NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 09.45 – 11.15 on Wednesday 5 December 2018
Family Life Centre, Southport

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
TB276/18 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**5**	**09.45**
TB277/18 (V)	**Declaration of Directors' Interests concerning agenda items** To **receive** declarations of interest relating to agenda items and/or any changes to the register of directors' declared interests	**Chair**		
TB278/18 (D)	**Minutes of the Meeting held on 7 November 2018** To **approve** the minutes of the Board of Directors	**Chair**		
TB279/18 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
STRATEGIC CONTEXT				
TB280/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**5**	**09.50**
QUALITY & SAFETY				
TB281/18 (D)	**Quality Improvement Plan** To **receive** the monthly report	**DoN**	**10**	**09.55**
TB282/18 (D)	**Quality Summit Proposal** To **receive** the proposal	**DoS**	**5**	**10.05**
TB283/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**IMD**	**10**	**10.10**
TB284/18 (D)	**Monthly Safe Nursing & Midwifery Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**10**	**10.20**

Ref No.	Agenda Item	Lead	Duration	Time
PERFORMANCE				
TB285/18 (D)	**Integrated Performance Report** To **receive** the monthly report. ***a. Quality Indicators*** ***b. Operational Indicators*** ***c. Financial Indicator*** ***d. Workforce Indicators***	**DoF** **DoN/MD** **COO** **DoF** **DoHR**	**15**	**10.30**
TB286/18 (D)	**Director of Finance Report** To **receive** the current financial position at Month 7 and progress on Internal Sustainability.	**DoF**	**10**	**10.45**
TB287/18 (D)	**Marketing & Communications Strategy** To **approve** the strategy	**DoS**	**10**	**10.55**
GOVERNANCE/WELL LED				
TB288/18 (D)	**Risk Management:** **Risk Register** To **receive** the monthly report on the Corporate Risk Register	**DoN**	**5**	**11.05**
TB289/18 (D)	**Items for assurance and Information:** **AAAs Highlight Reports from:** • *Finance, Performance and Investment Committee* • *Quality & Safety Committee* • *Workforce Committee*		**N/A**	
TB290/18 (V)	**Questions from Members of the Public**	**Public**	**5**	**11.10**
CONCLUDING BUSINESS				
TB291/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**		
TB292/18 (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**		
TB293/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**		

Ref No.	Agenda Item	Lead	Duration	Time
TB294/18 (V)	**Date and time of next meetings:** **Wednesday 9 January 2018**, **10.30am** Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**		**11.10** **CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair:

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 7 November 2018

Ruffwood Suite, Clinical Education Centre, Ormskirk & District General Hospital
(Subject to the approval of the Board on 3 December 2018)

Present

Jim Birrell, Non-Executive Director (Chair)
David Bricknell, Non-Executive Director
Juliette Cosgrove, Director of Nursing
Julie Gorry, Non-Executive Director
Jugnu Mahajan, Interim Medical Director
Silas Nicholls, Chief Executive
Therese Patten, Deputy Chief Executive/ Director of Strategy
Gurpreet Singh, Non-Executive Director

In Attendance

Pauline Gibson, NED Designate
Audley Charles, Company Secretary
Steve Christian, Chief Operating Officer
Caroline Griffiths, NHS Improvement
Terence Hankin, Incoming Medical Director
Jitka Roberts, Turnaround Director
Jane Royds, Director of Human Resources
Samantha Scholes, Interim PA to the Company Secretary
Kevin Walsh, Deputy Director of Finance

Observing

Angela Parfitt, Care Quality Commission (CQC)
Deborah Lindley, Care Quality Commission (CQC)

Apologies:

Richard Fraser, Chair
Ged Clarke, Non-Executive Director
Steve Shanahan, Director of Finance

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB250/18	**Chairman's Welcome and Note of Apologies**	
	Mr Birrell, as Chair of the meeting, opened by welcoming Board members and Mr Walsh on behalf of Mr Shanahan to the newly refurbished Ruffwood Suite at Ormskirk & District General Hospital.	

	He also welcomed Mr Hankin, Incoming Medical Director and Ms Lindley and Ms Parfitt from CQC. Apologies were received from the Chair, Mr Fraser, Mr Clarke and Mr Shanahan.	
TB251/18	**Declaration of Directors' Interests Concerning Agenda Items**	
	The Chair asked that members declare any 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 Company Secretary. There were no interests declared.	
TB252/18	**Minutes of the Meeting Held On 3 October 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 3 October 2018. Amendments made included: **TB238/18 Finance, Performance & Investment Committee (FP&I): Alert, Advise and Assure (AAA) Report:** amend *Chief Operating Officer* to *Accountable Officer* **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendments.	
TB253/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **Human Resources Contractual Agreement with St Helens & Knowsley (StHK):** that was scheduled to be resolved by end of March 2019. **TB214/18 Emergency Preparedness, Resilience and Response (EPRR) Annual Report 1 April 2017 – 31 March 2018:** that was included in November agenda.	
TB254/18	**Staff Story: The Associate Nurse**	
	The Chair welcomed Mr Tony Carson, Training Nursing Associate (TNA), Mrs Nicky Williams, Corporate Lead Non-Medical Clinical Education and Mrs Carol Fowler, Assistant Director of Nursing and Midwifery (Workforce). The Staff Story related to the experience of Mr Carson. Mrs Williams introduced him and explained that in 2015, Health Education England implemented a new role of Trainee Nurse Associates (TNAs). Mr Carson delivered his presentation which detailed his journey and experiences since he attended his first shift in May 2003 to today presenting to the Trust Board. TNAs would have the skill mix	

and knowledge to work across the different fields of nursing including paediatrics, mental health and learning disabilities/difficulties. The role of the TNA is a level 5 academic qualification, after two years at a Higher Education Institute, it resulted in a foundation degree and a Nursing & Midwifery Council qualified health care professional.

Ms Cosgrove stated that the role of a registered nurse had changed to become a director of care and planning, to be delivered by others including TNAs.

Mrs Gorry asked if the Trust was clear on the duties and responsibilities of TNAs as there was a risk that TNAs could be asked to undertake care that was not within their competency, due to staff shortage. Ms Cosgrove responded that there was no expectation that TNAs operated outside their level of competence. Mr Carson added that TNAs understood what they could or could not do, which Mrs Williams supported, referring to the Nursing and Midwifery Council (NMC) proficiencies.

Mrs Gorry thanked everyone for their responses and requested that the Trust ensured that for any avoidance of doubt, the scope of the role of TNAs was communicated effectively.

Mrs Fowler commented that Mr Carson had attended a Royal College of Nursing (RCN) event the previous week and presented the integration of the TNA role there. Additionally, there were other events to raise the profile of this role with Senior Leaders throughout the NHS. Mr Carson added that part of the role of TNAs was to educate those who might inadvertently request that they undertake something outside of the competency of the role.

Mr Nicholls thanked Mr Carson and Mrs Williams for the presentation. There was significant recognition of the changes taking place and the Trust was keen to support Mr Carson and others. The role would contribute to the solution of staff shortages and it was good that the Trust grew its own staff and therefore retained their expertise. The Director of Nursing and the Medical Director would be looking at the role as part of the long-term Workforce Strategy along with clinical colleagues.

The Chair concluded by thanking Mr Carson and Mrs Williams and commented that it was great that the Trust was one of the pilot sites for that valuable role.

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

STRATEGIC CONTEXT		
TB255/18	**Chief Executive's Report**	
	Mr Nicholls presented the report. The Trust had held its 10th staff awards, re-branded as 'Time to Shine' at Formby Hall on Friday 12th October. It was a new name for what was formerly the Pride Awards, with a new look and a new venue. This had been a wonderful opportunity to celebrate the commitment, dedication and professionalism of everyone who works and volunteers at the Trust. The Chair noted that the Trust had been chosen for a national programme to improve orthopaedic care and Mr Nicholls commented that this was likely due to increased confidence by Teams wanting to put themselves forward for pilot site opportunities. Ms Patten stated that the Red2Green programme was being rolled out across the Trust, with the intention of it being fully operational by the New Year. It was reasonable to ask how that roll-out was different to those which preceded it. The Board was assured that a number of factors, including each member of the Executive Team sponsoring a ward, alongside focusing on communicating with Healthcare Assistants and Assistant Practitioners would support that. Meg Langley, Head of Older Peoples Care & Directorate Manager for Urgent Care (Cardiology, Haematology, Oncology, MDU and Frailty) had been observed conversing with HCAs recently and was doing a phenomenal job, with a real desire to prevent 'red' days. It was imperative that the Board supported Meg in this role. **RESOLVED:** The Board **received** the report.	
TB256/18	**Operational Business Planning – 2019/20**	
	Ms Patten presented the report. The Approach to Planning Guidance was published by NHS Improvement (NHSI) and NHS England (NHSE) on 16th October. An initial 2019/20 plan would be required by 14 January 2019, with the submission of the final 2019/20 organisation operating plan required by 4 April 2019. There would also be a requirement to submit a system wide 5-year plan, signed off by all organisations within the Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). NHSI and NHSE would be publishing 5-year commissioner allocations in December 2018, giving systems a high degree of	

	financial certainty on which to plan. NHSI and NHSE were currently developing the tools and materials that organisations would need to respond to that, the final date for the 5-Year Plan would be in Summer 2019. It was accepted that the timeline was tight; however significant work had already taken place and would continue. The business planning process would commence with Quality Core Service Reviews, linked to CQC preparation of the Provider Information Return (PIR). That detailed information, once completed, would be aggregated up to give a view of the key areas for business planning to focus on. A Business Planning Workshop was scheduled in November where Vision 2020 would be considered from quality, financial and activity perspectives and what could be done differently. The Workforce Plan would build in new roles and would be considered with Further Education colleges and Edge Hill University. The Chair stated that a lot of work had already taken place, however there was much more to do to submit the plans by the dates required and stated that the Board was willing to help if necessary. Ms Cosgrove commented that the work was linked with CQC related one and the same approach would be used to understand developments and the business plan. It made sense to consolidate that with evidence-based information on choices made and co-ordinate the thinking around those. Investment in the workforce was a vital part of the success. Ms Roberts added that the Trust must ensure that there were links with commissioning intentions and that business cases were seen in advance of key changes. Mr Walsh agreed, stating that changes to tariffs by the beginning of December may impact on that. The Board was asked to approve the process for the development and sign-off of the 2019/20 Operational Business Plan. **RESOLVED:** The Board **approved** the plans and process.	
QUALITY & SAFETY		
TB257/18	**Quality & Safety Committee - Alert, Advise and Assure (AAA) Highlight Report**	

Mr Birrell presented the report.

