians Office

Quarter number and dates: Quarter 1, 1st April – 30th June 2018

Date Submitted: 23/07/18

Date National Data to be published: Unknown

Number of concerns raised: 9

Themes:

In April 3 concerns were raised:

1) Preliminary concern about mortality data recording and the possibility that national guidelines were not being followed. The person raising the concern now considers the issue is being addressed through the natural working of the new mortality operational group, which is working through the appropriate and correct coding according to national standards.
2) Historic issue about the way a service was lost to another trust and although suggestions of bullying were made the person felt it too late to pursue due to changes of key people. The person was very appreciative of the support.
3) Issue about a management and communication style and possible equality issue. The concern was addressed and resolved quickly by an e-mail conversation between the guardian and the people concerned. Upon the issuing of further information the person who raised the concern was pleased with the outcome.

In May 5 concerns were raised:

4) Related to unpaid holiday pay following retirement on health grounds. This was quickly resolved via HR / Pay role.
5) Anonymous concern in relation to patient safety on a ward. Issues in relation to this had already been escalated to the DON and a whole programme is in pace bringing about significant changes and improvement on the ward.
6) Related to space for Islamic prayer and inadequate provision for Friday prayers. The issue is now in the current review of space and a potential solution and location has been identified for prayers.
7) Concern about the time a process of investigation has taken. Various possible actions were identified. As yet the person raising the concern is still thinking about whether to pursue this.
8) Concern raised anonymously that a person had been appointed to a role they were not qualified for and that they did not fit the person specification. HR carried out an investigation into this and discovered the concern to be accurate and the job offer was withdrawn.

In June 1 concern was raised:

9) Issue raised by a person who felt they were being bullied in their department. Various options for going forward were identified, including the offer of mediation. In talking about the possibility with her manager the issues were resolved quickly and informally.

In relation to 4 closed concerns those raising concerns were asked if, given their experience, they would raise a concern again, and 4 reported yes.

National Picture

Following submission of our data, the national dataset is not yet available but a summary has been shared with Guardians and is listed below:

97 percent of trusts have provided data this quarter. The Q1 data headlines include:

- 2,348 cases were raised to Freedom to Speak Up Guardians, ambassadors or champions.
- 731 of these cases included an element of patient safety or quality of care.
- 1,003 included elements of bullying and harassment.
- 110 related to incidents where the person speaking up may have suffered some form of detriment.
- 264 anonymous cases were received.
- 12 trusts did not report any cases through their Freedom to Speak Up Guardian.

223 out of 230 NHS trusts sent returns.

2. National Guardians Office – Update on action plan following recommendations from visit in September 2017

The organisational wide action plan has been reviewed and updated by leads on 22nd August 2018.

Table 1 : NGO action plan Progress to Date

Rating	Number	Comment
Delivered and Sustained	1	
Action Completed	38	
On track to deliver	30	
No progress / Not progressing to Plan	10	Of the actions where the target date has passed: 2 – Audit of policy and procedures by MIAA, was planned for Quarter 1 escalated to lead 2– Objectives of E&D lead, delay in recruitment of post 1 – Training review of current provision of vision and values training 1 – local action planning from staff survey results 3 – Policy reviews and update in partnership with STHK 1 – Sharing of cultural review report delayed due to ongoing HR issue

3. Freedom to Speak Up self-assessment tool for NHS trusts and foundation trusts.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office (NGO) have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

The self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

As an organisation we have pledged with NHSI that we will complete the self-assessment, which the board completed in July 18. The tool is divided into 13 sections, each with several subsections. The findings of the self-assessment tool are set out below.

Table 2 : self-assessment tool current position

Self-review indicator	Expectation being met	
	Partial	Full
Leaders and knowledgeable about FTSU	4	
Leaders have a structured approach to FTSU	1	3
Leaders actively shape the speaking up culture	6	
Leaders are clear about their role and responsibilities	1	2
Leaders are confident that wider concerns are identified and managed		2
Leaders receive assurance in varying forms	4	4
Leaders engage with all relevant stakeholders		8
Leaders are focused on learning and continual improvement	6	2
Individual responsibilities CEO and Chair		5
Individual responsibilities Executive lead(s)	5	4
Individual responsibilities Non-executive lead(s)	5	1
Individual responsibilities HR and OD directors	2	1
Individual responsibilities medical and nursing directors	1	3

An action plan, integrated within the NGO action plan, is in place and will be submitted to NHSI by 31 August 2018. The FTSU quarterly report will continue to be presented through the board and will give update and assurance on progress.

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 28 August 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 month 4 financial performance is slightly better than the forecast Trust-approved deficit plan. However, the CIP is under-performing, further work is required to achieve some CQUIN targets, agency costs are above budget and allowance has not been made for any possible contractual sanctions/penalties. A revised assessment will be undertaken of all relevant factors so that an updated forecast can be submitted to the September FP&I meeting.

ADVISE

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

- the exercise to produce a medium term financial plan underpinned by a sustainable service model is underway; it is hoped that preliminary findings will be available for consideration at the next meeting.
- the Integrated Performance Report is being enhanced but the work to date, which has included a more detailed analysis of challenges faced and closer liaison with lead clinicians/managers, has already resulted in more immediate remedial action being taken in a number of areas.
- a detailed assessment of the cancer pathways, including a review of diagnostic capacity, has been undertaken. Findings suggest that the Trust will be back in line with cancer targets by December.
- an encouraging update was provided on the work designed to reduce the Trust's average length of stay, including roll-out of the SAFER programme. The Committee will closely monitor progress over coming months.

ASSURE

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

- the Trust's 2018/19 capital programme is broadly on course for delivery so it was agreed that the latest position be presented to the Board from the perspective of the tangible service improvements that will result from the planned investment.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 23 July 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)

- discussions are ongoing regarding the proposed tariff for the Ambulatory Care Unit. Even though Trust proposals are in line with arrangements elsewhere, it is felt that the matter may require the intervention of NHSI/NHSE in order to reach agreement with all the local CCGs

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)

- it is hoped that a system-wide winter plan will be agreed by the end of July.
- the 2018/19 forecast CIP delivery currently stands at £5.2m, with work ongoing to identify further measures that would enable the Trust to achieve its original target of £7.5m
- noting the importance of achieving safe staffing and maintaining financial control, the Committee asked that consideration be given to ways of achieving these objectives without employing additional staff. Reducing escalation beds was suggested as one possibility
- action for meeting cancer targets by the quarter 3 was supported by the Committee
- the Committee requested that a detailed analysis of the Trust's length of stay be prepared for the next FPI Committee meeting

ASSURE

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

- expenditure and income figures for month 3 are broadly consistent with recent months, providing a reasonable degree of assurance on the effectiveness of current financial controls

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

Alert, Advise, Assure (AAA) Highlight Report

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

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Committee was concerned that there was not full compliance with annual staff appraisals and advised that steps should be taken to ensure that this happens
- In order to prevent fraud there is a need to ensure new staff are aware of the requirement to divulge any criminal convictions and that the on-going fit and proper persons' process to continue at Board and senior level

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)

- Terms of Reference - to be revised to reflect the Audit Committee's role in overseeing, being aware of and ensuring that action plans relating to regulatory requirements are monitored and delivered
- Annual Audit Letter - to be revised and published on Trust website
- Reference Costs – going forward, timetables to be devised so as to ensure the Audit Committee receives details of proposed submissions in advance of submission to NHS Improvement.

ASSURE

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

MIAA Follow Up Review – it was noted that all recommendations had been implemented save for 2 rated as medium risk in relation to Critical Applications – EMIS web. Details of these outstanding actions would be provided for the next meeting.

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

5 September 2018

Agenda Item	TB217/18	Report Title	Integrated Performance Report
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Anita Davenport, Interim Performance Manager		
Action Required *(Definitions below)*	☐ To Approve ☒ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

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

Strategic Objective(s) and Principal Risks(s)

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

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

☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

CQC KLOEs	**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)*

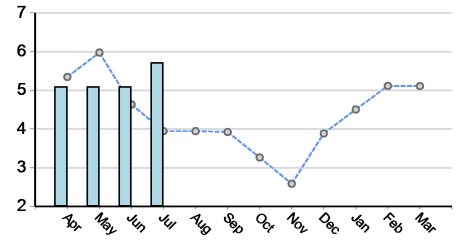
Previously Presented at:

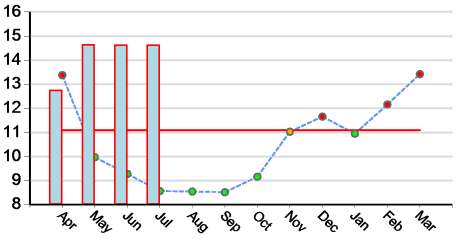
☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

Board Report - July 2018

NHS Southport and Ormskirk Hospital NHS Trust

Safe

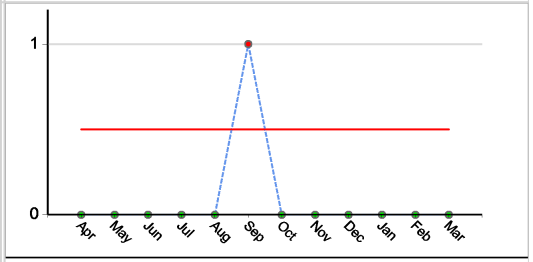
Indicator Name	Description	Narrative	Month Trend
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000). Line = Last Financial Year, Bar = This Financial Year.	There were 2 hospital cases in July. Both of these infections originated in the community but were tested >48 hours post admission as the diseases progressed irrespective of appropriate treatment. - Each of the bacteraemias were carefully reviewed by the respective medical team in consultation with the Consultant Microbiologist and treatment prescribed. There is no set target reduction for MSSA, however each case is reviewed by the clinical team, the Consultant Microbiologist and the IPC team to identify the source of the infection and identify any resulting actions	
Action Description	**Action Progress (%)**	**Action Narrative**	**Action Status**
Assess the viability of an ANTT (Aseptic Non-Touch Technique) E-learning Package	80	Most hospitals in the surrounding area provide some form of ANTT training; some have designated trainers, others combine trainers with some form of E-learning and other have E-learning and assessors. The IPC Consultant Nurse has identified an E-learning package that would have an annual cost of £6000. The viability of this needs to be further investigated and reported to the Executive Medical Director/Director of Infection Prevention and Control	Off Target

C.Diff - Infection Rate (Rolling 12 months)	The rate of Clostridium Difficile (C.Diff) infections over a rolling 12 month period calculated as follows: (12 month count/rolling 12 month av occupied bed days x 100,000). Line = Last Financial Year, Bar = This Financial Year.	There were Zero Hospital C diff Cases in July. The C.Diff rate remains static as a result. - The Trust's 2018/19 C.diff. objective as set by NHS Improvement is not to exceed 35 cases which equates to no more than 2.9 cases per month. As this figure is far above our actual of 21 cases for 2017/18, the Trust has set an internal stretch target of no more than 20 cases in 2018/19 (1.7 cases per month), hence so far this year the Trust is almost 3 cases below trajectory for the stretch target. In reviewing the 12 monthly trend it is evident that the trend is increasing even though the Trust C diff performance continues to be under trajectory; this apparent anomaly is caused by the trend for the same period in 2016/17 showing a decline which has accentuated the current trend. The national average rate is 15% and so the Trust is comparable with that rate. This KPI is being queried for its validity	
Action Description	**Action Progress (%)**	**Action Narrative**	**Action Status**
		No action required as there were no incidences in July and the trust is well below the target for actual cases	

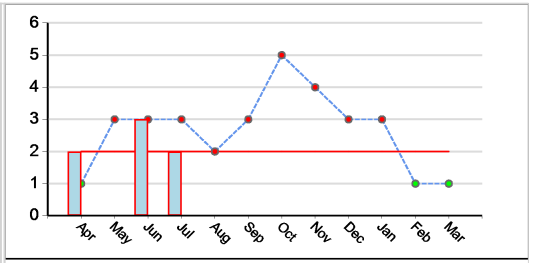
Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
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.	11 months since last MRSA bacteraemia - There is a zero tolerance for MRSA bacteraemia and it has now been 11 months since the last case. At the time of this report we currently have 14 patients who are isolated due to being colonised with MRSA, hence there is an ever present danger that any one of these patients could go on to develop an MRSA blood stream infection. The Trust currently monitors all in-patients for MRSA colonisation and when identified they are isolated in side rooms and treated with suppression therapy. The IPC team and the PEFs have provided clinical instruction to the new F1 doctors on Cannulation, Blood Culture Acquisition and Phlebotomy using ANTT. The IPC team provide induction training to all new employees as well as mandatory training - these sessions include a review into how to prevent MRSA infections. With respect to actions 1 and 2 below: Action 1 remains the same as the Senior Nurses monitor cannula care plan compliance. Action 2 has now been implemented with the electronic laboratory test ordering system being rolled out throughout the Trust	

Action Description	Action Progress (%)	Action Narrative	Action Status
Adherence to Trust Cannula Care Plan	80	IPC team have conducted a cannula audit and reported this through Trust meetings; the team has also updated the cannula care plan and will do a further audit in September 2018. The CBUs have determined that cannula care plans need to be assessed by senior nurses on the wards and that this will be monitored by the respective CBU Matrons, however the CBUs haven't as yet determined how the monitoring will be accomplished and recorded.	Off Target
Appropriate labelling of laboratory specimens	90	There has been a lot of reinforcement through mandatory training to promote the appropriate labelling of specimens, however the major impact will be the introduction of the electronic ordering of specimens (Order Coms). This has had some slippage due to a number of technical problems, however the system is currently live on the Ormskirk site and should be live on the Southport site by 31/7/18 - this should mean that all specimens are now required to have a location therefore reporting should be more timely	On Target

Indicator Name	Description	Narrative	Month Trend
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.	2 cases of E coli Bacteraemia in July - 1 E coli case from ITU and 1 from SIU (Weld Road out reach bed). Both of these cases will be reviewed by Planned Care CBU using the RCA process. Preliminary sources of infection have been identified as lower respiratory tract infection and catheter associated urinary tract infection. Affected patients have been treated by their respective clinical teams in collaboration with the Consultant Microbiologist. Under Action 1 below; the audit of the catheter care plan was started on 1/8/18 on SSU - initial shortfall has identified that daily review of the need of the catheter is rarely documented.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Reduce Urinary Catheters and Thereby Reduce CAUTI	70	Catheter Care Plans have been updated. The initiative is to monitor a poor performing ward (as identified by the safety thermometer) with their catheter usage and their adherence to the Catheter Care Plan from a month and see if this reduces catheter usage and therefore CAUTI. This is to start in August and will be reported on in September - if successful the process will be repeated on other in-patient wards.	On Target