The Committee alerted on:

- Seven new risks had been added to the Risk Register, including one that highlighted staffing shortages in the Anaesthetic Department that had implications for both critical care and surgical lists.

  Mr Nicholls commented that the Director of Nursing and the Medical Director would be considering the composition, recruitment and retention of the workforce over the coming years and alongside Higher and Further Education provision, would design bespoke programmes to support this.

  Mr Singh suggested that to ensure anaesthetic department shortages were managed and safe rotas in place, there could be an increase in SAS/Consultants. Dr Mahajan agreed that there were a number of different ideas and models of care to be considered.

- There had been an increased number of 12-hour breaches due to the lack of mental health in-patient/assessment facilities.
- The Committee expressed concerns about the Trust's Speech and Language Therapy Services so agreed to discuss the matter in more detail at their next meeting. Mrs Royds informed the Board that a Speech and Language Therapist had been recruited.

The Committee advised on:

- The Clinical Effectiveness Committee (CEC) would review the recent deterioration in performance on treating patients with a fractured neck of femur within 36 hours.
- The methodology used for capturing data on compliance with the "Duty of Candour - Evidence of Discussion" standard was under review; if necessary, a report on remedial action would be brought back to the Committee.
- Good progress had been made on the introduction of Structured Judgement Reviews (SJR) although the sensitivity of the tool requires adjustment to enable the Trust to meet the national target of examining 20% of relevant cases in-depth.

The Committee assured on:

- An analysis of Trust compliance with Bereavement Services good practice guidelines was broadly positive. However, there was a need to improve the facilities available for the families/carers of a bereaved/dying patient.

	• The Quality Assurance Panel, which would oversee progress on the Quality Improvement Plan, was up and running • The revised Pneumonia Pathway should be agreed later in the week following the committee meeting. • As per the AQuA report, the Trust was out-performing the regional average on 6 out of 8 sepsis indicators, which reflected the significant improvements implemented over recent months. • An IT update highlighted that clinicians feel they are receiving better and more timely support from IT, which was resulting in earlier implementation of new/upgraded clinical IT systems. **RESOLVED:** The Board **received** the report.	
TB258/18	**Quality Improvement Plan Progress Update**	
	Ms Cosgrove presented the report. The paper provided the Board of Directors with an update on the development of the Quality Improvement Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led Care Quality Commission (CQC) Inspections in November / December 2017 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018. The report included the Trust's preparation plan for future regulatory visits and a programme of work to March 2019 plus overall and monthly BRAG ratings. Significant improvement had been seen, with a reduction of patients in corridors and better environments The Deputy Director of Nursing (Risk, Compliance & Engagement) was reviewing all of the Improvement Project status': further information would be provided for Quality and Safety Committee to review on behalf of the Board and an update would be provided to Board in December 2018. In October 2018, the Board approved the Trust's Preparation Plan for future regulatory inspections. The priority was to demonstrate improvement and ensure that all functions in the Trust were fully engaged with the regulatory requirements and process anticipating any core services and well led inspections in March 2019. Ms Cosgrove and Ms Patten clarified that the use of *'Smartsheets'* was software which was currently used to track Quality Improvements and provided reports based upon the compliance	

	data received. The Chair stated that the BRAG reports were potentially underselling the work which had been achieved and there could be more green rated than amber rated. Ms Cosgrove agreed, however unless evidence was clear, the rating remained amber. Some actions were relatively simple and could be tested internally or by external assurance. That would be discussed further at the Quality & Safety Committee. Mr Nicholls commented that the work being undertaken was not an isolated response to the CQC Report, and demonstrated the close alignment of the Nursing, Clinical and Operational teams. Mr Christian added that that was part of continuous improvement by the Trust and common goals were identified, resulting in a simple narrative. Ms Cosgrove further added that the development of the Clinical Business Unit Triumvirates as a Team was essential. Mrs Gibson requested that BRAG status reported to the Board be defined and consistent. Ms Patten stated that the Project Management Office was now in place and focusing on Continuous Improvement Programmes (CIP) and efficiencies. Focus would be on the Quality Improvement Plan (non CQC) with AqUA, with a Quality Summit in January 2019, further detail of which would be provided at the December Board. Ms Roberts commented that an additional post to manage Commissioning for Quality and Innovation (CQUINs) on an interim basis had been agreed for the remainder of 2018/19, with a view to making that role permanent. **RESOLVED** The Board **received** the report.	**CoSec**
TB259/18	**Monthly Mortality Report**	
	Dr Mahajan presented the report on Quarter 4 which included: **Strategic Context** • The strategic context of Learning from Deaths activity. • An update on the roll out of the Structured Judgement Review method. **Measuring Mortality** • Summary Hospital-level Mortality Indicator (SHMI) – Quarter 4 2017/18 • Hospital Standardised Mortality Ratio (HSMR) - May 2018	

- Disease-Specific Mortality – May 2018
- Mortality Dashboard Highlights – August 2018

Structured Judgement Review (SJR)
Levels of compliance in the use of the screening tool for the third month had been reported at 59.7%. Paper based mortality screening in the Trust would be entirely discontinued in November 2018, ensuring that all mortality reviews were undertaken with the SJR methodology through the Datix system.

Dr Mahajan noted that the Mortality Screening Review tables on page 4 of the report indicated that there were 17 reports to the Coroner's Office. This was not due to 17 individual deaths, but to the number of contacts made by a range of people to that office. The number of enquiries had not increased.

Summary Hospital-level Mortality Indicator (SHMI)
An increase had been seen and was reflective of the Winter 2017/18 period.

Crude Mortality
A slight reduction had been seen.

Performance Distribution Chart for May 2018/19 HSMR
This chart demonstrated the co-factors which contributed to the increase in HSMR.

Mr Singh commented that there would appear to be a correlation of safe staffing impacting on the mortality rate to which Dr Mahajan responded that that was recognised. Mr Nicholls added that there was a triangulation of information, with staffing levels being impacted by sickness rates. Packages of intervention, including the monitoring of sickness were in place.

Lower Respiratory Tract Infection
The rolling 12 month local Standardised Mortality Rate (SMR) for:

- Lower Respiratory Tract Infection (LRTI) was 168 for May.
- Acute Bronchitis was recorded at 166.6 for the same month.
- Pneumonia SMR was 135.1 for May, a reduction on April.

A revised pneumonia pathway was currently being scoped which would incorporate new processes to ensure that patients are given the most appropriate treatment as soon as pneumonia was recognised whether it was community or hospital acquired.

Urinary Tract Infection

	A significant factor was catheterisation, which was higher than the norm due to the needs of patients within the Spinal Injuries Unit at the Trust. Mrs Gorry asked if the SJRs were undertaken by an external examiner. Dr Mahajan responded that there had been a national move towards external examination however it was now agreed that Trusts could appoint a medical examiner who had not been involved in the clinical care of the patient, which would be a pathologist or anaesthetist. Mr Singh asked if the Trust was working towards achieving review of 100% of SJRs and Dr Mahajan assured the Board that 80% were already reviewed with 100% was the goal. Mr Singh commented that the Quality & Safety Committee had identified that much good work was continuing with sepsis and pneumonia and that it was anticipating similar improvements in other areas. **RESOLVED:** The Board **received** the report.	
TB260/18	**Workforce Committee AAAs Report**	
	Workforce Mr Bricknell as Chair of the Committee presented the report. The Committee alerted on: • Sickness Policy – At the time of the meeting there was still no agreed Policy but it was hoped that a final meeting, the next day, would resolve it. The policy had been agreed at the final meeting. • Publication of Policies – Despite agreement of policies they were still not being published promptly on the intranet. • Retention Consultation – That should not be confined to nursing but should be widened in due course. • Quality of Medical Training – Visit from Health Education England North West had been brought forward to March 2019 from autumn 2019 because of significant concerns. Key issues had been set out in a letter to the Interim Medical Director. • Attendance at Meetings – the Workforce Committee in October and Joint Negotiating Committee in September were not quorate. If these meetings were to fulfil their purpose, they must be quorately attended, or have their Terms of Reference and memberships reviewed. • Valuing our People / JNC – Lack of consultation and apparent lack of EIA in relation to car parking. Ms Patten stated that car	

parking had been reviewed carefully and included access for disabled staff, plus parent and child spaces. She had also spoken with the Independent Chair of Staff Side who had agreed with the plans.

The Committee assured on:

- Sickness Absence – The sickness absence review was now examining the positives of areas with good attendance as a learning exercise for general Health & Well Being and its impact on sickness. Dr Bricknell added that some very busy areas saw very low levels of sickness absence.
- National Guardian's Office (NGO)/ Freedom to Speak Up (FTSU) – Excellent progress had been made in a significant number of actions with only a few left outstanding.
- Cheshire & Merseyside Streamlining project in relation to Human Resources – Whilst it was a drain on resources to attend meetings, there was significant assurance gained from our activities in relation to the peer group and an enhancement of our reputation regionally.

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

TB261/18 **Monthly Safe Nurse & Midwifery Staffing Report**

Ms Cosgrove presented the report.

The Board was advised that the current nurse staffing risk reported as Extreme (16) via the risk register (ID 1862).

For the month of September 2018, the Trust reported safe staffing against the national average (90%) at 91.99%.

Overall fill rate for August 2018 was 91.99%. compared to 89.97% in August and 90.43% in July.

- 86.27% Registered Nurses on days
- 94.11% Registered Nurses on nights
- 95.92% Care staff on days
- 96.40% Care staff on nights

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

September 2018 data:

	Funded WTE	**Contracted WTE**
Registered	864.21	757.00
Non -registered	377.78	343.66

	Total	1241.99	1100.66	

Ms Cosgrove reported that the daily morning safe staffing huddle acted as a 'confirm and challenge' forum focusing on ensuring safe staffing levels whilst highlighting roster efficiency. In addition, Ruth May, Director of Nursing for NHSI had set out a new framework of safeguards and Ms Cosgrove would update the Board on the regulatory requirements and update the Board.

Mr Christian commented that staffing levels were being proactively managed on a day to day basis. Mrs Royds added that the recruitment and retention of staff was being examined with clinical colleagues.

Ms Cosgrove stated that the Trust would commence the recording and monitoring of any 'Red Flag Event' by using the adverse incident reporting system (Datix), which would address four of the recommendations by NICE.

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

TB262/18	**Freedom to Speak Up Guardian Quarter 2 Report**	

Reverend Martin Abrams presented the report.

Since Reverend Abrams last visit to the Board, where the report on Freedom to Speak Up (FTSU) had not been significantly positive, he was pleased to report that following a journey of hard work and the visit by Henrietta Hughes, National Guardian's Office Representative, to the Trust in July 2018 there had been good feedback. October 2018 had been national Freedom to Speak Up month.

Mr Nicholls commented that the Trust had received a letter from an MP on behalf of a member of staff and whilst the Trust was investigating a further letter from the MP had stated the member of staff was entirely satisfied with the way the concern was being dealt with and they no longer required the MP's involvement.

Ms Cosgrove stated that a number of FTSU Champions had been identified to act as advocates and spread the values of FTSU. Mrs Royds added that that number was going to increase following recent conversations with staff members who were also interested in undertaking the role of a Champion.

Reverend Abrams stated that there had been 11 concerns raised in the period of 1 July to 30 September 2018 which was indicative of

	the willingness of staff to speak up. A YouTube video on this subject, including reassurance on speaking up and that staff members would be listened to, was shared at the Board and would be available via all social media and the Trust website. Mr Nicholls commented that Reverend Abrams attended all staff inductions so that new members of staff were aware of the process. Ms Patten stated that the e-learning module was very good. Ms Cosgrove related her experience of speaking up as a junior nurse and had thought that she would be disregarded; however her experience of being taken seriously and listened to was invaluable. The Chair thanked Reverend Abrams for his hard work and Reverend Abrams thanked the Executives for their support. Mr Singh added that at the National Guardian's Office visit in July, Ms Hughes had commented that the Trust was an exemplar organisation in this regard. Reverend Abrams and the wider team had done an amazing job, which he hoped would be reflected in the Staff Survey. **RESOLVED:** The Board **received** the Quarter 2 report.	
PERFORMANCE		
TB263/18	**Finance, Performance & Investment Committee (FP&I): Alert, Advise and Assure (AAA) Report**	
	Mr Birrell as Chair of the Committee presented the report. The Committee alerted on: • A review of cancer waiting times had concluded that the Trust would not meet the 62-day national cancer standards until the end of quarter 4. • Discussions on the winter plan were continuing, particularly around the scale and type of additional capacity needed to cope with the anticipated extra demand. • At Month 6 the Trust was overspent by £15.8m but was still aiming to meet the outturn target of a £28.8m deficit. • The increased volume of non-elective activity had generated some commissioner challenges and these are being dealt with in the regular contract monitoring meetings. The Committee advised on:	

	• Single sex accommodation breaches will be reviewed with the aim of improving compliance with the national standard. • Given the high level of sickness absence, it was agreed that as a matter of urgency a wide-ranging review would be undertaken of the potential ways in which the Trust could bring the position into line with neighbouring organisations. • The practice of admitting patients on the day before their surgery would be examined with a view to moving further towards same day admission. • The information contained within the Service Level Reporting system (PLICs) remained unvalidated so work to complete the exercise was continuing. The Committee assured on: • The detailed daily analysis of blocked beds had been significantly enhanced, which would facilitate much greater oversight and intervention as necessary. **RESOLVED:** The Board **received** the report.	
TB264/18	**Audit Committee: Alert, Advise and Assure (AAA) Report**	
	As Mr Clarke was on leave, Mr Birrell presented the report The Committee alerted on: • There were elements in the Audit Handbook that should be included in the Annual Business Cycle (Work Plan) of the Committee. They included Clinical Audit Strategy and periodical reports about same. • Mandatory training across all sectors remained a concern and the relevant leads had been alerted as to their responsibilities in that matter. • The Anti-Fraud Specialist alerted the Committee on a fraud scheme which was targeting the NHS and its suppliers. Decision makers have been warned to be on the alert. • The apparent non-disclosure of Gifts and Hospitality by staff needed an urgent awareness programme. The Committee advised on: • All staff, including medical, needed to be reminded of their responsibilities to declare outside work to their line manager and the Company Secretary as set out in the Standard of Business Conduct and Managing Conflict of Interests Policy. • All staff to be informed of new rules relating to the need for Privacy Notices in relation to their payroll information. The Committee assured on:	

	• MIAA-Internal Audit gave a fair assurance on Anti-Fraud in the Trust. There had been significant progress when benchmarked against other Trusts. • The Company Secretary had arranged meetings with key staff groups to refresh their knowledge and awareness around declaration of interests, outside work and gifts, hospitality and sponsorships. He was making arrangements for staff to make their declarations using Smartsheets - an online tool from which reports/registers could be generated. **RESOLVED:** The Board **received** the report.	
TB265/18	**Integrated Performance Report (IPR)**	
	Mr Walsh presented the report. Mr Walsh introduced the report, details of which were in the Board Pack. The report's format had been revised and condensed following consultation. Statistical Process Control charts would be included in the November report. Ms Anita Davenport would explain in detail the report's format, including the 60+ Key Performance Indicators (KPIs) which had been incorporated, in the afternoon's Workshop with the Board and key members of staff. Each Director spoke to their areas of responsibility and answered questions raised. **Quality Indicators** were summarised by the Director of Nursing and Interim Medical Director in such areas as: • Never Events • Falls – Moderate/Severe/Death • Fractured Neck of Femur • HSMR(Hospital Standardised Mortality Rate) • SHMI (Summary Hospital-level Mortality Indicator) • Stroke • Delivering Same Sex Accommodation **Operational Indicators** were presented by the Chief Operating Officer summarising the following areas: • A & E 4-hour and 12-hour compliance • Red to Green • Ambulance Handovers • Diagnostic Waits • 62-day GP referral to treatment • 62-day Pathway Analysis • Theatre Utilisation	

	Mr Birrell stated that non-Cancer targets should be included in the report, to which Mr Walsh agreed would be picked up at the Finance Investment & Performance Committee. **Financial Indicators** were presented by the Deputy Director of Finance Mr Walsh would report on the financial indicators in the Director of Finance Report and highlighted that the Trust was unlikely to reduce its agency spend. **Workforce Indicators** were presented by the Director of Human Resources and Director of Nursing • Well Led • Duty of Candour • Sickness rate • Personal Development Review (PDR) • Mandatory Training **RESOLVED** The Board **received** the report.	
TB266/18	**Director of Finance Report**	
	• Mr Walsh presented the report. • Current financial position at Month 6. • At month 6 the Trust's financial performance was a deficit of £15.75 million against a deficit plan of £15.788 million which was £39,000 better than plan. • The Trust was better than plan after the inclusion of £800,000 income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. • Agency spend was rising, particularly in nursing and the year's budget was two thirds spent. • There were a number of other risks which, if not addressed, would lead to the Trust not achieving the planned deficit of £28.8 million. • The main risks were CIP, agency spend and agreeing a satisfactory contract outcome with our commissioners. • Based on the current run rate the outturn will be in the region of £30-32 million deficit. • There was no plan at this stage to amend the forecast outturn from £28.8 million deficit. **Capital** The Trust was behind plan, which was not an unusual position at the time in the year. If further funding was secured, some schemes	

could be brought forwards.

- **Risks**
- Following an assessment by the Turnaround Director there was a significant risk of delivering the CIP of £7.5 million (£7 million 'in year').
- Agency spend was rising each month caused by high sickness levels and vacancies.
- No provision for contract sanctions had been accrued into September's financial position. Commissioners had indicated sanctions would be applied in full in order to balance back to their contract value.
- Current activity performance would lead to CCG payments exceeding their contract value. The risk was that contract challenges would lead to lower income levels that Trust needed in order to deliver its year end forecast.
- Future business cases or pressures were not covered by reserves

The Chair stated that there had been no drift in the financial position of the Trust month on month, which clearly indicated the Finance Team were on top of performance which was pleasing. Capital had been included in a Board paper, which was good news.

Mr Nicholls commented there are risks and this was not the position the Trust was in three to four months ago. Questions had to be asked regarding how the deficit should be apportioned across the Trust and other organisations within the health economy. Trusts within Cheshire & Merseyside had all performed worse financially (in month 6) with the exception of this Trust.

Mr Singh stated that the use of agency staff was a matter of concern as alongside the cost, they were not permanent members of staff and potentially not as safe.

Discussion took place on the recruitment process which was hindered by agency staff being offered more money elsewhere in the health economy. A Business Case was to be approved to assist HR to rapidly build a bank of administrative and clinical staff. The Director of Human Resources along with the Interim Medical Director and the Chief Operating Officer would establish an effective recovery plan for each long-term locum and 20 extra visas had been authorised by the Home Office for the Trust. Ms Cosgrove informed members that the hot spots for nursing and rostering were being reviewed in conjunction with HR.