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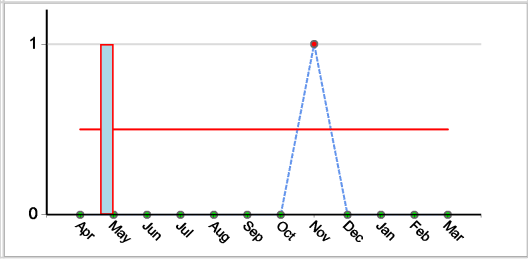
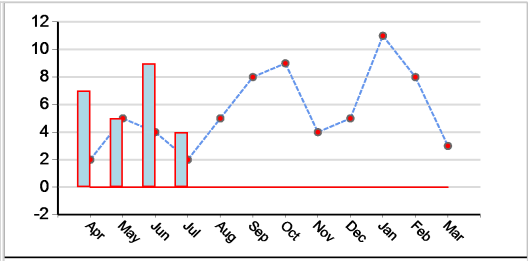
Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	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.	No Never Events for July - There were no never events reported in the month of July	
StEIS	Strategic Executive Information System (StEIS) is the national database for reporting serious incidents. The overall number of reported incidents. Line = Last Financial Year, Bar = This Financial Year.	There were 4 incidents reported to Steis in July - There has been a decrease in the number of STEIS reportable incidents. In June there were 9 incidents reported compared to 4 reported in July. 4 of the reported incidents were Urgent Care CBU incidents ;relating to 2 patient falls and the 3rd relates to lack of out of hours scope services. The 4th incident was from the Planned Care CBU relating to delay in diagnosis and escalation of a bowel perforation. The Women & Children's CBU reported 0 incidents in July. The Serious Incident Review Group (SIRG) has now been implemented on a weekly basis were the 72hr review for the incident is presented and a decision is made on the level of investigation , timescales are being monitored weekly with the CBU by the Risk Department . There is a 60 (working) day investigation period. This means that actions below relate to earlier incidents as per the narrative below: There was a total of 9 Steis reported incident which have all been agreed through the Serious Incident Review Group processes. The Planned Care Business Unit have had 3 reported incidents, 1 Information governance, 1 delayed diagnosis and 1 treatment issue relating to diabetes. The Urgent Care Business unit have had 4 reported incidents, 3 falls and 1 pressure ulcer. The falls will be reviewed for key themes through the falls working group. Women's and children's Business Unit, have had 2 incidents reported 1 safeguarding and 1 unexpected admission to Neonatal unit. All incidents are going through the Serious Incident Processes within the Business Units.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Falls Working group	100	Ongoing	On Target
ICO Review for IG Breaches W&C	50	Development of action plan in September	On Target
Pressure Ulcer Review	100	Ongoing	

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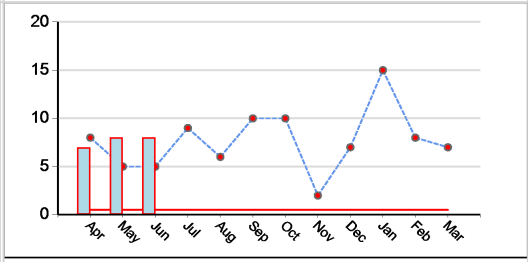
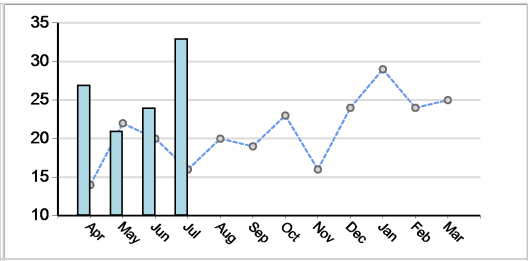
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Serious Untoward Incidents (SUIs)	A Serious Untoward Incident (SUI) is an accident or incident when a patient, member of staff or member of the public suffers serious injury, major permanent harm or unexpected death on Trust premises where the actions of health service staff is likely to cause significant public/media concern. Line = Last Financial Year, Bar = This Financial Year.	SUIs are all reported through the StEIS Process and the action plans reported under the StEIS KPI -	

Action Description	Action Progress (%)	Action Narrative	Action Status

Falls with Harm	The total number of falls in which a patient suffered harm. Line = Last Financial Year, Bar = This Financial Year.	The number of Falls with Harm have increased from 24 in June to 33 in July. This data relates to all falls as they are all graded as moderate initially. This is being reviewed - Currently all falls are graded as moderate harm until no harm has been established. This is to prevent accidental closure of DATIX potentially missing actual harms. Stephen Cooper is now the Falls Lead for the Trust	

Action Description	Action Progress (%)	Action Narrative	Action Status
Falls lead established	100	documentation review undertaken to align against NICE cg161	On Target
Re-Launch FRAP	30	to establish thematic review of falls and develop falls with harm reduction programmes	On Target

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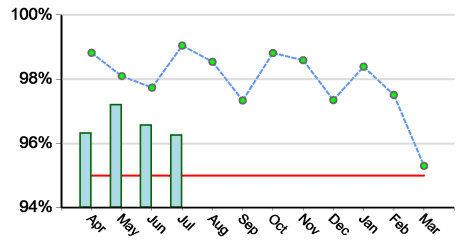
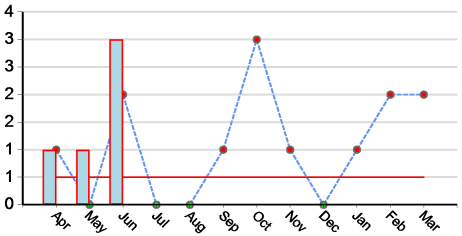
Safe

Indicator Name	Description	Narrative	Month Trend
VTE Prophylaxis Assessments	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.	Performance continues to consistently be above the 95% compliance -	
Hospital Pressure Sores - Grades 3 & 4	Number of reported Trust acquired pressure sores graded between 3 and 4. Line = Last Financial Year, Bar = This Financial Year.	- 3 category 3 pressure ulcers reported in June.2 were within planned care, one related to skin traction and one a heel ulcer. Both await full investigation. One category 3 incident within urgent care related to a heel ulcer fully investigated and an action plan is in place.	

Action Description	Action Progress (%)	Action Narrative	Action Status
all incidents investigated	80		On Target

Board Report - July 2018

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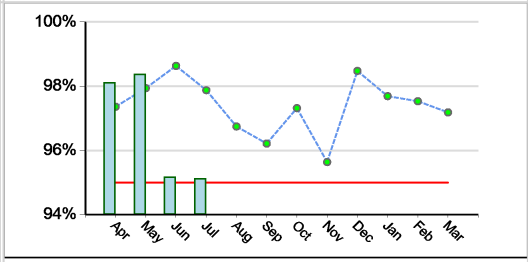
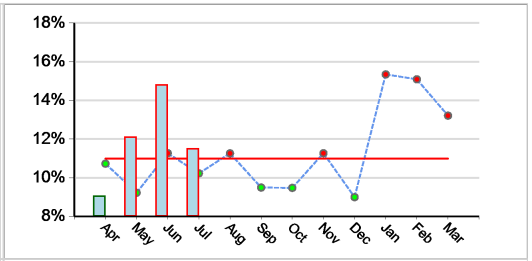
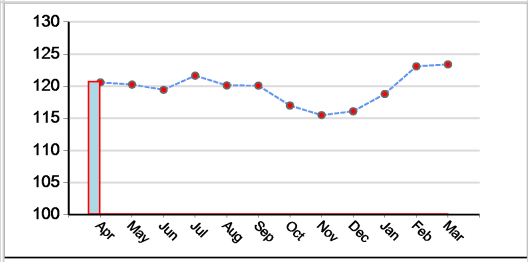
Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is bette. Line = Last Financial Year, Bar = This Financial Year.	Performance compliance reduces slightly but continued to meet national benchmark - National benchmark of 95% exceeded for month of July. During the census period of data collection (n= 370) the Trust reported 18 new patient harms which were made up of: 2 new HAPU (Grade 2 or above) - 14a (1 x Grade 2) and 9a (1 x Grade 2) 7 new falls resulting in harm - 9a (1x low), 9b (1x low), EAU (1x mod), 11a (2 x low), 14b (1 x mod) and 15b (1 x low) 5 new UTI in patients with indwelling catheter - 7b (x1), 9b (x2), 14a (x1) and Spinal (x 1) 4 new VTE - Spinal (1 x PE + 2 x DVT) and 10b (1 x other) The introduction of a single CENSUS DAY commences in August 2018 which will ensure that there is no potential for 'double counting' of those new harms reported due to patient moving wards during data collection period Actions are responsibility of respective CBU	
Emergency C-Section Rate	The proportion of all deliveries that resulted in an Emergency C-Section. Line = Last Financial Year, Bar = This Financial Year.	Emergency caesarean section rate will flutuate month by month. This is considered a normal variation. - This months emergency caesarean section rate is a reduction on the previous two months. Prior to the decision for emergency caesarean section all cases are discussed with a Consultant Obstetrician. Plan - continue to monitor	

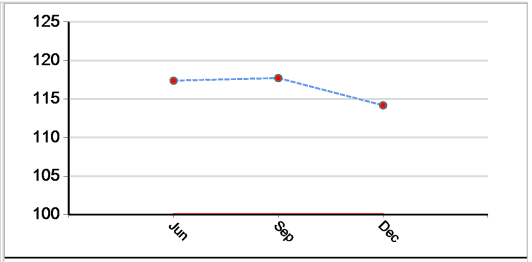
Action Description	Action Progress (%)	Action Narrative	Action Status

Board Report - July 2018

Effective

Indicator Name	Description	Narrative	Month Trend
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100. At Trust level, good performance is 100 or less. Source = Dr. Foster. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data. Line = Last Financial Year, Green = Previous Value, Blue = Corrected Value	The 12 month rolling HSMR for March 2018 was 121.30 which is a marginal decline on February 2018 was 120.90 - The HSMR is provided nationally by 'Dr Foster' and applies to in-hospital mortality (excluding palliative care).	

Action Description	Action Progress (%)	Action Narrative	Action Status
Best Practice Care Pathways	50	Revised and updated AKI, sepsis and pneumonia pathways. Best practice pathway for GI Bleed and revised, well publicised drugs charts	On Target
Communication and Escalation of the Deteriorating Patient	30	The use and development of the Safety Hub. Effective new processes to improve team working and management of the deteriorating patient. Business Case submission for Critical Care 24/7 Outreach Team	On Target
Future Care Planning	40	Advance Care Planning, Anticipatory Clinical Management Planning, Alternatives to Admission, Rapid End of Life Transfer, Reduce time to discharge for patients Medically Fit for Discharge ,	On Target
Learning Culture	60	Roll out and embedding of the Structured Judgement Review	On Target
Information	80	Continuous assessment for opportunities for improvement. Collaborative Working with AQUA and Dr Foster.	On Target

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, Bar = This Financial Year.	Standard Hospital Mortality Indicator for Quarter 3 2017/18 (up to 31st December 2017) iss 114.19 which is a slight improvement from 117.73 in quarter 2 - Despite the year on year improvement, the SHMI for the Trust remains high and above expected levels.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Best Practice Care Pathways	50	Improvement and revision of AKI, sepsis and pneumonia pathways. Best practice pathway for GI Bleed and revised, well publicised drugs charts	On Target
Commmunication and Escalation of the Deteriorating Patient	30	The use and development of the Safety Hub. Effective new processes to improve team working and management of the deteriorating patient. Business Case submission for Critical Care 24/7 Outreach Team	On Target
Future Care Planning	40	Advance Care Planning, Anticipatory Clinical Management Planning, Alternatives to Admission, Rapid End of Life Transfer, Reduce time to discharge for patients Medically Fit for Discharge	On Target
Learning Culture	60	Roll out and embedding of the Structured Judgement Review	On Target
Information	70	Continuous assessment for opportunities for improvement. Collaborative Working with AQUA and Dr Foster.	On Target

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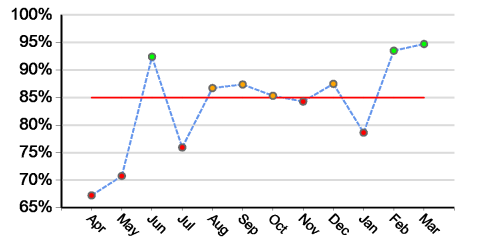
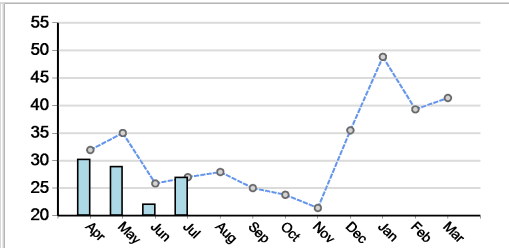
Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
Sepsis Screening & Antibiotic Administration	Sepsis Screening & Antibiotic Administration. Line = Last Financial Year, Bar = This Financial Year.	Updated Sepsis pathway to be launched in September 2018 - A revised Sepsis pathway has been developed and will be launched in the Trust during September 2018.	

Action Description	Action Progress (%)	Action Narrative	Action Status

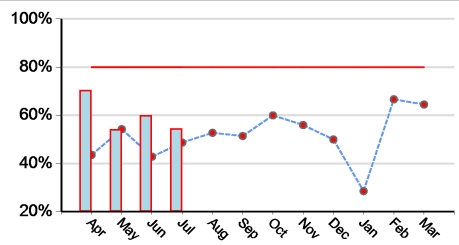
Crude Death Rate	Crude rate per 1000 Discharges (Excluding day cases)	Improving Crude Mortality Levels - The quality improvement activity of the Reducing Avoidable Mortality Project is designed to improve the SHMI, the HSMR and reduce crude mortality.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Best Practice Care Pathways	50	AKI, sepsis and pneumonia pathways. Best practice pathway for GI Bleed and revised, well publicised drugs charts	On Target
Commmunication and Escalation of the Deteriorating Patient	30	The use and development of the Safety Hub. Effective new processes to improve team working and management of the deteriorating patient. Business Case submission for Critical Care 24/7 Outreach Team	On Target
Future Care Planning	40	Advance Care Planning, Anticipatory Clinical Management Planning, Alternatives to Admission, Rapid End of Life Transfer, Reduce time to discharge for patients Medically Fit for Discharge	On Target
Learning Culture	60	Roll out and embedding of the Structured Judgement Review	On Target
Information - Mortality Reporting	80	Continuous assessment for opportunities for improvement. Collaborative Working with AQUA and Dr Foster.	On Target

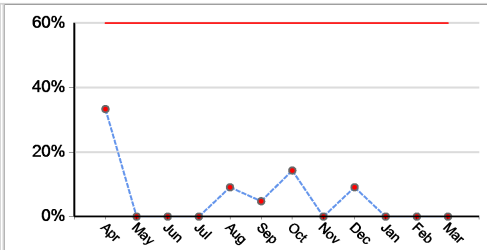
Board Report - July 2018

NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
Stroke - 90% Stay	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Please note: Indicator may change as a result of delayed validation. Line = Last Financial Year, Bar = This Financial Year.	Performance remains consistently below target. Bed pressures and patient flow directly affect the ability to meet the Stroke target - Performance remains consistently below target but performance is relatively static. Sentenal stroke national audit programme (SSNAP) - audit of stroke performance via SSNAP measures admission directly to a stroke unit within 4hrs of presentation. July's performance was 54.55% admitted within 4hrs. There are delays overnight when stroke nurses are not on duty (currently stroke nurses work 7days 7:30 - 8pm)	

Action Description	Action Progress (%)	Action Narrative	Action Status
Protected stroke bed	80	due to bed pressures and patient flow this is not always possible	On Target
Additional stroke nurse to provide 7day 24hr cover	50	awaiting Vacancy approval	On Target

Indicator Name	Description	Narrative	Month Trend
TIA	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 remains at zero for high risk patients being treated within 24 hours. - The Trust does not have capacity to run a 24 hour service. Following the loss of a consultant, a process review is underway	

Action Description	Action Progress (%)	Action Narrative	Action Status
Undertake process review	10		Off Target

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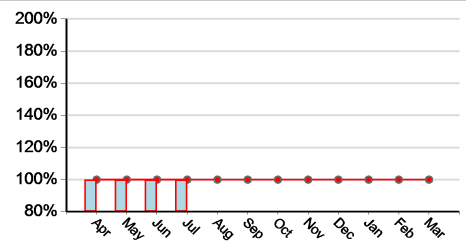
Effective

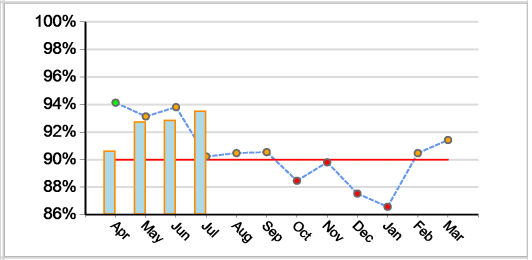
Indicator Name	Description	Narrative	Month Trend
WHO Checklist	WHO Checklist. Line = Last Financial Year, Bar = This Financial Year.	- WHO Checklist compliance remains at 100% and on target	

Action Description	Action Progress (%)	Action Narrative	Action Status
WHO Checklist Report	0	Discussed in clinical governance. Report required from audit team to include WHO checklist compliance in 2018-2019 audits	Off Target

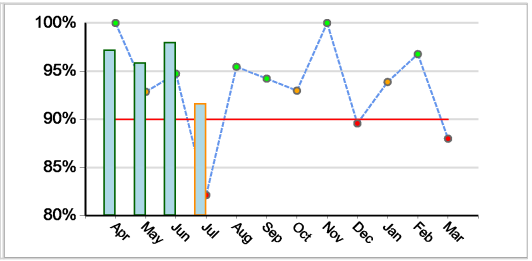
Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
Friends and Family Test - Inpatients - % That Would Recommend	The proportion of Inpatients who responded that they would be likely or extremely likely to recommend their ward to Friends and Family. Line = Last Financial Year, Bar = This Financial Year.	Increase in performance on previous month. - Increase in performance when compared to previous month. Pledge groups continue to support the Trust Patient Experience Strategy, Healthwatch reports and results of National Inpatient Surveys.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Patient Expereince Strategy - Pledge Groups.	40	Pledge Groups have been in place since October 2017	On Target
National Inpatient Survey	20	Areas of focus agreed June 2018	On Target

Friends and Family Test - Maternity - % That Would Recommend	The proportion of Maternity patients who responded that they would be likely or extremely likely to recommend their postnatal ward or birthing unit to Friends and Family. Line = Last Financial Year, Bar = This Financial Year.	Decrease in performance. - Performance has decreased since previous month data. Significant reduction in response rate also noted.	

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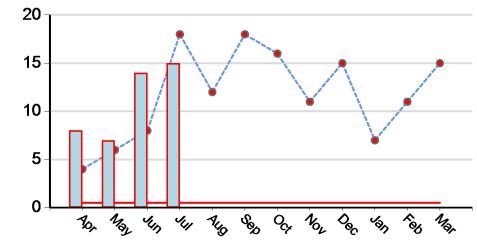
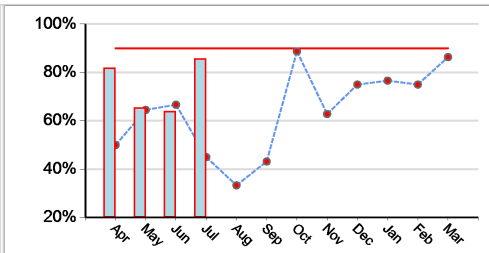
Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
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.	There were 15 DSSA breaches in July. The SAFER Care Bundle was launched at the end of July to address patient flow. This is being rolled out on a ward by ward basis starting with 14B, and currently 14A - 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.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Ongoing patient flow management	100	Ongoing	On Target

Indicator Name	Description	Narrative	Month Trend
Friends and Family Test - A&E - % That Would Recommend	The proportion of A&E patients who responded that they would be likely or extremely likely to recommend the department to Friends and Family. Line = Last Financial Year, Bar = This Financial Year.	Improving performance - Recent Healthwatch report received which highlights positive patient feedback and experience (Listening event held March'18) . Action plan to be developed and returned to Healthwatch by 31st August'18. Monthly performance continues to be monitored.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Recruitment of A+E volunteers	70	Recruitment checks ongoing.	On Target
Health watch report action plan	50	Healthwatch report action plan to be completed and returned by 31.8.18.	On Target

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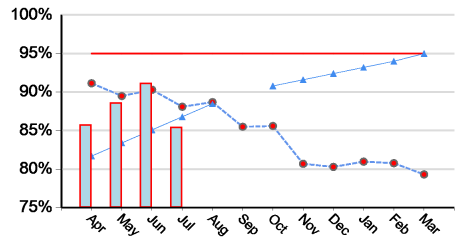
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	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.	4-hour breaches fell to 85.51% during the month of July - 5.9% increase in attendances during the month of July compared to July 17 (257 additional patients) - all were majors category. The department escalated to level 4 on a number of occasions across the month, and the Trust was routinely escalating between black and red escalation for bed pressures. ED saw medical staffing challenges with heavy reliance on agency usage to fill vacant trainee gaps, leading to ad-hoc skill mix. All trainee posts have been filled from 1 August and 2 new substantive consultants will be in post by the end of September. The current ED estate is not fit for the patient demand seen month on month. Phase 3 rebuild with 4 protected cubicles, extended triage space for walk in and ambulance patients, in addition to 2 ambulant majors cubicles will support flow. However, an increase pace to release inpatient beds, coupled with protection of assessment spaces is critical to reduce some of the bottlenecks that prevent patients leaving ED timely.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Phase 3 Rebuild	30	Tender has now closed. Estate plans agreed with clinical teams. regular project meetings established. Due for completion mid Oct 18	On Target
Medical Staffing Workforce	50	x1 new substantive consultant appointed - start date 1 September 2018. Interview for 2nd additional substantive consultant scheduled 30 August 2018 with 1 candidate. All junior trainee medical posts filled from August. Expansion SAS posts back out to advert with international recruitment also being pursued. Expansion ANP post to be advertised.	On Target
Opening of dedicated discharge lounge	90	Dedicated discharge lounge opened mid July. Protected clinical area to support early discharges to enable to wards to release acute beds to ED timely	On Target
Increase in ambulatory streaming	20	Workforce paper prepared to go the Exec Team meeting 9/8/18. Discussion held regarding ring-fencing clinical space in ACU to enable ED to stream.	On Target
Opening of Surgical Assessment Unit	90	Estates work almost completed. Due to open 13/8/18. Once completed, 6 trolleys will be available to stream appropriate surgical patients from ED for specialty input in an appropriate clinical area. Will support improved ED flow and reduce the need to pull surgical patients down to A&E	On Target

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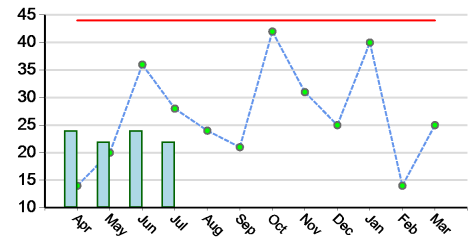
NHS Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
Written Complaints	The total number of complaints recieved. A lower number is good. Line = Last Financial Year, Bar = This Financial Year.	There were 22 complaints in July. The Trust has consistently exceeded its target in the last 12 months -	

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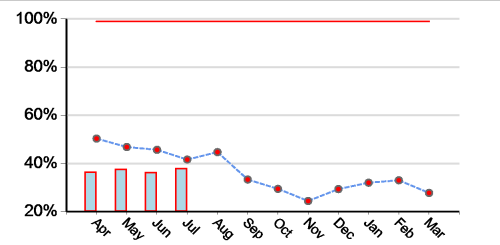
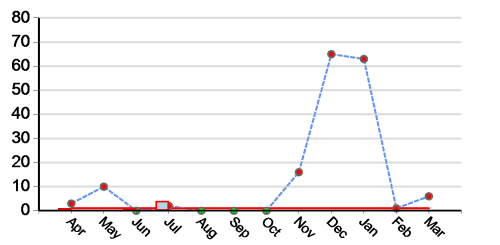
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes. Line = Last Financial Year, Bar = This Financial Year.	Ambulance handover times remain a challenge. - Compliance with timely ambulance handovers remains a significant challenge. Towards the end of July, the department trialled a change in the way that patients brought in by ambulance were triaged. On one day during the month, the Trust had the lowest ambulance turnaround times in North Mersey. However the department struggles to maintain flow across the department due to a number of exit blocks outside of the ED's control. The number of attendances month on month is increasing significantly, however the number brought in by ambulance remain static. The Phase 3 estates work is critical to ensuring protected, safe, clinical space for patients brought in by ambulance to have timely access to triage and commencement of treatments, whilst ensuring that ambulances can be released promptly. ECIST are running a live audit with NWAS to test other alternatives to ED - this had been due to be completed in August but has been put back to September. ED maintains close links with NWAS North Sector Manager to ensure partnership working.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Phase 3 Rebuild	20	Plans agreed with clinical teams. Contractor has been identified. Works to commence w/c 3 September. End date has slipped to 23/11. 4 clinical cubicles for ambulance arrivals and extended triage space will be created.	On Target
Ambulance rapid improvement event	80	Rapid improvement event held. New way of working in place. Significant reduction in extended ambulance waits in ED, however the overall turnaround times are still too high, largely due to lack of assessment capacity in the department.	On Target

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0. Line = Last Financial Year, Bar = This Financial Year.	- Disappointingly there were 4 12-hour breaches during the month of July. 3 were patients awaiting mental health bed and 1 was due to a delay in securing a side room. 2 mental health bed delays were awaiting Lancashirecare beds; 1 was awaiting a Merseycare bed. ED and mental health liaison continue to work together. Patients are risk assessed to understand the risk that they pose to themselves and others - the best interest of the patient remains paramount at all times. All 3 patients indicated significant risk to harm themselves and it was the agreement of all partners that they remained in ED whilst awaiting a suitable mental health bed. The Deputy COO has held a meeting with the CCGs, mental health partners to discuss mental health demand and actions required. The patient who breached whilst awaiting a side room attended on a day when there was significant demand for side rooms, with extremely low numbers of patients suitable to be transferred to a bed in a bay. On this occasion, the patient who was vacating the side room was being transferred home but clinically could not sit out. The room required a fog following vacation, and unfortunately the discharge and subsequent fog did not occur in time to avoid the breach.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Continue to work with mental health partners in conjunction with CCGs	50	Meeting held. Re-circulation of comms for escalation of 12 hour breach.	On Target
Continued liaison with IP&C to ensure that side room utilisation is appropriate	80	IP&C attend daily bed escalation meetings. Support given to wards and ED ensuring appropriate use of side rooms. Continued liaison with community IP&C to ensure awareness of community issues that may affect side room demand	On Target

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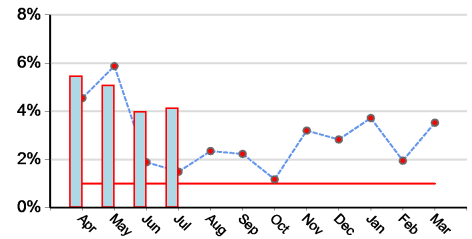
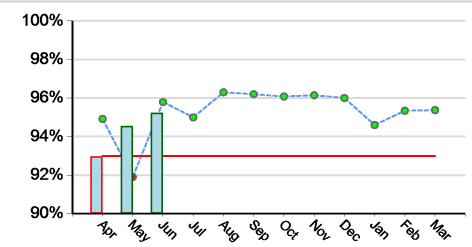
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	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.	Diagnositc waits was 4.16% in July which is below target. The trust has failed to meet the threshold of 1% in the last 12 months. The Diagnostics Improvement Programme is focusing on Endoscopy and Non-Obstetric Ultrasound to address this - Diagnostic waits was 4.16% in July which is below target of 1% breaching the 6 week deadline. The trust has failed to meet the threshold of 1% in the last 12 months. The Diagnostics Improvement Programme is focusing on Endoscopy and Non-Obstetric Ultrasound to address this. Phase 1 to the end of September focuses on establishing current state. Phase 2 (October to March inclusive)focuses on process improvements and developing a business plan. Phase 3 runs from April 2019 where larger scale improvements are identified	

Action Description	Action Progress (%)	Action Narrative	Action Status
Colonoscopy/Cystoscopy/Flexi Sigmoidoscopy - open up room 4 once trained staff available	50	Opening of additional room in endoscopy, once nurse training has been completed. Agreement to be reached over safe staffing levels	Off Target
Endocsopy WLIs	50	For all scopes there are WLIs On Saturdays. Demand and capacity work underway - completion end September	On Target
Cystoscopy capacity	50	Reviewing OPD and IP lists for capacity	On Target
Non Obs Ultrasound - increased activity	50	Remedial plan being drafted. Demand and Capacity work underway - completion September	On Target

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 has remained fairly stable - 95.23% in June, although work continues to ensure compliance is maintained. - Performance has remained fairly stable, although work continues to ensure compliance is maintained. Including CCG communication with GP's to ensure patients are aware they have the availability to attend appointments within 14 days. To note ERS has introduced further delays as GPs are booking into dedicated cancer rapid access clinics with routine appointments therefore blocking appointment slots for 2 week waits referrals.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review of all cancer pathways fort he need to implement RAS into ERS	40	Awaiting emplyment of ERS lead	On Target

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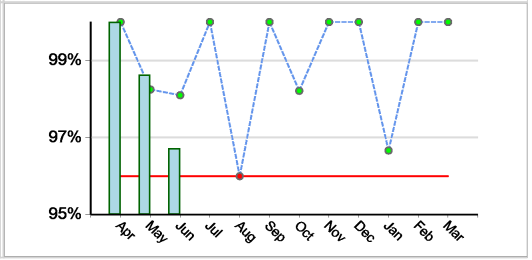
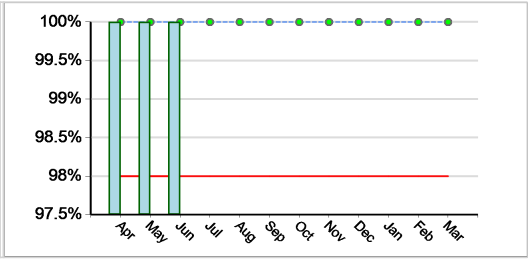
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	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.	- 31 day performance - Trust is able to meet 31 day performance targets	
31 day treatment (Anti-cancer drugs)	Percentage of patients receiving first definitive anti-cancer drug treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Line = Last Financial Year, Bar = This Financial Year.	- Trust is able to meet national target	

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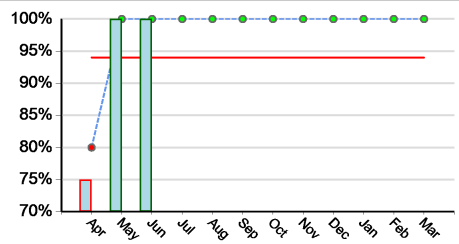
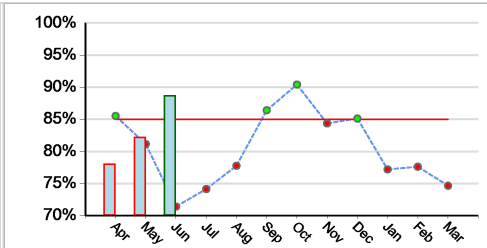
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
31 day treatment (Surgery)	Percentage of patients receiving first definitive surgical treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Line = Last Financial Year, Bar = This Financial Year.	Performance is maintained at 100% in June. April breach occurred due to reduced -	

Action Description	Action Progress (%)	Action Narrative	Action Status

62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment. Line = Last Financial Year, Bar = This Financial Year.	Cancer Performance failing but achieved target in May - Cancer Performance failing but achieved target in May - Performance is inconsistent due to number of factors: small numbers of patients diagnosed therefore small denominator, previous issues within diagnostic services now shown in figures, Cancer Services holding regular telephone conversations with NHSE, face to face meeting due to take place with NHSE and NHSI in coming weeks. New internal pathway relating all cancer pathways due to be introduced which should bring cancer performance back within national target Action	

Action Description	Action Progress (%)	Action Narrative	Action Status
IT link from Medway to Somerset Cancer Registrey	0	Awaiting new update from SCR due Friday 20th	Off Target
Introduction of daily Cancer pathway huddles	0	Awaiting Medway SCR link to be actioned.	Off Target

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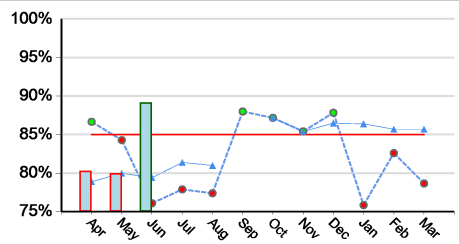
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
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.	- Achieved national 62 day national standard. To note new reallocation rules have the potential to reduce our performance further and predicting performance going forward will be more difficult.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Changes to interal cancer pathway	0	To commence once Medway and SCR link available.	On Target

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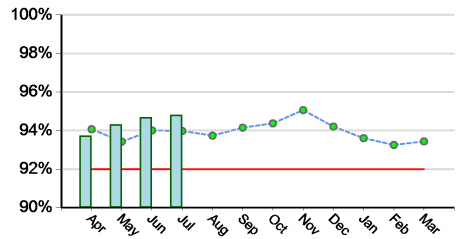
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
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.	Overall RTT performance is above the agreed target - An action plan is under review following an external review of internal processes.	