	Mrs Royds added that a policy was being written regarding pay rates and that regular discussion was taking place. **RESOLVED:** The Board **received** the report.	
TB267/18	**Statement of Compliance 2018/2019 Core Standards Self-Assessment - Emergency Preparedness, Resilience and Response (EPRR)**	
	Mr Christian as the Chief Operating Officer presented the report. NHS England (NHSE) had a statutory requirement to formally assure both itself and NHS organisations in England were in a state of EPRR readiness. That was provided via the NHS England Core Standards for EPRR Annual Assurance Process. There was a requirement that a Statement of Compliance was approved annually by the Board. This year's Statement of Compliance was required to be submitted to NHS England before 11 October 2018. NHS England was informed that the Board would not be able to formally approve the Statement, as its next meeting was scheduled for 7 November 2018. NHSE agreed that the Trust's Accountable Emergency Officer, namely the Chief Operating Officer, could sign the submission subject to approval by the Board at its next meeting. At present the departmental Business Continuity Plans were updated every two years, however, to improve resilience the Trust would review the documents on an annual basis. **RESOLVED** The Board **approved** the Statement of Compliance.	
GOVERNANCE/WELL LED		
TB268/18	**Risk Management:** **Risk Register**	
	Ms Cosgrove presented the report. There were currently eight risks on the High Level Risk Register. Mr Birrell noted that all risks had been examined at the appropriate committees and Ms Cosgrove added that a new Risk & Compliance Group would be set up, reporting to the Audit Committee. The Group's Terms of Reference had been approved at the last Audit Committee. Mr Nicholls commented that risks were discussed on a day to day basis, which was encouraging progress for the Trust.	

	RESOLVED The Board **received** the Risk Register.	
TB269/18	**Regulation and Compliance**	
	a) Board & Senior Leaders Development, Well Led Review and Quality Improvement Training Mrs Royds presented the report. The Trust's Board Development Programme was an integral part of the Trust's *Vision 2020* and one action of several in the Trust's response to CQC's Well Led rating (March 2018) to ensure that the Board governs effectively and in doing so builds patient, public and stakeholder confidence that their health was in safe hands. The version of the Board Development Programme commenced in September 2018 and was designed around the Trust's Strategic Objectives and CQC Well Led Domains - *Strategy & Planning, Capability & Culture, Process and Structures, and Measurement.* It was comprised of a variety of assessment and developmental activities which at its core had monthly workshops to deliver on the following three Board objectives: *1. To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up* *2. To support the Board to set the strategic direction of the organisation underpinned and monitored by robust governance structures and processes* *3. To work effectively as a high performing team who role model exemplary behaviours* The Board Development Programme acts as one work stream combining a series of connecting and supporting strategies and improvement plans. It included working closely with AQuA (Advancing Quality Alliance) to undertake a Well Led Development Review, the outcomes of which will inform future Board development; and to deliver a Quality Improvement training programme to embed a robust, proven improvement methodology. Dates had been agreed for a range of masterclasses to create an intensive programme. A leadership masterclass would be led by Michael West, Professor of Work and Organisational Psychology at Lancaster University Management School. The importance of the programme including the Board, Senior	

	Leaders and the triumvirate of each Clinical Business Unit was agreed and the Workforce Committee would oversee the progress Mrs Gibson added that there must be focus on Board behaviours and adoption of recommendations to be responsive. Mrs Royds thanked Mr Charles and Mrs Tracy Gunn for their hard work in developing the programme. **b) External Well Led Review** The Board **approved** the Board Development and Senior Leaders Programme and **received** the details of the Well Led Development Review.	
TB270/18	**Items for Approval/Ratification**	
	a) Statutory Instruments 2018/19: Scheme of Reservation and Delegation – Proposed Amendments Current approval levels in respect of non-pay revenue expenditure, requisitioning, ordering, payment of goods and services in Trust's Statutory Instruments 2018/19: Scheme of Reservation and Delegation 2018/19 were higher compared to other Trusts in similar financial position. The petty cash spending limits were to be amended / revised down. The Board **approved** the recommendation and updated Scheme of Reservation & Delegation. **b) The Remuneration Committee's approval of the Interview Panel's recommendation that Dr Terence Hankin be appointed Medical Director subject to the relevant checks and due diligence including Regulation 5 of the FPPT Regulations**. Mr Charles confirmed that all relevant checks and due diligence had been undertaken and Mr Hankin's had successfully met the Fit and Proper Persons requirements. The Board **ratified** the decision of the Remuneration Committee held 3 October 2018. **c) Utilisation Loan Application** The Board **ratified** the decision taken under Emergency Powers to approve the application of the loan application. **d) 2018 Education & Training Self-Assessment Report (SAR)**	

	The Board **ratified** the decision taken by Non-Executive Director members of the Workforce Committee, the Chief Executive, Interim Medical Director and Director of Human Resources **to approve the Self-Assessment Report.**	
TB271/18	**Questions From Members of the Public**	
	No questions were raised	
CONCLUDING BUSINESS		
TB272/18	**Any Other Business**	
	Mrs Gibson reflected on a ward visit to the Maxo Facial Unit she had recently undertaken with Dr Mahajan and read out a poem a patient had written about the care received by Sister Debbie Lucas. The Chair thanked Mrs Gibson and it was recommended that the poem be shared with all staff, via Trust News.	**CoSec**
TB273/18	**Items for the Risk Register/changes to the BAF**	
	There were no additional items or changes.	
TB274/18	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • Staff Story: Associate Nurse • Business Plan Process • Quality Summit in January 2019 • Structured Judgement Reviews • Agency costs • Financial Position • Continuous Improvement Programme • Board and Senior Leaders Development	
TB275/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 3 December October, 09:30 **The Family Life Centre, Southport**	

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	✓	✓	✓	✓		A	A	✓				
Audley Charles	✓	✓	A	✓		✓	✓	✓				
Steve Christian			A	A			✓	✓				
Ged Clarke	✓	✓	✓	A		✓	✓	A				
Jenny Farley						A						
Juliette Cosgrove			✓	✓		✓	✓	✓				
Pauline Gibson	✓	✓	✓	A		✓	✓	✓				
Julie Gorry	✓	✓	✓	✓		A	✓	✓				
Jugnu Mahajan	✓	✓	✓	✓		✓	✓	✓				
Therese Patten	✓	✓	✓	✓		A	✓	✓				
Jane Royds	✓	✓	A	✓		✓	✓	✓				
Steve Shanahan	✓	✓	✓	✓		✓	✓	A				
Gurpreet Singh	✓	✓	✓	✓		✓	✓	✓				
A = Apologies, ✓ = In attendance, ***** = Non-voting Member												

Public Board Matters Arising Action Log
as at 5 December 2018

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	**DoHR**	Sep 2017	Mar 2019	**December 2018** ADHR was TUPEd and appointed as Director of HR in November 2018. Work continues to transfer other services back to the Trust by March 2019.	**GREEN**
TB258/18	Nov 2018	**Quality Improvement Plan Progress Update**	BRAG status reported to Board to be defined and consistent.	**CoSec**	Jan 2019	Jan 2019		**GREEN**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Completion Date	Status Outcomes	BRAG STATUS
TB241/18	Oct 2018	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report 1 April 2017 – 31 March 2018**	For 2018, the self-assessment would be brought to Trust Board in November 2018, along with the Major Incident Plan	**COO**	Nov 2018	Nov 2018	**November 2018** This was an item on the November agenda	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	**TB280/18**	**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

- Appointment of new Trust Chair
- Allegations of bullying
- Red2Green and #LongStayTuesday get patients moving
- Patients reap benefits of investment and new work practices

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)*
N/A

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 – DECEMBER 2018

Appointment of new Trust Chair

I am delighted to welcome **Neil Masom** as the new Chair of the Trust Board this month.

Neil has nearly 20 years of Board-level experience in executive and non-executive roles in both the commercial and public sectors, including as a non-executive at East Cheshire NHS Trust in Macclesfield.

His wide-ranging experience and knowledge will be invaluable in shaping our hospitals and the great health care we want to provide for local people. The appointment by NHS Improvement also reflects a growing confidence in the Trust which can only be of benefit to patients and staff.

Neil succeeds Richard Fraser who steps down after two years in the post. He is continuing as Chair at St Helens and Knowsley Teaching Hospitals NHS Trust

I wish Richard well for the future and thank him for his dedication to the Trust, common sense chairmanship and good humour through occasionally difficult times.

Neil's appointment all but completes our refreshed Board. **Dr Terry Hankin** will join the Trust in January as Medical Director. He is currently deputy medical director at St Helens and Knowsley.

I am also pleased announce **Jane Royds** has been appointed Director of HR and Organisational Development.

She was appointed Associate Director of Strategic HR for the Trust in June 2017 following the transfer of HR, Payroll, Health and Wellbeing, and Education and Training to St Helens and Knowsley Teaching.

Her TUPE-transfer to Southport and Ormskirk will now be followed by further discussion with St Helens and Knowsley on the future provision of other services Jane is responsible for and which they currently provide to the organisation.

Allegations of bullying in the Trust

I was very concerned to read about allegations of bullying at the Trust published in the Liverpool Echo last month.

Since becoming Chief Executive, both I and the Executive Team have made it clear we take accusations of bullying and harassment extremely seriously. There is no

room for bullying in this organisation. It will not be tolerated, and we will do what it takes to address it and change the culture.

I am very sorry the individuals who have spoken to the Echo did not feel confident to raise their concerns with the Trust. I have urged them publicly to come forward either directly or in confidence to our independent Freedom to Speak Up Guardian Martin Abrams.

Their concerns, and those of any other colleagues who feel the need to speak up, will be fully investigated and appropriate action taken where necessary.

We are also working with our junior doctors and staff representatives to improve the reporting of any behaviours that run counter to Trust values.

All staff have a responsibility to speak up where they have a concern which may affect patient care or has implications for the welfare of colleagues. Last month the Board saw a video the Trust had published as part of this work to help raise awareness that speaking up should be business as usual for all staff.

Red2Green and #LongStayTuesday get patients moving

Staff across the Trust remain firmly focussed on delivering the best and most timely care for patients.

Our Red2Green programme focuses on preventing “red days” for patients; that is days when blockages and obstacles stop a patient moving closer to going home. In that way as many days as possible become “green days”.