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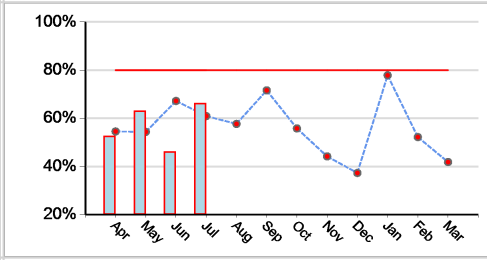
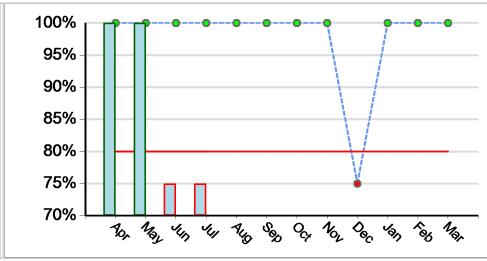
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Dementia assessment and referral - Case Finding	Dementia assessment and referral - those with diagnosis of dementia or delirium or to whom case finding is applied. Line = Last Financial Year, Bar = This Financial Year.	Performance declining - 46.31% in comparison to previous months data - 63.13%. Vital pac performance shared through bi-monthly Dementia strategy group meetings. Vital pac leads are also in attendance at these meetings as there continues to be some minor glitches on the system regarding breach time. Leads also frequently attend wards for re-training. Planned June Vital pac upgrade delayed buy approx. six weeks. Performance continues to be monitored monthly.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Vital Pac upgrade	0	Late due to technical issues. Due to go live July'18	Off Target
Vital Pac Training	80	Continuous programme of training.	On Target
Ward Level performace data	0	Provision of ward level data to share with areas and senior nursing teams.	Off Target

Dementia assessment and referral - Assess and Investigate	Dementia assessment and referral - who, if identified as potentially having dementia or delirium, are appropriately assessed. Line = Last Financial Year, Bar = This Financial Year.	Performance has declined from 100% to 75% - 1 patient out of 4 didn't receive a diagnostic assessment. This is being reviewed to ensure performance returns to 100%.	

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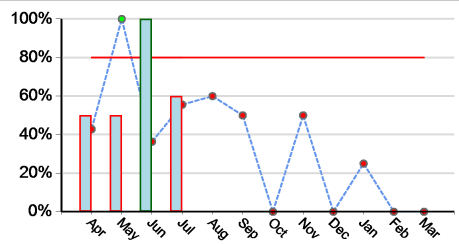
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Dementia assessment and referral - Referral	Dementia assessment and referral - where the outcome was positive or inconclusive, are referred on to specialist services. Line = Last Financial Year, Bar = This Financial Year.	Performance at 100% - All 3 patients were referred for further diagnostic advice appropriately.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Medical staff training	0	New medical staff induction in August.	On Target

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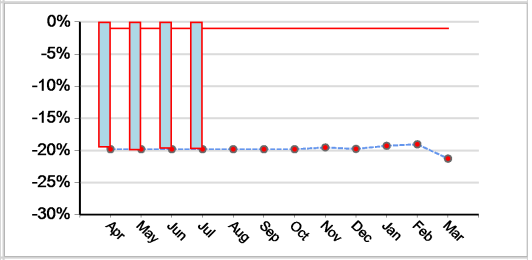
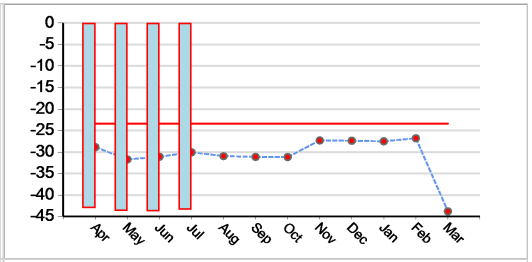
Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust. Line = Last Financial Year, Bar = This Financial Year.	Performance adverse to plan in month. In month deficit consistent with previous months . - Although the in month deficit is similar to previous months July's performance is adverse against plan as the CIP profile increases significantly from this month; the level of CIP required has not been achieved. A Turnaround Director has now been appointed and one of the key tasks will be to review the existing programme and to identify and make recommendations for further schemes to be introduced in order to avoid any slippage this financial year.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review current CIP schemes	80	Interviews held with those involved in the CIP process to establish deliverability in 2018/19	On Target
Detailed review of budgets to identify where furher savings can be made to mitigate current CIP underperformance	20	Scheduled for end August/September	On Target

Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations. Line = Last Financial Year, Bar = This Financial Year.	Metric is relatively static although there is a minor improvement in July - There was a step-change in the metric with the re-classification of one of the loans as a current liability which worsened the metric by 17 days. Whilst there maybe some scope for a reclassification of loans it will still mean that the Trust is significantly away from meeting its liquidity target (0 days or better). The only solution is for the Trust to become financially sustainable and for DH to convert the loans into public dividend capital.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Reclassification of DH loans	0	If DH agree to defer payment of the loan due to be repaid in February 2019 to a future financial years, this will reclassify it as non-current and improve the metric by 11 days.	On Target

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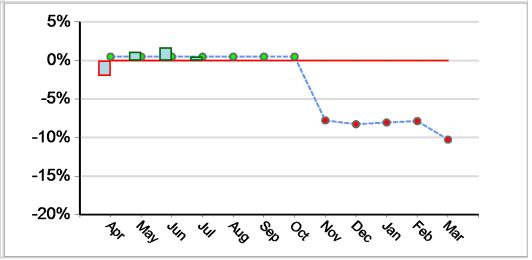
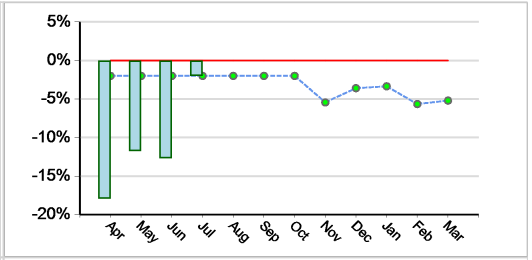
Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Control Total	Distance from Control Total. Line = Last Financial Year, Bar = This Financial Year.	At Month 4 Year to date the Trust remains ahead of its financial plan. - Performance has deteriorated in month which is mainly due to CIP performance. CIP performance needs to improve in month 5 or other mitigating actions need to be in place to avoid a further deterioration.	
Distance from Agency Spend Cap	Distance from Agency Spend Cap. Line = Last Financial Year, Bar = This Financial Year.	YTD performance is within the YTD plan but performance has deteriorated in July - The agency cap target has been profiled higher in quarter 1. In July the planned agency spend reduces (from £645k to £415k) but actual agency spend has not reduced in line with this plan. This metric is expected to be rated Red in August as agency spend is expected to exceed the lower monthly plan now in place for the remainder of the financial year.	

Action Description	Action Progress (%)	Action Narrative	Action Status

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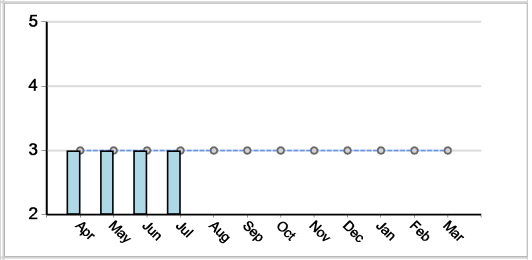
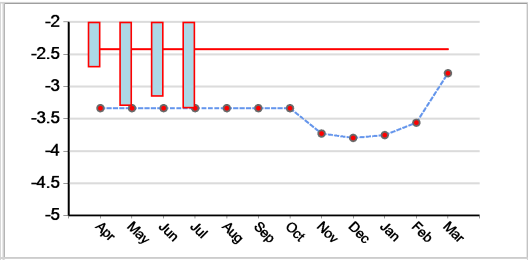
Southport and Ormskirk Hospital NHS Trust

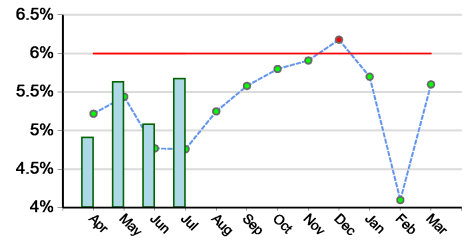
Well-Led

Indicator Name	Description	Narrative	Month Trend
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework. Line = Last Financial Year, Bar = This Financial Year.	Overall score remains static at 3 (A score of 1 is best and 4 is the worst) - The unrounded rating is 2.8 and is helped by achieving scores of 1 in distance from financial plan and the agency metric. The scale of improvement required to improve the overall rating is too great for the short-term and therefore the Trust should focus on maintaining agency controls and delivering the financial plan.	
Action Description	**Action Progress (%)**	**Action Narrative**	**Action Status**
Resourcing plan		Development of a detailed resourcing plan to minimise requirements; to release shifts to agency locums and to continue to recruit to medical and nursing posts wherever possible	
Capital Service Capacity	The level of debt the Trust is required to service. This indicator is 1 of 5 used to derive the 'Use of Resources (Finance)' score. Line = Last Financial Year, Bar = This Financial Year.	The Trust moves closer to the planned financial deficit - The Trust is now only £250k ahead of its financial plan compared to £674k in June. In order to improve this metric, the Trust needs to be making an operating surplus. This requires the delivery of a long-term strategic plan to make the Trust financially sustainable.	
Action Description	**Action Progress (%)**	**Action Narrative**	**Action Status**
Develop a plan to move the Trust into a surplus position	0	Reconfiguration of hospital services in medium to long term to address the structural deficit	On Target

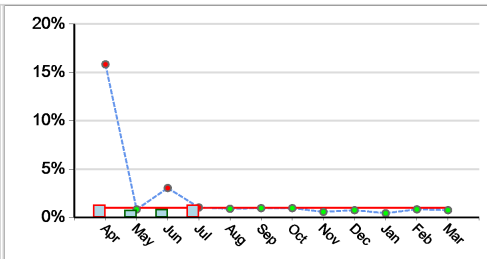
Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	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.	NHSI agency cap equates to 4.4% monthly target; performance worsening - The two main staff group that need to be addressed to improve performance are nursing and medical. Severe pressures in terms of rota gaps and availability over the summer period are contributing to the adverse performance. The introduction of the medical bank (TempRE) has enabled a reduction in agency spend. Recruitment to vacant posts is vital in order to achieve this target.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Nurse recruitment	50	Despite the number of recruitment events and nursing vacancies advertise there has been no noteable reduction in nurse agency spend over the last 12 months	On Target
Non medical/non clinical	20	List of all agency staff produced with an action plan for replacement	On Target
Medical recruitment	30	Each CBU has been tasked with establishing action plans to recruit substantively to posts or utilise bank/short term contracts on payroll in order to avoid premium rate agency spend.	Off Target
TempRE platform to be utilised for AHP staff	60	meeting 16.8.18 to discuss next steps including pay rates which need further review following recent pay award	On Target

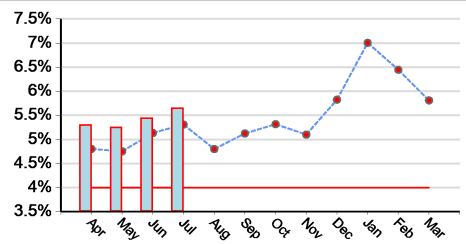
Indicator Name	Description	Narrative	Month Trend
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month. Line = Last Financial Year, Bar = This Financial Year.	The monthly turnover figure has significantly increased to 1.35% from 0.87% in June 2018 - YTD figure is 3.99%. The annual figure is 11.23% A retention project is currently underway that will focus upon understanding why staff choose to leave us and what the Trust can do to retain staff. Please see the remedial action plan below. This is a 90 project that will focus initially on nursing staff however a lot of the practice and interventions will be rolled out Trust wide.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Develop retention action plan	100	Action plan developed and sent to NHSI 04/08/18.	Complete
Establish retention task and finish group	100	Task and finish group set up and to commence from 22/08/18	Complete
Review of exit questionnaire	70	The exit questionnaire is in the prcoess of being reviewed and is being revised with a view to the new process going live from September 2018.	On Target
Stability Indicator to reported on at CBU peformance review boards	80	Stablity figure to be made available for August's figures.	On Target

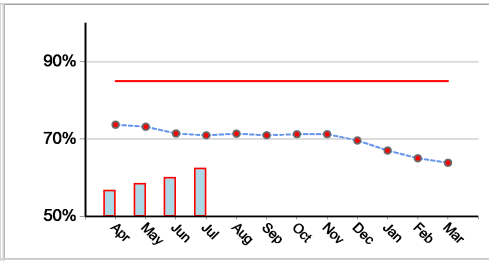
Board Report - July 2018

NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
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.	Sickness absence has increased again in month - Sickness absence has increased again in month. Each CBU has identified 3 hot spots to focus attention and formulate strategy and interventions to maintain and support individuals attendance to work. Additionally the Trust is working closely with NHSi on a project to increase attendance to work by ensuring that staff are well supported to remain in work. The Trust has conduced a self assessment and is in the process of developing an action plan.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review of sickness absence policy	80	Further meeting took place on 6/08/18 to discuss the sickness absence policy consequently a revised policy has been agreed on and shared with staff side for final sign off.	Off Target
Intergrate Health and Wellbing, Sickness absence and self assessment action plans	60	Draft action plan being formulated, presentation to NHSi should take place in September	On Target
Sickness Absence Policy Training	100	Ongoing training is availbale to managers on the Trust's sickness absence policy	Complete