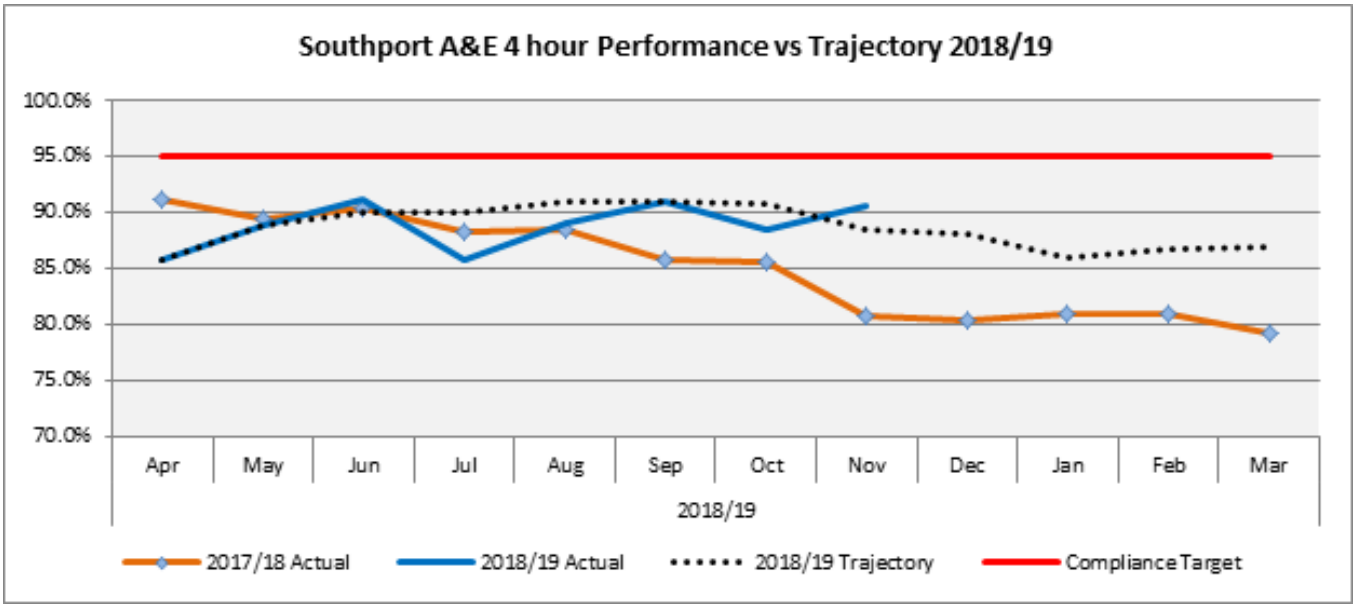
Those teams who have embraced the concept have seen very promising results. The entire executive team is sponsoring the roll out of Red2Green across the Trust. Our intention is for it to be fully operational by the New Year.

In addition, we have introduced #LongStayTuesday when staff get together with social care colleagues to review all patients who have been with us for more than 20 days. Where appropriate, they aim to minimise any blockages which are preventing patients from going home.

Patients reap benefits of investment and new work practices

Initiatives like Red2Green and #LongStayTuesday get admitted patients treated and returned home as quickly and safely as possible. This, in turn, prevents A&E backing up with patients awaiting admission and contributes towards improving the Trust’s performance against national standards.

A&E performance has improved considerably this year. October was the fourth consecutive month in which we beat last year's performance. We have kept pace with our trajectory agreed with NHS Improvement – only dipping below during the summer when we had record attendances at Southport hospital.



A new clinical communications hub has been a combined effort between the IT, Information and the clinical teams to help coordinate patient flow. We are embracing the use of technology and business intelligence to support senior decision makers at times of heightened demand.

Activity numbers are already prepared for the winter and Christmas period which will help all departments prepare for this busy time of year.

We have also begun to reap the benefits of the £1.25m investment in A&E that began in the spring. The first part of the final phase of the work was completed in November and includes a dedicated ambulance reception area.

The A&E team showed Damien Moore, MP for Southport, the work in progress as they prepared to open. The investment and benefits were also showcased by Jane Lawson, Matron for A&E, in a BBC North West Tonight feature about how the NHS is preparing for winter.

The final 40% of the A&E project, which includes a bigger, brighter reception area and waiting room, will be completed before Christmas.

Silas Nicholls Chief Executive

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	**TB281/18**	**Report Title**	**Quality Improvement Plan - Progress Update**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality Paul Jebb, Deputy Director of Nursing		
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 the 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 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018.

The report also outlines the Trust's preparation plan for future regulatory visits and the programme work up to March 2019.

Recommendation:
The Board is asked to **receive** the report for assurance.

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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✓ **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)*

The plan will be continuously reviewed and updated as necessary.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on the development of the 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 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018.

2. BACKGROUND

As reported previously to the Board, a Quality Improvement Action Plan has been developed incorporating priorities from the Draft Quality Improvement Strategy, CQC Must and Should Do recommendations and the Trust's key quality priority themes emerging from complaints, incidents and patient feedback.

3. URGENT & EMERGENCY SERVICES QUALITY IMPROVEMENT PLAN

Following the publication of the Urgent and Emergency Services CQC Quality Report in September 2018, the Trust was asked to develop an improvement plan detailing the actions the Trust is taking to improve quality of care for patients; the plan was submitted to the CQC on 11 October 2018.

The Deputy Director of Nursing and Assistant Director Quality have met with the Emergency Department (ED) team who have engaged with the action plan and future meetings are planned to ensure continued improvement against actions several of these relate to the improvements in the environment and the impact on patient experience.

Areas that have improved are:

- Medicines management
- Caring for patients nursed on corridor
- Privacy and dignity
- Access and flow
- Infection prevention control

ED BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	1	0	1
Action Completed	9	8	17
On track to deliver	3	4	7
No progress / Not progressing to Plan	0	0	0
TOTAL	13	12	25

ED BRAG rating monthly reported completion

Rating	Sept 18	Oct 18	Nov 18
Delivered and Sustained	0	1	1
Action Completed	4	15	17
On track to deliver	21	9	7
No progress / Not progressing to Plan	0	0	0

4. COMPLIANCE

Assurance panels continue to be held, the November panel will be held in the w/c 26 November 2018 and is expected to focus on the ED improvements. Of the 97 improvement actions, 58 are currently rated amber (on track to deliver), 34 Green (action completed) and five blue (delivered and sustained).

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	3	2	5
Action Completed	18	16	34
On track to deliver	38	20	58
No progress / Not progressing to Plan	0	0	0
TOTAL	59	38	97

BRAG rating monthly reported completion

Rating	Baseline	June 18	July 18	August 18	Sept 18	Oct 18	Nov 18
Delivered and Sustained	0	1	1	1	2	5	5
Action Completed	0	0	6	22	21	19	34
On track to deliver	97	96	90	74	74	73	58
No progress / Not progressing to Plan	0	0	0	0	0	0	0

5. QUALITY IMPROVEMENT DELIVERY GROUPS

The Deputy Director of Nursing (Risk, Compliance & Engagement) review of all the Improvement Projects continues. Several groups have continued the work and have brought the improvement actions to be part of other formal groups to ensure these areas are continued to be sighted across the organisation and be part of every day delivery.

6. QUALITY VISIT / CQC PREPARATION – UPDATE

Core Service Self Assessments

CBUs have been requested to complete core service self-assessments to identify areas of strengths, areas for improvement and gaps against the Key Lines of Enquiry (KLOE) for each core service.

Core Services include:

- Urgent and emergency services (adult and children)
- Medical care – including older peoples care
- Surgery – both sites
- Critical care
- Outpatients (including Radiology) – both sites
- Spinal injuries
- Maternity
- Services for children and young people
- Sexual health

Provider Information Return (PIR)

Using the Trust's 2017 PIR process, the PIR template has been circulated to the identified leads to update and populate for 17/18.

Core Service Inspection (Mock Inspection)

Dates have been identified for a full mock inspection of core services. We are in the process of inviting external experts to support our own staff to undertake the inspection and through our NHSI Improvement Director we have identified an independent Chair.

7. QUALITY SUMMIT

The Trust is holding a Quality Summit in January 2019 to support the relaunch of the quality priorities and progress against the quality improvement plan. It will also contribute towards the development of a quality improvement culture through showcasing best practice tools, the use of actual case studies (including Learning from Deaths and Reducing Avoidable Mortality) and giving recognition to staff who have delivered quality improvement. The event will introduce our quality partners including AQuA, NHSI, The Academy of Fabulous NHS Stuff and Quality Ambassadors. It will provide an opportunity to clearly demonstrate the golden thread of quality improvement from Board to Ward.

8. CQC NATIONAL UPDATE

Published early October the CQC State of Care 2017/18 was published this is the CQC annual assessment of health and social care in England.

The report shows that most people are still receiving good care - when they can access it. Overall good quality has been maintained, but there are still significant workforce pressures as all sectors struggle to recruit and retain staff.

The CQC found that people's experiences of care often depend on how well local systems work together where they live. Some people can easily access good care, while others cannot get the support they need. They may experience disjointed care, or only have access to providers with poor services.

The report highlighted the challenge for all local health and social care services is to recognise the needs of their local populations and find sustainable solutions that put people first. In this context, CQC have considered 5 factors that affect the sustainability of good care for people which are:

- Access - Access to care varies from place to place across the country. Some people cannot access the services they need, or their only reasonable access is to providers with poor services
- Quality - The overall quality of care in the major health and care sectors has improved slightly. At the same time, too many people are getting care that is not good enough.
- Workforce - Workforce problems have a direct impact on people's care. Getting the right workforce is crucial in ensuring services can improve and provide high-quality, person-centred care.

  Each sector has its own workforce challenges, and many are struggling to recruit, retain and develop their staff to meet the needs of the people they care for
- Demand and Capacity - Demand is rising, not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia.

  Providers face the challenge of finding the right capacity to meet people's needs. Services need to plan – together – to meet the predicted needs of their local populations, as well planning for extremes of demand, such as sickness during winter and the impact this has on the system
- Funding & Commissioning - Care providers need to be able to plan provision of services for populations with the right resources, so good funding and commissioning structures and decision-making should be in place to help boost the ability of health and social care services to improve. Funding challenges of recent years are well known, and in June 2018 the government announced an extra £20.5 billion funding for the NHS by 2023/24. However, at the time of publication the CQC highlighted that there is no similar long-term funding solution for adult social care.