Indicator Name	Description	Narrative	Month Trend
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Line = Last Financial Year, Bar = This Financial Year.	Slight increase in compliance which is a consistent 4 month improvement - Increased scrutiny of PDR compliance, roll out of training programme has taken place, PDR paperwork has been streamlined, a focused report and analysis has been ran to prioritise and focus immediate action.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Improvement Trajectory to be presented at PRB	100	To be presented on 03/08/18	Complete
Report ran to establish staff who had not had a PDR for 3 or more years	100	Report ran and shared with CBU's all CBU's mandated to complete outstanding PDR's by 17/08/18. Improvement should be seen in August's figures.	On Target
Monthly monitoring to continue at all operational and strategic meetings	80	Workforce dashboards to be provided monthly focusing on progress	On Target

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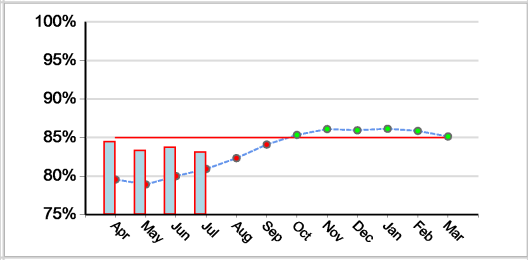
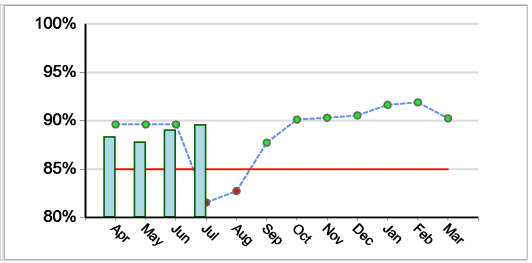
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Line = Last Financial Year, Bar = This Financial Year.	Performance remains below Trust target - All Managers have access to their own team's ESR training dashboard and monthly mandatory training reports to monitor training compliance within their areas. Managers need to plan their rotas to allow staff time to update their training via face to face or eLearning. All staff have access to ESR Self Service to view their own training records which are RAG rated. The Consultant/SAS mandatory training day will be re-instated once subject matter experts have been scheduled to ensure our Doctors have access to mandatory training without the need to cancel clinics/procedures. The first Clinical Competency Working Group will be re-scheduled for September 2018 due to failed attendance in Aug. Subject matter experts should be held to account to review their own subject areas and provide targeted training or follow ups for non compliant areas.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Clinical Competency Working Group	0	A Clinical Competency Working Group will be re-scheduled to Sept 2018	Off Target

MCA Training	The proportion of staff who have undertaken Mental Capacity Act (MCA) Training within the required timeframe. Line = Last Financial Year, Bar = This Financial Year.	-	

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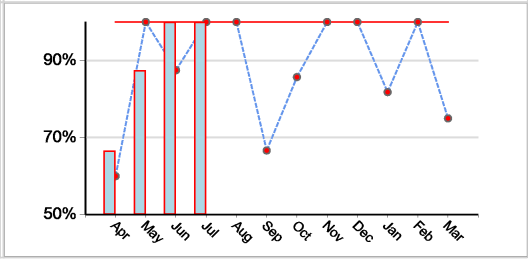
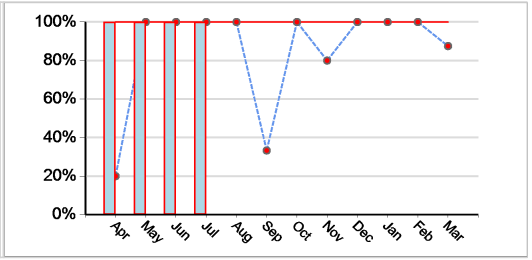
Southport and Ormskirk Hospital NHS Trust

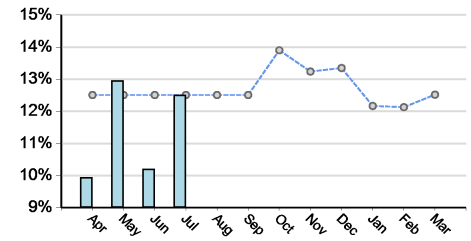
Well-Led

Indicator Name	Description	Narrative	Month Trend
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care. Line = Last Financial Year, Bar = This Financial Year.	-	
Duty of Candour - Evidence of Letter	The proportion of patients who have received a letter of apology when something that has gone wrong with their treatment or care. Line = Last Financial Year, Bar = This Financial Year.	Compliant for the month of July - Duty of candour letters are 100% compliant for the month of July	

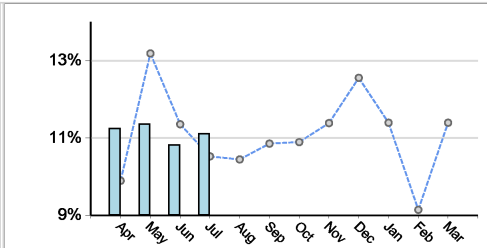
Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant. Line = Last Financial Year, Bar = This Financial Year.	-	

Action Description	Action Progress (%)	Action Narrative	Action Status
Pull together a comprehensive medical workforce strategy	10	Meeting currently being arranged.	On Target

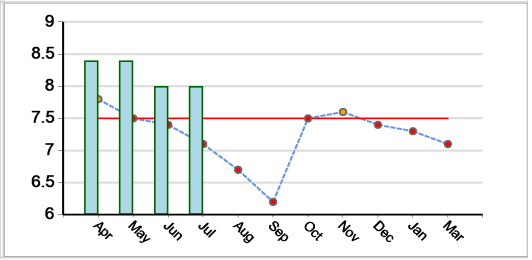
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant. Line = Last Financial Year, Bar = This Financial Year.	Nursing vacancies have increased slightly in month - Nursing vacancies continue to be high as there is a national shortage of nurses. There are a number of programmes of work to be undertaken that will have an impact on the nursing vacancy rate that are as follows: Retention 90 day pilot focussing on nurses to ensure that the nurses we have stay. Health and Wellbeing Project - to ensure that staff feel supported and have access to services to maintain their own health and wellbeing.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Attendance at Southport Flower Show	100	Trust has a stand at the Southport Flower Show, showcasing the Trust and informing of vacancies	Complete
Rolling B5 nurse advert	100	Ongoing rolling recruitment programme	Complete
HCA recruitment campaign	70	Recruitment and selection process has taken place, currently undertaking pre-employment checks.	On Target
NHSi retention pilot	70	Action plan submitted and task and finish group set up to commence from 22/08/18	On Target

Board Report - July 2018

NHS
Southport and Ormskirk Hospital
NHS Trust

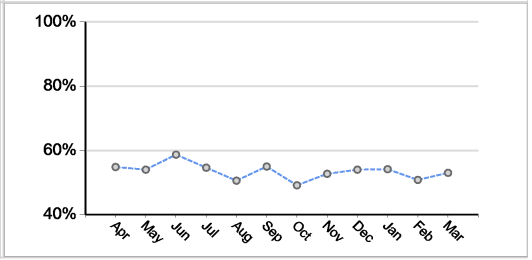
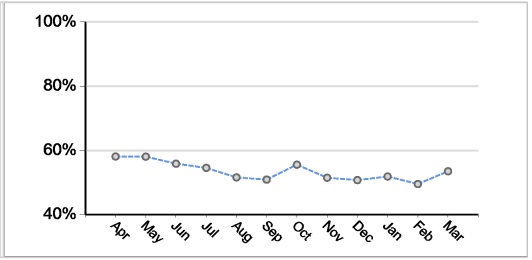
Well-Led

Indicator Name	Description	Narrative	Month Trend
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels. Line = Last Financial Year, Bar = This Financial Year.	Performance above target - This indicator has been added to the IPR this month to ensure the Board has assurance around Nurse Staffing. This month has seen CHPPD stay at 8 which is above target. Ensuring fill rates are maintained by using Bank Staff and where necessary Agency Staff to supplement substantive staff in areas not meeting acceptable fill rates.	

Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Market Share - SF&WL CCG - Elective	Market Share for Elective activity from Southport & Formby CCG and West Lancashire CCG. Line = Last Financial Year, Bar = This Financial Year.	-	
Market Share - SF&WL CCG - Outpatient	Market Share for Outpatients activity from Southport & Formby CCG and West Lancashire CCG. Line = Last Financial Year, Bar = This Financial Year.	-	

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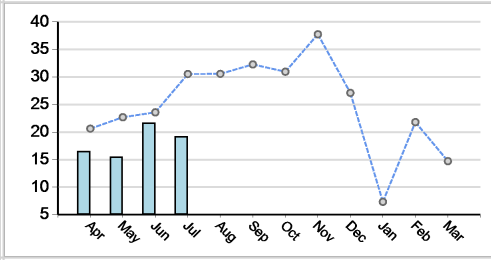
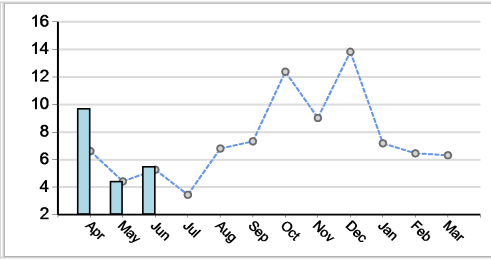
Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Post MOFD (Medically Optimised for Discharge) - Number of Beds lost per month	Number of beds lost from 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.	reduction in last month, start dates for discharge facilitators - 3 new starters within discharge facilitators for August. competency framework in place in preparation. will require period of training. SAFER roll out commenced on 14b with significant increase in discharges within 1st week, now identifying issues that will impact on red-green. Weekly MOFD meetings recommenced with system leaders to review all MOFD patients and ensure reduction continues.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Appointment of discharge facilitators	70	interviews completed, 3 new starters in August	On Target
Improvement data accuracy	20	part of the discharge facilitators compency framework	On Target
Implimentation of SAFER as part of the 10 high impact actions	10	From PFIB 10 high impact actions have been identified, the implementation of SAFER is one of these	On Target
Review weekly system leaders MOFD meeting	30	current process to continue until review by new Head of Patient Flow	On Target

DTOC - Number of Beds lost per month	The number of beds lost per month from patients who have experienced a Delayed Transfer of Care (DTOC). Line = Last Financial Year, Bar = This Financial Year.	-	

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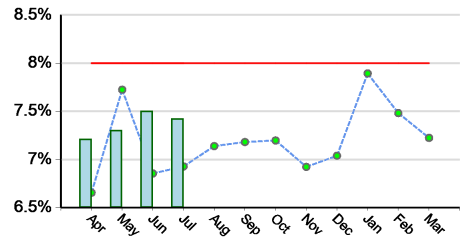
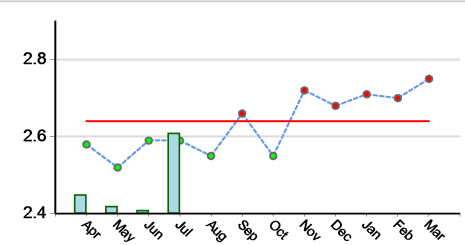
Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	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.	DNA Rate - remains consistently within target - As part of the OP performance board there was a review of the texting reminder system. This was increased from 1 text to 3 texts in Dec 2017. Initially there was a recognisable improvement in attendance, however on review this appears to have plateaued again. Initial analysis of the issues has identified there are high levels in paediatrics, however a deep dive is required by the OP Board to develop action plan to address.- As part of the OP performance board there was a review of the texting reminder system. This was increased from 1 text to 3 texts in Dec 2017. Initially there was a recognisable improvement in attendance, however on review this appears to have plateaued again. Initial analysis of the issues has identified there are high levels in paediatrics, however a deep dive is required by the OP Board to develop action plan to address.	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor. Line = Last Financial Year, Bar = This Financial Year.	New to FU ratios are being managed within the agreed target - New to FU ratios are being managed within the agreed target	

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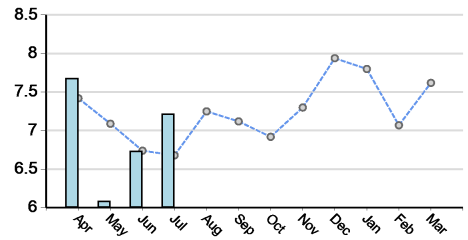
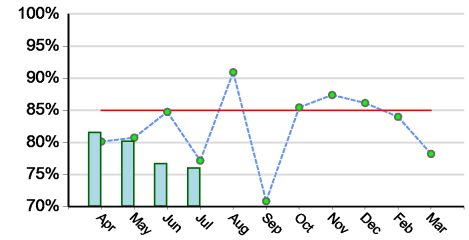
NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Length Of Stay	The average amount of time in days that patients spent as an inpatient from an emergency admission. Excludes ZERO Length of Stay. Line = Last Financial Year, Bar = This Financial Year.	increase in LOS over past 2 months - Appointment of new discharge facilitators, interviews completed and 3 due to start within August. SAU due to open August to support streaming from ED and improving bed allocation to right area, Safeguarding ACU for ED streaming by maintaining capacity within ACU by reducing usage for escalation. Interviews completed for bed managers and all vacancies filled pending HR checks. SAFER roll out on 14b has improved patient flow with 31 discharges from this area in first week. although excellent numbers this is highlighting issues in relation to complex discharges and delays due to confirmed capacity within community team. re-launch of weekly LOS meeting will identify delays and also improve relations with system leaders.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Appointment of discharge facilitators	70	Interviews completed, awaiting recruitment checks. 3 new starters in August	On Target
weekly LOS meetings	50	re-launch of weekly meetings with social and community leaders	On Target
Vacancies within bed management	30	Interviews completed 4 appointed pending recruitment checks	On Target
Introduction of SAFER	10	commenced in August with support from NHSi	On Target
safegaurding assessment areas	20	reduce use of ACU for escalation, opening of SAU	On Target

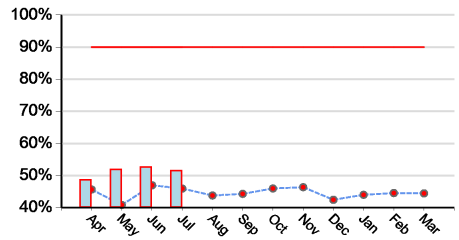
Bed Occupancy	The proportion of Inpatient beds occupied of the total bed stock. Beds at both Southport and Ormskirk are included. Line = Last Financial Year, Bar = This Financial Year.	Occupancy remains high on SDGH, bed rightsize part of winter planning HIA - 6 beds closed for estates work on 10B impacting on occupancy on SDGH, bed rightsize work on-going as part of winter planning. Pathway for transfer to ODGH in place but limited safe options due to medical staffing. impact on planned activity must be considered prior to transfer. On-going work to keep assessment areas free for streaming and alternative pathways for admission avoidance continues. Frailty practitioner and appointment of frailty Consultant also improving admission avoidance. SAFER rollout has commenced on 14b with an massive increase on discharges in the first week, identifying area of concern with increase of >21 LOS patients from 3 to 11 in first week.	