The CQC has recently published a consultation document about the fees we propose to charge registered providers in 2019/20 and are inviting responses. https://www.cqc.org.uk/get-involved/consultations/regulatory-fees-201920-consultation

There have been a number of updates to the CQC core service and the trust-wide well-led assessment frameworks. Updates include guidance on eight high impact actions to improve the working environment for junior doctors, the addition of the new National Dementia Action Alliance Dementia Charter, and updated AMSAT prompts.

New Ionising Radiation (Medical Exposures) Regulations 2017 that came in to force in February this year require providers to update procedures and working practices.

While many of the principles remain the same as the previous regulations, there are now some additional requirements that must be met. Where the CQC find providers are not meeting legal obligations they will take appropriate enforcement action.

The Department of Health and Social Care has published guidance to accompany the new regulations. This has been sent to the Radiology Dept. for awareness and update on their actions.

9. RECOMMENDATIONS

The Board of Directors are asked to note progress identified in this report as assurance that systems and processes are in place to deliver quality improvement

Jo Simpson
Assistant Director of Quality

Paul Jebb
Deputy Director of Nursing

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	**TB282/18**	**Report Title**	**Quality Summit Proposal**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Donna Lynch, Head of PMO		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

- In order to support Quality Improvement within the Trust it has been suggested that it may be appropriate to hold a Quality Summit.
- Given that Vision 2020 has quality improvement as a key deliverable, this event would not only support the formal launch of the quality strategy and priorities, but contribute to the development of a quality improvement culture through showcasing best practice tools, with the presentation of actual case studies, giving recognition to staff who have delivered quality improvements.
- A planning group has been established, this group held its first meeting on Thursday 8th November, it was proposed that the group be used to support the Quality Summit and the AQuA training programme roll out.
- It is proposed that there are a number of events during the week commencing 28th January, across both sites, culminating in the Quality Summit being held on Friday 1 February 2019.
- The Quality Summit group will meet regularly to complete the planning for the week, to include external partner engagement (CQC, CCGs, Student Quality ambassadors (SQAs from Edge Hill & UCLAN).

Recommendation:

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

The outcomes of the Quality Summit will be reported to the Committees and the Board.

Previously Presented at:

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

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS
Southport and Ormskirk Hospital
NHS Trust

Trust Board 5th December 2018

Quality Summit Proposal

1. Introduction & Background

In order to support Quality Improvement within the Trust it has been suggested that it may be appropriate to hold a Quality Summit. The purpose of the event would be to;

- relaunching of the Trust Quality Improvement Strategy & Plan
- re-establishment of the Quality Priorities,
- formally introduce our quality partners across a broader Trust footprint including AQuA and NHSI, including The Academy of Fabulous NHS Stuff, and Student Quality Ambassadors
- Update on Learning from Deaths process and Quality improvement for Reducing Avoidable Mortality.
- an opportunity for staff to showcase Quality Improvement in their areas;
- support development of a culture of quality improvement, and
- develop a proposal for Quality Awards for best practice and innovation across the Trust – recognising those areas and staff who have improved quality in the last year.

2. Purpose of the Event and Strategic Fit

Given that Vision 2020 has quality improvement as a key deliverable, this event would not only support the formal launch of the quality strategy and priorities, but contribute to the development of a quality improvement culture through showcasing best practice tools, with the presentation of actual case studies, giving recognition to staff who have delivered quality improvements.

It will be an opportunity to discuss the quality priorities and programmes including but not limited to Mortality.

Through the attendance of our quality partners we will raise their profile across the Trust and demonstrate how in adopting their approach we have improved quality while identifying future areas of focus for support, and identify key quality improvement tools to be used across the Trust and ensure the right knowledge is within the organisation

It will also be an opportunity to clearly demonstrate the golden thread of Quality Improvement from Board to Ward, as such we will need to consider the audience invited to

the event to ensure that we have all leaders in attendance but also those staff who are presenting quality improvement schemes and the impact that these have had.

3. Development & Planning

A planning group has been established, the membership of the group includes;

- Associate Medical Director (Patient Safety) - Dr Chris Goddard
- Assistant Director Quality - Jo Simpson;
- Deputy Director of Nursing - Paul Jebb;
- Communications and Marketing Manager - Tony Ellis;
- Head of Education and Training - Tracy Gunn, and
- Head of PMO – Donna Lynch.

This group held its first meeting on Thursday 8th November; it was proposed that the group be used to support the Quality Summit and the AQuA training programme roll out.

4. Proposed Quality Summit

It is proposed that there are a number of events during the week commencing 28th January, across both sites, culminating in the Quality Summit being held on Friday 1 February 2019.

Suggested Programme for the week
Day 1 – AQUA Day/Education and Training Day
Day 2 – Staff Wellbeing & Patient Engagement Day
Day 3 – Department & Lesson Learnt Day – including departments showcasing their work in their own areas including audit, risk, complaints, FTSU
Day 4 – FAB NHS Day (confirmed 31st Jan 2019). Academy of FAB NHS stuff to visit the Trust and walk areas, including event with Execs/Leadership Team.
Day 5 – Showcase Day – launch of QI strategy etc. showcases some of the week – use of films, stands, talks etc.

5. Next Steps

The Quality Summit group will meet regularly to complete the planning for the week, to include external partner engagement (CQC, CCGs, Student Quality ambassadors (SQAs from Edge Hill & UCLAN).

6. Recommendations

The committee is asked to agree the proposal and consider any changes to the proposal.

D V Lynch - Head of PMO

Paul Jebb - Deputy Director of Nursing

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
5 December 2018

Agenda Item	**TB283/18**	**Report Title**	**Monthly Mortality Report**
Executive Lead	Jugnu Mahajan, Interim Medical Director		
Lead Officer	Dr Chris Goddard, Associate Medical Director of Patient Safety Rachel Flood-Jones, Project Delivery Manager Mike Lightfoot, Head of Information		
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
An overview of the new Structured Judgement Review method is given along with the headlines from the External Mortality Review. Learning from Deaths data for Quarter 1 (April to June 2018) is also detailed.

Measuring Mortality

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

Reducing Avoidable Mortality (RAM) Project
Updates are given on activity for each of the six work streams alongside a revised list of milestones and risks.

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)*

There will be revisions to the format and content of the Mortality Report to the January 2019 Trust Board.

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 December 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 and the roll out of the RCP's Structured Judgement Review. Learning from Deaths activity is 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>An overview of the new Structured Judgement Review method is given along with the headlines from the External Mortality Review. Learning from Deaths data for Quarter 1 (April to June 2018) is also detailed.</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. 1 2018/19</td><td>Qtr. 4 2017/18</td><td>June 2018</td><td>June 2018</td><td>September 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>Mortality Dashboard Highlights</td><td>Detail is given to explain the headlines from the Mortality Dashboard looking at activity in September 2018.</td></tr>
<tr><td>5.0</td><td>Reducing Avoidable Mortality Project</td><td>Updates are given on activity for each of the six work streams alongside a revised list of milestones and risks.</td></tr>
<tr><td colspan="3">Appendices</td></tr>
<tr><td></td><td>Appendix 1</td><td>Mortality Dashboard Highlights, September 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 2nd July 2018.

The method currently requires a junior doctor to use the in-house screening tool which will trigger a request for a Structured Judgement Review where required. The RCP recommendation is that screening should trigger between 10-20% of deaths for an in-depth structured judgement review. As you will see from the table below, the percentage triggered for review in the first four months has been on average three times this amount. Adjustment of the screening tool was therefore necessary in order to provide a cohort of mortality from which in-depth review will be instructive for improvement of care without making review un-responsive by overloading the reviewers. The adjustment has been performed based on our experience to date and the trigger rate is now at recommended levels.

The final switch over from paper mortality reviews occurred on 1st October for Planned Care and 1st November for Urgent Care. While there have been a small number of paper reviews received by Clinical Audit in the month of November, we expect these to have stopped by December.

This month the new Structured Judgement Review activity is reported below however the figures reported under 'Learning from Deaths' (and in the Mortality Dashboard Narrative) is based upon the paper mortality reviews from April, May and June. These two sets of data will continue to be reported in tandem in the Quarter Two Learning from Deaths Report (March/April 2019), after which time all reported data will be based solely upon Structured Judgement Review method.

Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review	Trigger based on revised criteria	% Triggering for Review revised criteria
July	77	30	39.0%	18	60%	5	17%
August	66	39	59.1%	26	67%	8	21%
September	73	43	58.9%	33	77%	8	19%
October	58	30	51.7%	20	67%	11	37%

2.2 Learning from Deaths Quarter One 2018/19

Mortality Review Headlines	**April 18**	**May 18**	**June 18**
Total Number of Deaths	74	85	65
Number of Learning Disability Deaths	0	1	1
Number of Mortalities Reviewed	83	59	53
Percentage of Mortalities Reviewed [1]	112.%	69%	80%
Outcomes of Mortality Review	**April 18**	**May 18**	**June 18**
1) Not preventable death due to terminal illness or condition upon arrival at hospital	23	22	27
2) Not preventable death and occurred despite the health team taking preventative measures	56	37	30
3) Not preventable death BUT medical error of system issue was present	0	0	1
4) Possibly preventable death resulting from medical error or system issue	0	0	1
5) Likely preventable death resulting from medical error or system issue	0	0	0

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.

2.3 External Mortality Review

The External Mortality Review (July 2018) was presented to the Board on 7th November by authors Tracey Sparkes and Dr Jean McLeod. Dr Chris Goddard from the Trust presented the Trust's draft Action Plan in response to recommendations. The Action Plan gave assurance that activity through existing project work (through the Reducing Avoidable Mortality Project and the Patient Flow Improvement Programme) activity was already underway to resolve the issues identified.

Appraisals of the Report and draft Action Plan were also given to groups of senior nursing, clinical and corporate staff on the day from which feedback was taken. Consultation to further develop the Action Plan is to be organised with Nursing while a best practice scoping session with the Specialist Palliative Care Team will be held at Queenscourt Hospice on 7th December 2018.

[1] 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.