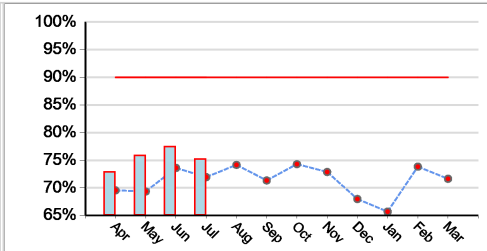
Action Description	Action Progress (%)	Action Narrative	Action Status
bed right size	60	meetings in place with appropriate clinicans to review bed useage at ODGH	On Target
SAFER	10	ist ward in 2nd week of intensive support from NHSI	On Target
Assessment areas	30	reduced overnight use of ACU as escalation, aiming for min 2 beds held for morning streaming	On Target

Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Efficiency

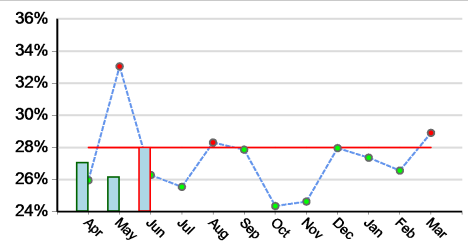
Indicator Name	Description	Narrative	Month Trend
OP Slot Utilisation	The proportion of used Outpatient clinic slots (attended or DNA) over the total number of Outpatient slots. Line = Last Financial Year, Bar = This Financial Year.	- Slot utilisation continues to show an underperformance against target. The OP Review and Productivity & performance review are being relaunched, after which action plans will be created.	
Action Description	**Action Progress (%)**	**Action Narrative**	**Action Status**
OP & Productivity & Performance Reviews	0	OP Review and Productivity & Performance Review Relaunch	

Indicator Name	Description	Narrative	Month Trend
Theatre Utilisation	The proportion of elective Theatre slots used over the total elective planned capacity. Line = Last Financial Year, Bar = This Financial Year.	- Performance has declined over the last month from 77.57% to 75.31%, although overall theatre utilisation has improved slowly over the last 6 months as part of the Theatre performance programme. - Utilisation is currently sitting at 75.97%. The theatre utilisation board have identified further areas for improvement and have set a target of 85%. Action plans are reviewing late start and early finish times, cancellations, process mapping.	
Action Description	**Action Progress (%)**	**Action Narrative**	**Action Status**
Review of late start and early finish times, cancellations, process mapping			

Board Report - July 2018

Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Cancelled Ops	Percentage of Operations Cancelled. Line = Last Financial Year, Bar = This Financial Year.	Performane declined in June and did not achieve target - - plan commenced to implement partial booking for all specialties was pulled back to enable the Trust to achieve its ASI cquin at the end of the last financial year. Discussions are currently underway to re implement this plan.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Implement partial booking		Planning underway	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 September 2018

Agenda Item	**TB218/18**	**Report Title**	**Director of Finance Report - July 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

At month 4 the Trust's financial performance is a deficit of £10.725M against a deficit plan of £10.898M which is £173K better than plan.

This is a reduction of £436K from Quarter 1's performance against plan.

Income continues to perform to plan.

A&E activity is up by 4%; Elective activity is down by 10.4%; Non elective activity is up by 14%; Outpatient activity is down by 3.3%.

Total expenditure remains within plan at month 4 YTD despite an adverse CIP performance in July.

Both Pay and non pay expenditure are consistent with June.

Agency spend has increased to £616K in month which means significant risk of achieving the NHSI cap of £5.6M as current spend is heading towards circa £6-7M.

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 NHSI.

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

- CIP delivery of £7.5M.
- Sanctions
- ACU and CDU tariffs
- CQUIN performance

If the above issues are not addressed then the Trust will not achieve the planned deficit of £28.8M

and, based on the current run rate, will be in the region of £31M.

There is no plan at this stage to amend the forecast outturn from £28.8M deficit.

The Board is asked to **receive** the month 4 Director of Finance 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

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 4 (the financial period ending 31st July 2018).

2. Executive Summary

2.1. The Trust control total for 2018/19 was £6.9M, £13.681M excluding Provider Transformation Funding (PSF).

2.2. The Trust could not sign up to its control total and set a deficit plan of £28.8M.

2.3. At month 4 the Trust's financial performance is a deficit of £10.725M against a deficit plan of £10.898M which is £173K better than plan.

2.4. This is a reduction of £436K from Quarter 1's performance against plan.

2.5. Income continues to perform to plan.

2.6. A&E activity is up by 4%; resulting in a financial impact of £126k

2.7. Elective activity is down by 10.4%; resulting in a financial impact of -£444k

2.8. Non elective activity is up by 14%; resulting in a financial impact of £1.229M although this has been reduced for ACU and CDU until an agreement has been reached.

2.9. Due to the high level of non elective performance the Trust has provided for a reduced level of non elective income to take account of the marginal rate (70%) for activity above the agreed baseline.

2.10. The Trust continues to make provision for ACU and CDU activity while tariff discussions continue with CCG's. The deadline for completion under the terms of the Expert is 30 September.

2.11. Any agreement reached regarding ACU and CDU would have a positive impact on the current financial position.

2.12. Outpatient activity is down by 3.3%; resulting in a favourable financial impact of £51k.

2.13. Total expenditure remains within plan at month 4 YTD despite an adverse CIP performance in July.

2.14. Pay expenditure remains consistent with previous months.

2.15. Non pay spend is consistent with June.

2.16. Agency spend has increased to £616K in month which means significant risk of achieving the NHSI cap of £5.6M as current spend is heading towards circa £6/7M.

2.17. The table below is the I&E statement for July:

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	148,882	49,500	49,566	66	12,399	12,351	(48)
PP, Overseas & RTA	1,384	461	428	(33)	116	51	(65)
Other Income	14,063	4,229	4,353	124	1,170	1,182	12
Total Income	**164,329**	**54,190**	**54,347**	**157**	**13,685**	**13,584**	**(101)**
Operating Expenditure							
Pay	(128,885)	(43,555)	(43,305)	250	(10,557)	(10,844)	(287)
Non-Pay	(53,080)	(17,814)	(17,963)	(149)	(4,457)	(4,492)	(35)
Total Expenditure	**(181,965)**	**(61,369)**	**(61,268)**	**101**	**(15,014)**	**(15,336)**	**(322)**
EBITDA	**(17,636)**	**(7,179)**	**(6,921)**	**258**	**(1,329)**	**(1,752)**	**(423)**
Non-Operating Expenditure	(11,217)	(3,740)	(3,749)	(9)	(935)	(935)	(1)
Retained Surplus/(Deficit)	**(28,853)**	**(10,919)**	**(10,670)**	**249**	**(2,264)**	**(2,687)**	**(424)**
Technical Adjustments	63	21	(55)	(76)	6	(6)	(12)
Break Even Surplus/(Deficit)	**(28,790)**	**(10,898)**	**(10,725)**	**173**	**(2,258)**	**(2,693)**	**(436)**

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

2.19. 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 NHSI.

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

2.20..1. CIP delivery of £7.5M.

2.20..2. There is a risk that commissioners will apply sanctions as the Trust cannot sign up to its control total. Following discussions with CCG's it is likely that any sanctions applied will be reinvested for winter pressures.

2.20..3. Following Expert Determination the Trust has still to agree new local tariffs for ACU and CDU by 30 September 2018: the impact has been mitigated to date due to the financial impact of increased non elective activity.

2.20..4. Current CQUIN performance is predicting an income shortfall at the year end. The Trust YTD income positon assumes full payment as further work is planned in order to address performance.

2.21. If the above issues are not addressed then the Trust will not achieve the planned deficit of £28.8M and, based on the current run rate, will be in the region of £31M deficit.

2.22. There is no plan at this stage to amend the forecast outturn from £28.8M deficit.

3. Income Performance

3.1. The Commissioning income budget has underperformed in month due, in part, to the Trust reflecting the expected marginal rate adjustment for the non elective overperformance to date.

3.2. Non elective activity is overperforming and a reduction of £287K has been actioned this month to reflect the fact that overperformance above the agreed baseline is payable at 70%.

3.3. Elective continues to underperform. There are plans to reduce the elective shortfall back to plan and, therefore, it is likely that overall activity levels will generate a significant overperformance on CCG contracts.

3.4. The issue regarding the tariffs for Ambulatory Care Unit (ACU) has still not been agreed. MIAA have now visited the Trust to form a view on the tariff being proposed. It is expected that a recommendation will be made by the end of September 2018. The commissioning income position currently reflects the decision reached by the Expert and is a “worst case scenario”.

3.5. 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. As in 3.2 above the Trust awaits MIAA’s recommendation; no additional income has been accrued for this activity in the month 4 position.

3.6. In summary, non elective activity is generating a favourable variance against plan of £243k after deductions for ACU, CDU and marginal rate.

3.7. Outpatient activity has recovered and is generating a YTD favourable variance.

3.8. The Trust may be subject to sanctions in 2018/19 for non compliance with performance standards. The YTD income position does not include any reduction for sanctions. The CEO has discussed the application of sanctions with CCG’s and agreed that any sanctions that are applied would be reinvested to the Trust to fund winter pressures.

4. Expenditure

4.1. Total underlying expenditure levels for pay remain consistent compared to last year.

4.2. The pay award for Agenda for Change staff has been applied in July. The payment for April, May and June will be made in August.

4.3. Pay expenditure in July is consistent with previous month’s performance.

4.4. The Trust received £164K from the DoH (for July) for the element of the pay award not in tariff. A further £656K will be received in August (for April, May, June and August). The DoH will then pay a monthly amount of £164K for the remainder of the year.

4.5. Annual budgets for income and pay expenditure have been increased and profiled in line with the amounts in 4.4.

4.6. The Trust’s financial plan has not been adversely impacted by the central calculation for additional DoH funding.

4.7. All pay budgets are underspent in month except for non-consultant medical staff and nursing.

4.8. Although non pay spend is consistent with June budgets have overspent in July.

5. Agency spend

5.1. The Trust has spent £616K on agency staff in July (6.5% of the substantive payroll) which is above the planned spend submitted to NHSI. The monthly profile of the plan reduced considerably in July, however spend has increased with more Thornbury agency nurses being used to cover the increasing nurse vacancies and holidays.

5.2. Based on the current level of agency spend there is a significant risk of not achieving the

£5.67M NHSI agency cap.

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 posts and this is an area the Turnaround Director will be addressing.

5.5. Nurse agency spend is £191k in July which is the highest level of spend experienced in the last twelve months

5.6. 62% of the monthly nurse agency spend is within A&E (£118k); with the remaining spend incurred in medical wards, ITU, spinal injuries and theatres. 73% of July's agency spend is within Urgent Care CBU.

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

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

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

5.10. The cost of providing cover for nurse sickness in July was £91k (bank £77k; agency £14k) based on the information provided by NHSP. It is not known what Thornbury cost can be attributed to sickness cover.

5.11. With regard to medical staff 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.

5.12. A revised escalation procedure has been discussed at the Executive Team Meeting. This procedure plans to speed up decision making but also take into consideration the required executive authorisation (as per NHSI rules) before shifts are booked. This will be implemented in September.

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

5.14. The cost of providing cover for medical sickness in July was £7k (£6k bank; £1k 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 NHSI.

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

	Annual Plan £000	YTD Plan £000	YTD Actual £000	YTD Var £000	In Month Plan £000	In Month Actual £000	In Month Var £000
18/19 Plan	7,006	1,280	848	(432)	662	331	(331)
17/18/ balance to FYE	535	179	179	0	45	45	0
Total	7,541	1,459	1,027	(432)	707	376	(331)

6.4. The CIP was profiled to deliver a much higher target from July onwards. This has not been achieved and contributed materially to the adverse budget performance in month.

6.5. The Turnaround Director has now reviewed the current CIP plans and has revised the CIP forecast down to £4.494M (£3.959M of the £7M "in year" plan). Of this, £2.872M is rated blue and already delivered with the remaining £1.087M rated red, amber or green.

6.6. Further schemes are being explored to replace the CIP shortfall.

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 NHSI, usually in the second working week of the month; this forms the basis of any cash draw downs in the future month (July's cash flow was sent on 7th June).

7.3. It is anticipated that the cash required to resolve 2017/18 contract issues following the results of the Expert Determination will be required in October 2018. Total borrowing for October is forecast to be £5m.

7.4. The Trust borrowed £2.718m in July which was the below the maximum available. Note that as the Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

7.5. Performance against the cash target in July was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,018	Brought forward balance.
Cash inflows	16,128	17,065	DHSC AfC funding (£164k) not in plan, Health Education income higher than planned (£200k). Progress on NHS Property debt (£53k) and other debt (£115k)
Cash outflows	-16,128	-16,637	Non-NHS payment runs £225k higher than planned. Weekly payroll £125k higher than planned, offset by lower than planned payroll statutory payovers £124k
Closing balance	**1,000**	**1,446**	

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. August's loan request of £2.573m was approved under emergency powers on 26th July and will be ratified at Private Board on 5th September.

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. Finance Committee agreed a revised capital plan in July to address the expected overspends in the discharge lounge, UPS Theatre replacement and A&E redesign. Additional schemes for car parking (£50k) and sexual health accommodation (£200k) have been added to the 2018/19 capital programme within the existing capital resource limit (£4,311k).

8.3. Capital expenditure was £270k in month with a cumulative position of £1,337k (planned year to date £2,217k). The Trust is also committed to spend of £2,354k at the end of July.

8.4. GE contract remodeling completed on the 8th August. The Trust is now in a position to order a new CT scanner for Southport. Work has commenced and is due to be completed by November. The new model also includes an MRI scanner for Southport (replacement has been deferred to June 2019) and another CT scanner for Ormskirk due for replacement in 2022.

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.

9.2. At Quarter 1 there is a risk of losing £181K with a potential full year risk of £812K of schemes rated Red.

9.3. The Trust is responding formally to the CCG's requests for further evidence to support the Quarter 1 position.

9.4. Full CQUIN delivery has been assumed in the month 4 income position.

9.5. This is an area of focus for the Turnaround Director.

10. Risks

10.1. Following an assessment by the Turnaround Director there is a significant risk of delivering the CIP of £7.5M (£7M 'in year').

10.2. No provision for contract sanctions has been accrued into July's financial position. CEO discussions with CCG's have indicated that any sanctions applied would be reinvested back into the Trust for winter pressures. The financial risk value would be the level of investment required by the Trust across the winter period.

10.3. The financial plan assumed full payment for ACU. The month 4 YTD position has been reduced to reflect the expert's decision but additional activity has mitigated the impact. The risk is that this doesn't continue.

10.4. No deduction for CQUIN assumed.

11. Forecast Outturn 2018/19

11.1. The Trust continues to work with NHSI regional finance team to forecast best, likely, worst case scenarios.

11.2. There is no plan at this stage to amend the current forecast outturn from £28.8M deficit.

12. Recommendations

12.1. The Board is asked to receive the month 4 Director of Finance report.

Southport and Ormskirk Hospital NHS Trust

Statement of Comprehensive Income (Income & Expenditure Account)

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	148,882	49,500	49,566	66	12,399	12,351	(48)
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Total Income	**164,329**	**54,190**	**54,347**	**157**	**13,685**	**13,584**	**(101)**
Operating Expenditure							
Pay	(128,885)	(43,555)	(43,305)	250	(10,557)	(10,844)	(287)
Non-Pay	(53,080)	(17,814)	(17,963)	(149)	(4,457)	(4,492)	(35)
Total Expenditure	**(181,965)**	**(61,369)**	**(61,268)**	**101**	**(15,014)**	**(15,336)**	**(322)**
EBITDA	**(17,636)**	**(7,179)**	**(6,921)**	**258**	**(1,329)**	**(1,752)**	**(423)**
Non-Operating Expenditure	(11,217)	(3,740)	(3,749)	(9)	(935)	(935)	(1)
Retained Surplus/(Deficit)	**(28,853)**	**(10,919)**	**(10,670)**	**249**	**(2,264)**	**(2,687)**	**(424)**
Technical Adjustments	63	21	(55)	(76)	6	(6)	(12)
Break Even Surplus/(Deficit)	**(28,790)**	**(10,898)**	**(10,725)**	**173**	**(2,258)**	**(2,693)**	**(436)**

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/07/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	126,036	(754)	(251)
Other assets	1,382	1,688	306	(55)
TOTAL NON CURRENT ASSETS	**128,172**	**127,724**	**(448)**	**(306)**
CURRENT ASSETS				
Inventories	2,454	2,528	74	0
Trade and other receivables	9,591	8,097	(1,494)	(472)
Cash and cash equivalents	1,079	1,446	367	428
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**12,071**	**(1,053)**	**(44)**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(24,634)	597	324
Provisions	(131)	(158)	(27)	(24)
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)	(196)	275	10
TOTAL CURRENT LIABILITIES	**(32,199)**	**(31,354)**	**845**	**310**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(19,283)	(208)	**266**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**108,441**	**(656)**	**(40)**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(76,729)	(10,114)	(2,718)
PFI/Finance lease liabilities	(13,807)	(13,915)	(108)	71
DH Capital loan	(1,400)	(1,200)	200	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(92,110)**	**(10,010)**	**(2,647)**
TOTAL ASSETS EMPLOYED	**26,997**	**16,331**	**(10,666)**	**(2,687)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	97,241	0	0
Retained earnings	(83,484)	(94,150)	(10,666)	(2,687)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**16,331**	**(10,666)**	**(2,687)**

In month material movements are as follows:

No significant in month variances to highlight. The Trust received a loan of £2,718k which was entirely used to fund the deficit.