The areas identified for improvement were:

1. Improve Patient Flow:
    a. Alternative to admission
    b. Criteria Led Discharge
    c. Proactive escalation planning
    d. Multi-speciality team working
2. Improve Awareness of Sepsis
3. Review or establish Pneumonia Pathway.
4. Ensure that antibiotic guidelines meet current national guidance.
5. Review doctors' rotas to ensure sufficient daily senior cover so that junior doctors are supported and are not working beyond their capabilities.
6. Review standards of documentation to ensure that staff always sign and date their entries and that handover of care is clearly documented including detailing the responsible consultant.
7. Review nursing and AHP documentation to ensure that it is fit for purpose in focusing and promoting essential care, particularly fluid balance and nutritional needs.
8. Ensure prescribing is legible, clearly signed and in line with national guidelines.
9. Review escalation and ceilings of care policies to include timely access to to critical care and a shared understanding of Early Warning Scores and when to escalate care levels.
10. Review the End of Life Policy to ensure that doctors of appropriate seniority complete DNACPRs / have end of life discussions with patients and their families where relevant.
11. Ensure that individual end of life care plans are commenced promptly and are well documented including the preferred place of care.
12. Ensure the development of a more robust mortality review process with centralised reporting and an emphasis on the dissemination of learning from deaths across all specialties with involvement from medical, nursing and allied healthcare professionals.

The strategy for the communication of the outcome of the External Mortality Review is to be confirmed by the Executive Team, after which time further activity will be undertaken in tandem with the continued roll out of the finalised Action Plan.

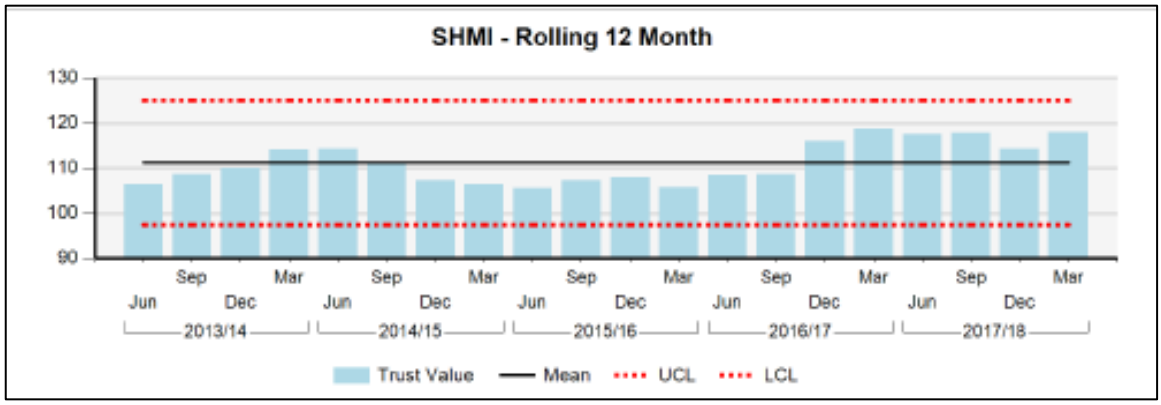
3 Measuring Mortality

3.1 SHMI & HSMR

3.1.1 Summary Hospital-level Mortality Indicator (SHMI)

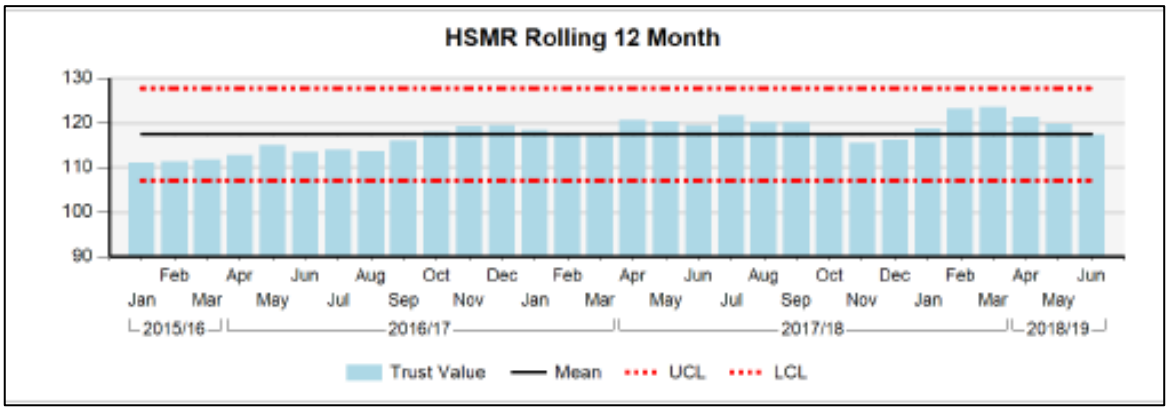
The SHMI ratio for Quarter Four is 118. This represents a rise on the previous quarter; however, when compared against the same time period in the previous year, the SHMI is marginally lower despite an increase in patient acuity and an increase in patient numbers. Therefore this is an improvement in performance. Changes in performance will be reflected in SHMI gradually due to its method of construction.

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)		Qtr. 4 2017/18 (12 month rolling up to 31st March 2018)	
SHMI	**No. of Deaths**	**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	118	1381 deaths over an expected figure of 1170



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 June was 117.2 while the in-month HSMR was 92.9. HSMR is constructed using a 'basket' of diagnosis codes and deaths of patients receiving palliative care are excluded. In recent months, the coding department have increased their accuracy of coding palliative care input and clinical awareness of good end of life care is rising. Coding reviews performed by a nurse specialist ae identifying co-morbidity which has been missed previously. Therefore one aspect driving the improving performance will be better identification of the complexity of our patients and the care they receive at the end of life.

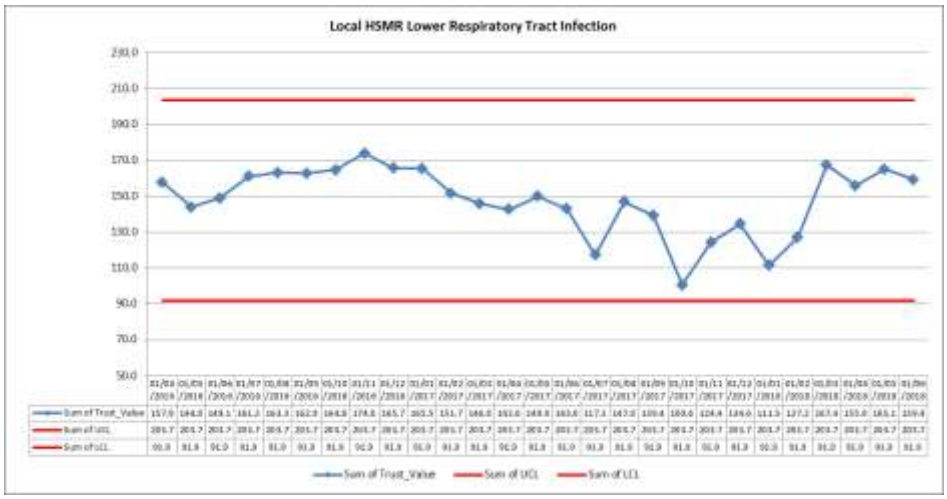


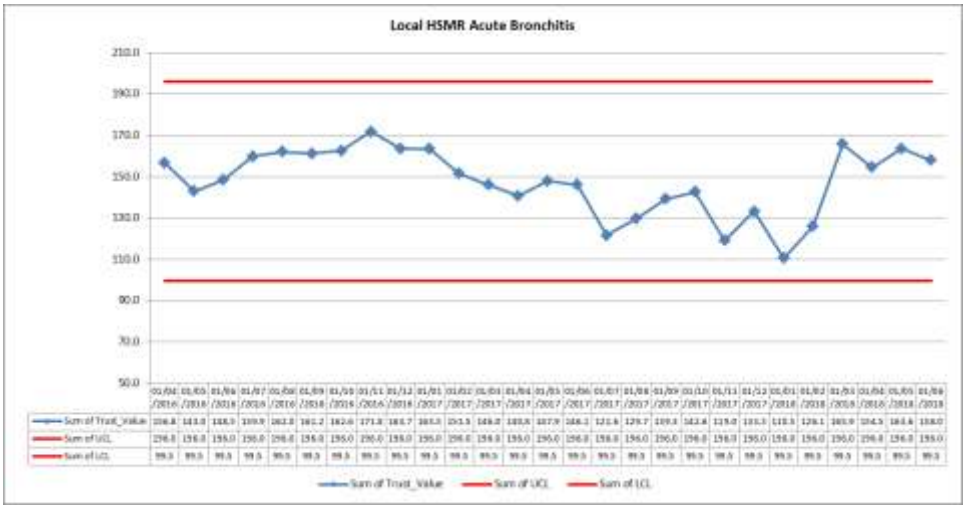
3.2 Disease-Specific Mortality – June 2018

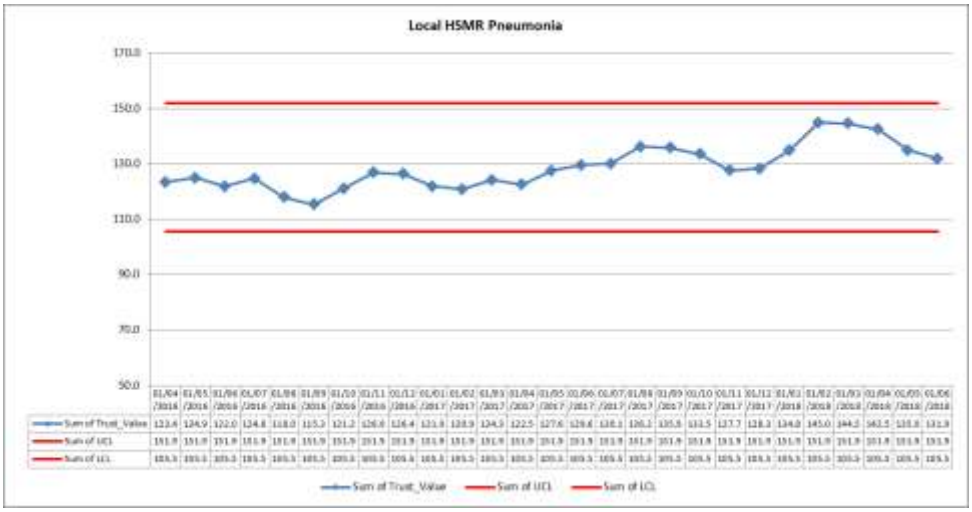
3.2.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