Reduction in propery, plant & equipment is due to low in month spend on capital.

Retained earnings decreased by £2,687k in line with the in month deficit excluding technical adjustments.

Source of information from Financial se\controlxxYY\balance sheets

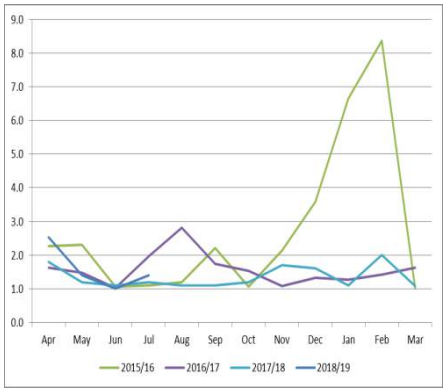
Statement of cash flows

NHS Southport and Ormskirk Hospital NHS Trust

The Trust held enough cash to cover 2.78 days of operating expenditure at the end of July 2018 (June = 1.95 days).

	Actual Apr-18	Actual May-18	Actual Jun-18	Actual 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)	(2,192)	(2,274)	(2,225)	(2,231)	(1,344)	(1,491)	(2,159)	(1,545)	(2,138)	(1,739)	(23,885)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)			(15)				(11)		(131)
Depreciation and Amortisation	523	524	523	524	518	518	518	518	517	517	517	517	6,234
Impairments and Reversals	0	0	0	0									0
(Increase) in Inventories	(50)	59	(83)	0								74	0
(Increase) in Trade and Other Receivables	976	153	(468)	558								(1,219)	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(402)	1,707	(3,204)	(193)	191	(651)	450	1,261	(1,818)
Increase in Provisions	(3)	(3)	(61)	82			(30)		(27)		(28)	10	(60)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(2,109)	(6)	(4,075)	(1,166)	(1,478)	(1,679)	(1,210)	(1,096)	(19,660)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	2	3	2	2	3	2	2	28
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(39)	(44)	(50)	(44)	(57)	(56)	(39)	(39)	(546)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(726)	(1,007)	(363)	(313)	(317)	(433)	(492)	(437)	(5,609)
Receipts from disposal of fixed assets	0	0	1	2									3
Receipt of cash donations to purchase capital assets	5	52	30	18			15				9		129
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(763)	(1,049)	(395)	(355)	(372)	(486)	(520)	(474)	(5,995)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0		127							127
Public dividend capital repaid	0	0	0	0									0
Loans received from DH	2,739	2,178	2,479	2,718	3,065	1,942	5,628	1,826	2,356	2,356	2,356	2,357	32,000
Loans repaid to DH	(200)	0	0	0			(200)						(400)
Capital element of finance leases	(8)	(8)	(8)	(8)		(545)		(114)			(203)		(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	0	0			(314)	(5)			(205)		(524)
Interest element of PFI, LIFT	(80)	(80)	(196)	(80)	(44)	(96)	(43)	(43)	(79)	(43)	(44)	(76)	(904)
PDC dividend (paid)/refunded	0	0	0	0			(81)					(36)	(117)
Net Cash Inflow/(Outflow) from Financing Activities	2,338	1,973	1,966	2,512	2,871	783	4,832	1,500	1,923	2,146	1,706	1,026	25,576
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**(1)**	**(272)**	**362**	**(21)**	**73**	**(19)**	**(24)**	**(544)**	**(79)**
Cash - Beginning of the Period	1,079	2,531	1,380	1,018	1,446	1,445	1,173	1,535	1,514	1,587	1,568	1,544	1,079
Cash - End of the Period	**2,531**	**1,380**	**1,018**	**1,446**	**1,445**	**1,173**	**1,535**	**1,514**	**1,587**	**1,568**	**1,544**	**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	735	150	172	(22)	57		735	229	506
	Beds / Trolleys	G0060	50	50	51	(1)			50	51	(1)
	Sub total MEDICAL DEVICES		**785**	**200**	**223**	**(23)**	**57**	**0**	**785**	**280**	**505**
IM&T	Electronic Patient Record	F6409	190	45	51	(6)	1		190	52	138
	Vitalpac	G0007	30	9	1	8			30	1	29
	eDMS	F6447	160	54	13	41			160	13	147
	Wireless network upgrade	G0073	302	175	0	175	302		302	302	0
	Server warehouse infrastructure incl. storage	G0078	75	75	25	50			75	25	50
	Telephony system replacement	G0059	95	95	0	95			95	0	95
	Cyber security	G0071	50	17	0	17	7		50	7	43
	Fixed network infrastructure	F6498	100	32	0	32	9		100	9	91
	Datacentre	G0075	50	50	0	50	5		50	5	45
	Virtual desktop infrastructure	G0076	25	8	2	6			25	2	23
	Equipment refresh	G0077	50	17	0	17			50	0	50
	Sub total IM&T		**1,127**	**577**	**93**	**484**	**324**	**0**	**1,127**	**417**	**710**
ESTATES	GE Turnkey works for Radiology equipment replacement programme		200	50	0	50	121		200	121	79
	Southport A&E Redesign	G0068	485	200	175	25	14	533	485	722	(237)
	Ward reconfigurations	G0064	140	140	64	76		79	140	143	(3)
	Medical gasses	G0067	30	30	15	15	9		30	24	6
	UPS Theatre	G0053	100	50	0	50			100	0	100
	Waste management storage facilities		100	100	0	100			100	0	100
	Theatre airplant controls		45	45	0	45			45	0	45
	Generator connectors		65	65	0	65			65	0	65
	Fire compartmentation	G0052	165	60	12	48			165	12	153
	Fire Precautions - Fire Doors	G0019	45	0	7	(7)			45	7	38
	Discharge lounge	G0074	134	70	128	(58)			134	128	6
	Spinal isolation works		200	25	0	25			200	0	200
	Additional Car Parking		50	0	0	0			50	0	50
	Sexual Health Accomodation		200	0	0	0			200	0	200
	Capital team	F6305	155	58	75	(17)		121	155	196	(41)
	Aseptic isolator		30	0	0	0			30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,144**	**893**	**476**	**417**	**144**	**733**	**2,144**	**1,353**	**791**
FACILITIES	Catering equipment	G0026	100	60	0	60			100	0	100
	Sub total FACILITIES		**100**	**60**	**0**	**60**	**0**	**0**	**100**	**0**	**100**
	CONTINGENCY	**F6301**	**155**	**110**	**48**	**62**			**155**	**48**	**107**
	Capital plan excluding donations and IFRIC 12		**4,311**	**1,840**	**840**	**1,000**	**525**	**733**	**4,311**	**2,098**	**2,213**
OTHER	Donated assets	000000	120	30	105	(75)			120	105	15
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,488	347	392	(45)		1,096	1,488	1,488	0
	Sub total Donations and IFRIC 12		**1,608**	**377**	**497**	**(120)**	**0**	**1,096**	**1,608**	**1,593**	**15**
	TOTAL CAPITAL SPEND		**5,919**	**2,217**	**1,337**	**880**	**525**	**1,829**	**5,919**	**3,691**	**2,228**

Actual year to date spend is £1,337k with a further £2,354k committed.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5th September 2018

Agenda Item	TB219/18	Report Title	Review of Board Assurance Framework and High Level Risk Register
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

For the year 2017/18, the BAF was introduced in September 2017 after a Board timeout in July 2017. Refreshed strategic objectives and principal risks based on key concerns discussed at the July timeout of the Board and were approved by the Board in September 2017.

The Corporate Risk Register was also updated to take account of the new strategic objectives and principal risks.

Given the challenges faced by the Trust it took some time to put in place the assurances and controls needed so detailed action plans were drawn up to mitigate against the management of the risks identified in gaps in controls.

The Corporate Risk Register:

- Showed a number of risks which remained Extreme between September 2017 and January 2018
- A number of new risks introduced between November 2017 and April 2018 remained Extreme
- A couple risks: 1549- Postgraduate Medical Education 'enhanced monitoring' GMCF/HENW and 1638- Optometry Service Vacancies, began with a rating of High but rose to Extreme from February 2018 to September 2018. Interestingly the latter then reduced to Low after mitigation measures
- A number of risks which began as Extreme reduced to High
- Two risks were reduced from Extreme to Moderate and one was closed during the period.

Board Assurance Framework

There is still a lot of work to do with regards to adequate controls and assurances being in place and gaps in both controls and assurances remain.

Actions are continuously being taken to mitigate the risks and there has been slight increase in ensuring that adequate assurances and controls are in place and that there is evidence of the efficiency of those controls.

Management have worked hard to give assurance to the Board that risks are being managed against a background of changes and challenges that achievement of the Trust's strategic objectives are not being impeded by the principal risks.

All BAF risks are shown as Extreme or High but there has been improvement in some areas:

- **Risk I**: *Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards* has been downgraded due the work being done on Acute Sustainability, the Sefton Transformation Board, Sustainable Transformation Partnership and the appointment of a full time substantive Director of Strategy. These steps have helped to put more controls in place and given additional assurances
- **Risk 6**: *Inability to provide direction and leadership,* although remaining high has had its score reduced due to the Trust now having in place a more sustained senior management team with the appointment of a substantive Chief Executive, substantive Director of Nursing & Midwifery, a substantive Director of Strategy and a substantive Chief Operating Officer. Additionally, recruitment is ongoing for a substantive Medical Director and there is now a full complement of Non-Executive Directors

Details of risk scores and movement of same can be found at **Appendix 1**

An innovative step taken is to manage the BAF via the Trust's risk management system, Datix.

The Director of Nursing, Company Secretary, Associate Director of Human Resources, Improvement Manager and the Turnaround Director have been reviewing the way risks are escalated, managed and the method by which assurance is received by the relevant forums including the Board. One of the innovations is to link risks to the KPIs

A proposed structure showing how this will be done will be discussed at the Executive Team and along with the BAF and the High Level Risk Register will be brought to the Board in October.

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 ✓ 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)*

Previously Presented at:

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

Appendix 1 REVIEW OF HIGH LEVEL RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

September 2017 – July 2018

September 2017

13 extreme risks

- 1362 - CQC Registration
- 1491 - Lack of Chaperones For Sonographers Performing Intimate Examinations
- 385 - Mental Health Patients Attending A&E
- 482 - No Outflow from AED for Admitted Patients
- 1366 - Mandatory and Job Specific Training Compliance
- 1367 - Failure to have a motivated and engaged workforce (culture)
- 1329 - Returning to financial balance by 2021
- 1439 - Financial pressure from medical staff job planning
- 1328 - Reliance on external cash support
- 1530 - Stranded overhead costs following transfer of Community Services

October 2017

One new risk added

- **1614 - Cyber-attack may impact diagnostic services affecting patient care delivery**. Risk was added due to the potential impact of a cyber-attack on diagnostic imaging devices.

November 2017

Four new risks added

- **1623 - Impact on business continuity within obstetrics and gynaecology due to shortage of middle grade medical staff.** Risk added due to shortages of middle grades and resulting impact on financial position, reputation and ability for consultants to provide a safe service.
- **1624 - Lack of evidence of professional curiosity**. Risk added as a result of an audit which demonstrated lack of routine enquiry/documentation for high risk safeguarding cases.
- **1664 - In ability to provide outpatient review appointments in the required timescales**. Risk added due to backlog outpatient reviews within some specialties resulting in potential delays for patients.
- **1640 - Backlog of diabetic patients waiting for eye screening**. Risk added due to vacancies resulting in delays seeing patients in required timescales with potential risk to patients' vision.

Changes to risks

- **1362 - CQC Registration. Risk downgraded from extreme to high** following review of CQC plans. It has become unlikely that the Trust will not address the areas of concern, therefore risk reduced to high.

- **1614 - Cyber-attack may impact diagnostic services affecting patient care delivery. Risk downgraded from extreme to high** due to a robust action plan in place with a number of key actions completed.

December 2017

No new risks added

Changes to risks

- **1327 - Replacement medical equipment programme. Risk downgraded from extreme to high** as a result of an automated 3 year rolling programme for the replacement of medical equipment for all the equipment assets covered by EBME in Theatre. The remaining assets are being updated weekly. The asset register and rolling replacement programme are now up to date.
- **1491 - Lack of Chaperones for Sonographers Performing Intimate Examinations. Risk downgraded from extreme to high** following review and pending confirm of the intimate exams. Risk likelihood downgraded to likely.
- **1366 - Mandatory and Job Specific Training Compliance. Risk downgraded from extreme to high** due to Trust achieving compliance threshold. Risk then closed in February 2018.

January 2018

One new risk added

- **1760 - Lack of Trust Equality & Diversity Lead**. Risk added due to compliance with NGO report and potential failure to fulfil E&D legislation, regulations and agenda.

Changes to risks

- **1439 - Financial pressure from medical staff job planning. Risk closed** due to new policy in place and up to date job plans so future financial risks have been identified.
- **1530 - Stranded overhead costs following transfer of Community Services. Risk downgraded from extreme to high** as risk minimised on transfer of Community services. Risk closed July 2018.
- **1623 - Impact on business continuity within obstetrics and gynaecology due to shortage of middle grade medical staff. Risk closed** as managed under overarching risk relating to medical staff in Obs & Gynae, currently rated high risk.

February 2018

One new risk added

- **1641 - Bed Occupancy in excess of 100% on Southport site.** Risk added due to the pressures faced by the Trust and resulting possible impact on patient safety.

Changes to risks

- **1328 - Reliance on external cash support. Risk downgraded from extreme to high** likelihood of the Trust being allowed to run out of cash.
- **1570- Limited out of hours cover from West Lancashire CAHMS service. Risk downgraded from extreme to high** due to partial resolution with new safe room.
- **385 - Mental Health Patients Attending A&E. Risk downgraded from extreme to high** due to Core 24's response time of 1 hour from referral. Merseycare is in the process of expanding the

workforce to have mental health liaison and support workers on site 24/7. A dedicated room has been provided at Southport for the team as a base.

- **1549 - Postgraduate Medical Education 'enhanced monitoring' GMC/HENW. Risk increased from high to extreme** due to the Trust being placed under enhanced monitoring by GMC and HENWE with the resulting risk of removal of junior doctors from some areas of the Trust.

March 2018

No new risks added

Changes to risks

- **1638 - Optometry Service Vacancies. Risk downgraded from extreme to low** due to recruitment to vacant Optometrist post.

April 2018

One new risk added

- **1815 - Patient Flow**. Risk added to manage bed occupancy and patient flow risks already on extreme risk register.

Changes to risks

- **482 - No Outflow from AED for Admitted Patients. Risk closed** as managed under new Patient Flow risk 1815.
- **1641 - Bed Occupancy in excess of 100% on Southport site. Risk closed** as managed under new Patient Flow risk 1815.
- **1640 - Backlog of diabetic patients waiting for eye screening. Risk closed** as managed under risk 1664 (In ability to provide outpatient review appointments in the required timescales).

May 2018

No new risks added

Changes to risks

- **1368 - Safe Staffing Levels - Impact on Quality and Finance. Risk downgraded from extreme to high** due to Trust achieving compliance with safe staffing levels.
- **1624 - Lack of evidence of professional curiosity. Risk downgraded from extreme to high** due to further training, communication and changes to risk assessments.
- **1701 - Failure of equipment, central monitoring suite ITU/HDU/CCU which could be fatal for the patient. Risk downgraded from extreme to moderate** following purchase of new equipment. Risk closed July 2018.
- **1760 - Lack of Trust Equality & Diversity Lead. Risk downgraded from extreme to high** following recruitment of E&D lead. Risk closed June 2018.
-

June 2018

No new risks added

Changes to risks

- **1664 - In ability to provide outpatient review appointments in the required timescales. Risk downgraded from extreme to high** due to reduction in waiting lists and controls in place.
- **1815 - Patient Flow. Risk downgraded from extreme to high** due to additional controls in place with resulting improvements.

July 2018

One new risk added

- **1132 - AED Staffing. Risk increased from high to extreme** due to reliance on locum staff to cover shortfalls in rotas and loss of regular agency locums due to capped rates. Paper from Ernst Young has indicated that the department's budgeted establishment is under resourced.

Current extreme risk register below:

- 1367 - Failure to have a motivated and engaged workforce (culture)
- 1329 - Returning to financial balance by 2021
- 1549 - Postgraduate Medical Education 'enhanced monitoring' GMC/HENW
- 1132 - AED Staffing

Corporate Risk Register – September 2017 to July 2018

Risk	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	April 18	May 18	June 18	July 18
1570 – Limited out of hours cover from West Lancashire CAHMS Service	Extreme	Extreme	Extreme	Extreme	Extreme	High	High	High	High	High	High
1327 – Replacement medical equipment programme	Extreme	Extreme	Extreme	High	High	High	High	High	High	High	High
1368 – Safe Staffing Levels – Impact on Quality and Finance	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	High	High	High
1362 – CQC Registration	Extreme	Extreme	High	High	High	High	High	High	High	High	High
1491 – Lack of Chaperones for Sonographers Performing Intimate Examinations	Extreme	Extreme	Extreme	High	High	High	High	High	High	High	High
385 – Mental Health Patients Attending A&E	Extreme	Extreme	Extreme	Extreme	Extreme	High	High	High	High	High	High
482 – No Outflow from AED for Admitted Patients	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Risk closed			
1366 – Mandatory and Job Specific Training Compliance	Extreme	Extreme	Extreme	High	High	Risk closed					
1367 – Failure to have a motivated and engaged workforce (culture)	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme
1329 – Returning to financial balance by 2021	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme
1439 – Financial pressure from medical staff job planning	Extreme	Extreme	Extreme	Extreme	Risk closed						
1328 – Reliance on external cash support	Extreme	Extreme	Extreme	Extreme	Extreme	High	High	High	High	High	High
1530 – Stranded overhead costs following transfer of Community Services	Extreme	Extreme	Extreme	Extreme	High	High	High	High	High	High	Risk closed
1614 – Cyber-attack may impact diagnostic services affecting patient care delivery		New Risk - Extreme	High	High	High	High	High	High	High	High	High
1623 – Impact on business continuity within obstetrics and gynaecology due to shortage of middle grade medical staff			New Risk - Extreme	Extreme	Risk closed						
1624 – Lack of evidence of professional curiosity			New Risk – Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	High	High	High
1664 – Inability to provide outpatient review appointments in the required timescale			New Risk – Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme	High	High
1641 – Bed Occupancy in excess of 100% on Southport site						New Risk – Extreme	Extreme	Risk closed			
1549 – Postgraduate Medical Education 'enhanced monitoring' GMCF/HENW	High	High	High	High	High	Extreme	Extreme	Extreme	Extreme	Extreme	Extreme
1638 – Optometry Service Vacancies	High	High	Extreme	Extreme	Extreme	Extreme	Low	Low	Low	Low	Low
1640 – Backlog of diabetic patients waiting for eye screening			New Risk – Extreme	Extreme	Extreme	Extreme	Extreme	Risk closed			
1701 – Failure of equipment, central monitoring suite ITU/HDU/CCU which could be fatal for the patient			New Risk – Moderate	Moderate	Moderate	Moderate	Extreme	Extreme	Moderate	Moderate	Risk closed
1760 – Lack of Trust Equality & Diversity Lead					New Risk – Extreme	Extreme	Extreme	Extreme	High	Risk closed	
1815 – Patient Flow								New Risk - Extreme	Extreme	High	High
1132 – AED Staffing	High	High	High	High	High	High	High	High	High	High	Extreme

Board Assurance Framework

Strategic Objective	Principal Risk	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18
SO1 Agree with partners a long term acute services strategy	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards	Extreme	High				High	Extreme		Extreme		High
SO2 Improve clinical outcomes and patient safety	Poor clinical outcomes and safety records	Extreme	High				High	Extreme		Extreme		Extreme
SO3 Provide care within agreed financial limit	Failure to live within resources leading to increasingly difficult choices for commissioners	Extreme	Extreme				Extreme	Extreme		Extreme		Extreme
SO4 Deliver high quality, well-performing services	Failure to meet key performance targets leading to loss of services	Extreme	High				High	Extreme		Extreme		Extreme
SO5 Ensure staff feel valued in a culture of open and honest communication	Failure to attract and retain staff	High	High				High	High		High		High
SO6 Establish a stable, compassionate leadership team	Inability to provide direction and leadership	Extreme	High				High	High		High		High

Southport and Ormskirk Hospital NHS Trust

15 steps Quality Visit Plan 2018/2019

Month	Where to visit	Who
July 18	Theatres Southport	Richard Fraser Silas Nicolls
	Maternity ward and deliver suite	Jim Birrell Juliette Cosgrove
	7b	Julie Gorry Steve Shanahan
	14a	Pauline Gibson Jugnu Mahajan
	A&E	Gupreet Singh Jane Royds
	9b	David Bricknell Chief Operating Officer
	Spinal Unit	Ged Clarke Therese Patten
Aug 18	Theatres Ormskirk	Richard Fraser Silas Nicolls
	11a	Jim Birrell Juliette Cosgrove
	ANC and ward Ormskirk	Julie Gorry Steve Shanahan
	9a	Pauline Gibson Jugnu Mahajan

	15a	**Gupreet Singh** **Jane Royds**
	CCU	**David Bricknell** **Chief Operating Officer**
	Paediatrics	**Ged Clarke** **Therese Patten**
Sept 18	**Treatment Centre**	**Richard Fraser** **Silas Nicolls**
	14b	**Jim Birrell** **Juliette Cosgrove**
	15b	**Julie Gorry** **Steve Shanahan**
	G / H ward	**Pauline Gibson** **Jugnu Mahajan**
	11b	**Gupreet Singh** **Jane Royds**
	Neonatal	**David Bricknell** **Chief Operating Officer**
	7a	**Ged Clarke** **Therese Patten**
Oct 18	**EBME and Equipment Library** **(southport)**	**Richard Fraser** **Silas Nicolls**
	10a	**Jim Birrell** **Juliette Cosgrove**
	10b	**Julie Gorry** **Steve Shanahan**
	Maxillofacial unit **Ormskirk**	**Pauline Gibson** **Jugnu Mahajan**

	MDU	**Gupreet Singh** **Jane Royds**
	Outpatients and radiology **Southport**	**David Bricknell** **Chief Operating Officer**
	Pharmacy **Southport**	**Ged Clarke** **Therese Patten**
Nov 18	**Sexual health** **(COMMUNITY)**	**Richard Fraser** **Silas Nicolls**
	ENT and Ophthalmology **Southport**	**Jim Birrell** **Juliette Cosgrove**
	Outpatients and radiology (Ormskirk)	**Julie Gorry** **Steve Shanahan**
	Catering dept (patient mealtime observation) **(Southport)**	**Pauline Gibson** **Jugnu Mahajan**
	Pharmacy Ormskirk	**Gupreet Singh** **Jane Royds**
	Decontamination unit	**David Bricknell** **Chief Operating Officer**
	Estates and Facilities **(Southport)**	**Ged Clarke** **Therese Patten**
Dec 18	**Estates and Facilities** **(Ormskirk)**	**Richard Fraser** **Silas Nicolls**
	Catering dept (patient mealtime observation) **(Ormskirk)**	**Jim Birrell** **Juliette Cosgrove**
	Ward F	**Julie Gorry** **Steve Shanahan**

	Discharge Lounge	**Pauline Gibson** **Jugnu Mahajan**
	Theatres Southport	**Gupreet Singh** **Jane Royds**
	Maternity ward and deliver suite	**David Bricknell** **Chief Operating Officer**
	7b	**Ged Clarke** **Therese Patten**

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS
Southport and Ormskirk Hospital
NHS Trust

Standard Operating Procedure (SOP)
For
'15 Steps' Visits

Target Audience				
Who should read this SOP:	**Planned Care CBU**	**Urgent Care CBU**	**CBU**	**Corporate**
All staff	✓	✓	✓	✓

OUR VALUES
Supportive
Caring
Open and honest
Professional
Efficient

Standard Operational Procedure
'15 Steps' Visits

1 Why we have a procedure?

This standard operation procedure (SOP) is in place to ensure consistency across the trust in quality visits across all wards and departments. This will ensure good governance principles are in place and support assurance against national standards and required legislation. The tool to be used will be the **15 steps Challenge** tool, developed by Institute of Innovation and Improvement and recommended as part of the CQC well led framework.

2 Who does the procedure apply to?

This SOP should be followed by all staff who undertake a **15 steps** visit and by the ward / dept leader receiving the visit.

3 How to carry out this procedure (Appendix 1)

3.1 If you have been allocated or have chosen an area to undertake a quality visit please arrange a convenient date between yourself and the ward / dept being visited.

3.2 On arrival please introduce yourself to the ward / dept leader. You must be 'bare below the elbow' follow infection control guidance (use of hand gel) and have your staff pass visible.

3.3 Please introduce yourself to all staff / patient / relatives you come into contact with.

3.4 If at any time you are asked by the ward / dept leader to leave the area, please do so immediately. (This will be on the rare occasion a clinical incident is unfolding and your presence may compromise care).

3.5 Using the 15 Steps Proforma (Appendix 2) please proceed with the visit and document your findings onto the form.

3.6 If at any time you feel patient safety is being compromised please escalate IMMEDIATELY to the ward / dept leader

3.7 When you have completed your visit, please give initial feedback to the ward / dept leader and explain your timeline of getting the full report back to them.

3.8 Please complete the 15 steps proforma (Appendix 2) and send to Assistant Director of Quality. (ADQ)

3.9 ADQ to send out completed 15 steps feedback form (Appendix 2) to ward / dept and the staff feedback form (Appendix 3)

3.10 Ward / dept leader to complete action plan on Datix and monitor completion through the CBU monthly Quality and safety report.

3.11 ADQ to provide quarterly update reports to QSC and visits completed, good practice identified, recommendations and actions taken.

4 Where do I go for further advice or information?

4.1 Training

Training requirements are not formal but please contact ADQ if you require assistance or support in completing the forms. In your role it is expected that you would be in a position to make an assessment of findings, but if you need any additional support please contact ADQ or Deputy Director of Nursing Midwifery Therapies (DDON)
The full 15 steps Challenge document is embedded for information and guidance.

5 Monitoring / Review of this Procedure

The ADQ will be responsible to ensure:

- Visit takes place as planned
- Report is completed and shared
- Appropriate action is in place
- Monitor action until completion
- Submit Quarterly reports to QSC

This SOP will be reviewed as a minimum 3 yearly and revised as necessary to maintain its accuracy and effectiveness. Compliance to the SOP will be monitored through the internal audit programme of board / committee / group effectiveness.

6 Equality Impact Assessment

Equality Impact Assessment (EIA) is not required for the SOP.

7 Document History

Author	Deputy Director of Nursing Midwifery Therapies and Governance Gill.murphy1@nhs.net
Date ratified	July 18
Ratified by	Quality and safety Committee
Review date	July 2021

01 The 15 Steps Challenge toolkit.pdf

Appendix 1

15 Steps Challenge Process

Southport and Ormskirk Hospital NHS Trust

Director or visit leads PA to liaise with NED and arrange visit and inform the ward / dept leader of date within the month assigned.

Assistant Director for Quality (ADQ) to be informed of all visits

In the event of any visits needing to be rearranged this is to be completed by the PA's and confirmation of new date & time to be sent to ADQ

Once visit has taken place the visit pro-forma (appendix 2) is to be completed by the relevant Director / NED / visiting clinician and returned to the ADQ

ADQ to send copy of proforma to leads identified within 3 working days of the visit, together with the feedback form (appendix 3) which then needs to be completed and returned to ADQ

All visit action plans to be managed through Datix with update on progress fed through the CBU monthly quality and safety report.

Quarterly summary report of all visits and the issues and actions arising from the visits and the feedback from staff in the areas visited is reported through the Integrated governance quarterly report to QSC

Appendix 2

15 Steps Challenge

The Reviewers: Date:
Patient:
Non Executive Director/Governor:
Staff:
Ward area:

Welcoming:

Positives	Recommendations

Safe:

Positives	Recommendations

Caring and Involving:

Positives	Recommendations

Well organised and Calm:

Positives	Recommendations

Overall Comments:

Appendix 3

Southport and Ormskirk Hospital NHS Trust

15 Steps Challenge Visit staff feedback form

Ward / Department Visited:

Date of Visit:

1 Staff rated the value of the visit as follows:

Very helpful	
Helpful	
Not helpful	

2 The visit was arranged at a time which was convenient for the ward / department / staff:

Yes	
No	
Don't Know	

3 The Director was interested in speaking to staff and understanding any issues of concern which the staff may have:

Yes	
No	
Don't Know	

4 Please include any suggestions to how future visits may be improved:

Comments:

Thank you for your feedback: please return to Jo Simpson, Assistant Director for Quality.

15 Steps Challenge

Reviewers:

Dept :

Date:

Welcoming

Positives	Recommendations

Safe

Positives	Recommendations

Caring and Involving

Positives	Recommendations

Well organised and calm

Positives	Recommendations

Overall Comments

NHS
Southport and Ormskirk Hospital
NHS Trust

DIRECTOR VISIT STAFF FEEDBACK FORM

Ward / Department Visited:

Date of Visit:

1 Staff rated the value of the visit as follows:

Very helpful	
Helpful	
Not helpful	

2 The visit was arranged at a time which was convenient for the ward / department / staff:

Yes	
No	
Don't Know	

3 The Director was interested in speaking to staff and understanding any issues of concern which the staff may have:

Yes	
No	
Don't Know	

4 The actions which the Director agreed to take away from the visit have been completed:

Yes	
No	
Don't Know	

5 The following changes have occurred further to the visit:

Comments:

6 Please include any suggestions to how future visits may be improved:

Comments:

Thank you for your feedback: please return to Jo Simpson, Assistant Director for Quality.