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

- Lower Respiratory Tract Infection (LRTI) 159.4
- Acute Bronchitis 158
- Pneumonia

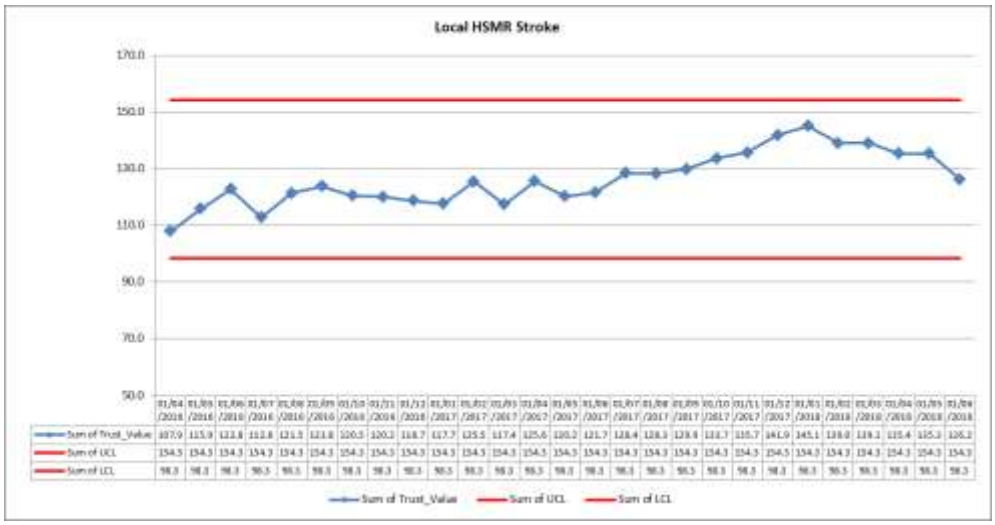






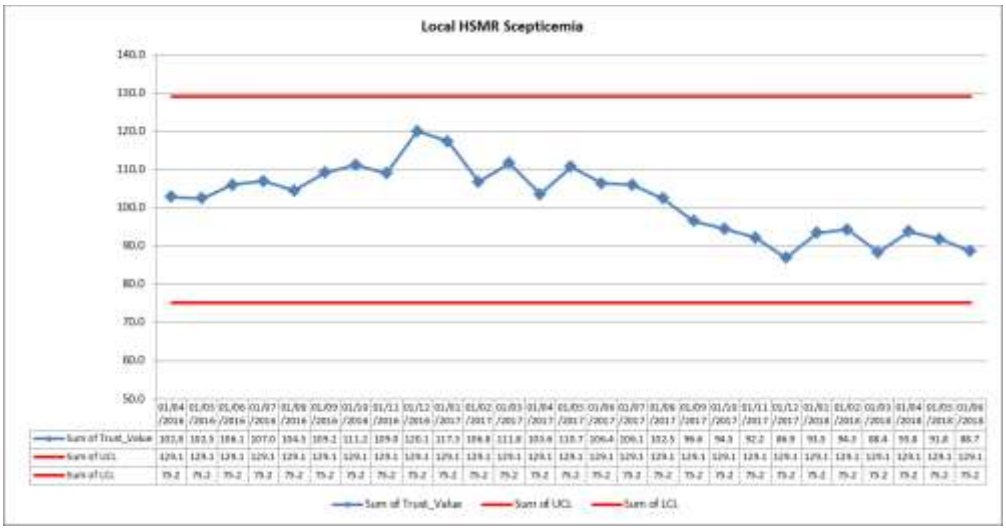
3.2.2 Stroke

The rolling 12 month SMR for Stroke for June was 126.2



3.2.3 Septicemia (Except in Labour)

The rolling 12 month SMR for septicemia for June 2018 was 88.7



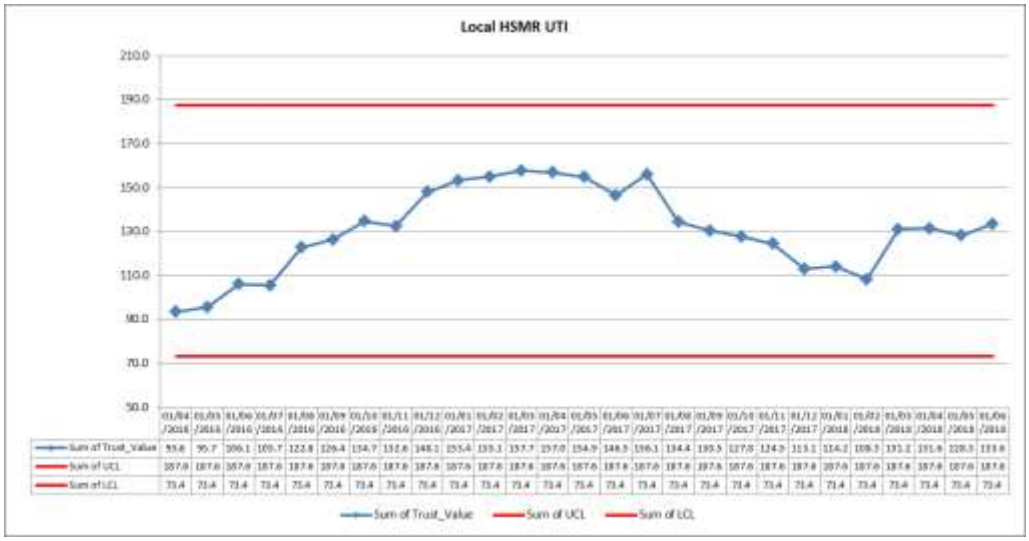
Sepsis has been a focus area for the trust for some time. The improved processes of care introduced over the past year are showing region leading figures for antibiotic administration in sepsis and pathway initiation. Further work is needed to understand and remove barriers to blood culture acquisition and senior assessment within the 2 hour timescale.

Process compliance for AKI and pneumonia care requires improvement. The recently launched AKI pathway is yet to be embedded; the pneumonia pathway has been re-submitted to CEC after revision in the light of comments received. The success of both of these pathways will be monitored by the ongoing AQ programmes.

SepsisNEWS		SEPSIS-11	SEPSIS-12	SEPSIS-13	SEPSIS-14	SEPSIS-15	SEPSIS-16	SEPSIS-17	CPS	ACS
	Target	National early warning score (NEWs) recorded within 1 hour of hospital arrival	Blood cultures taken within 1 hour of sepsis diagnosis	Antibiotics administered within 1 hour of sepsis diagnosis	Serum lactate taken within 1 hour of sepsis diagnosis	IV fluids commenced within 1 hour of sepsis diagnosis	Senior review within 2 hours of sepsis diagnosis	Care pathway commenced following sepsis diagnosis	COMPOSITE PROCESS SCORE	APPROPRIATE CARE SCORE
East Cheshire	75.0%	61.9%	77.8%	68.4%	84.2%	58.3%	52.6%	84.2%	67.6%	28.6%
Lancs Teaching	75.0%	85.5%	66.4%	55.7%	73.7%	70.1%	33.8%	20.5%	64.6%	29.6%
Royal Liverpool	75.0%	100.0%	76.6%	61.7%	80.9%	74.1%	73.4%	72.0%	78.4%	55.4%
Southport	75.0%	94.7%	58.0%	77.5%	82.0%	77.8%	35.6%	87.8%	70.6%	20.0%
Pennine Acute	75.0%	87.4%	63.6%	77.0%	82.1%	80.8%	50.0%	55.3%	74.6%	49.6%
All North West		88.5%	66.3%	66.1%	78.8%	75.5%	45.2%	50.1%	70.6%	38.5%

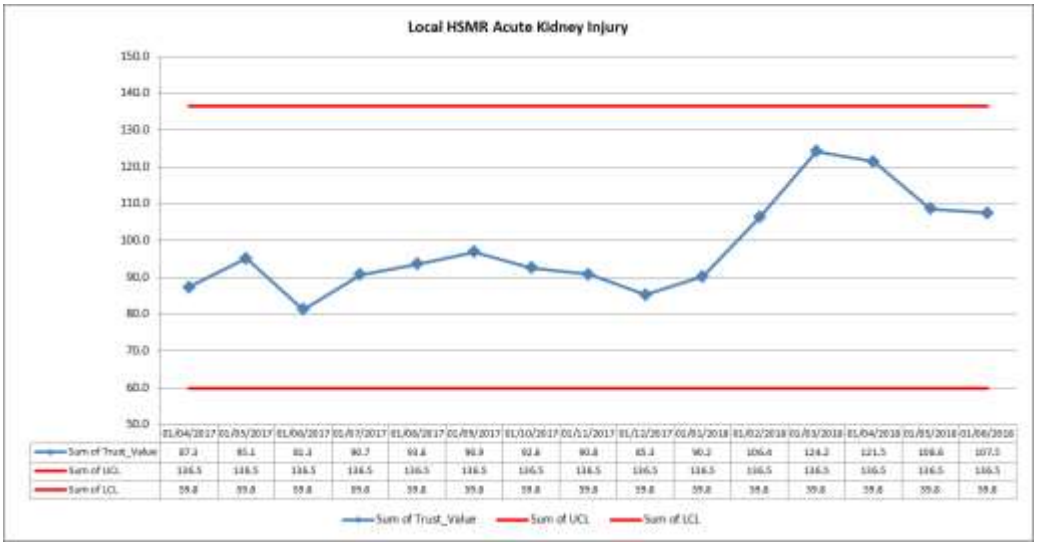
3.2.4 Urinary Tract Infection

The rolling 12 month SMR for Urinary Tract Infection for June 2018 was 133.6



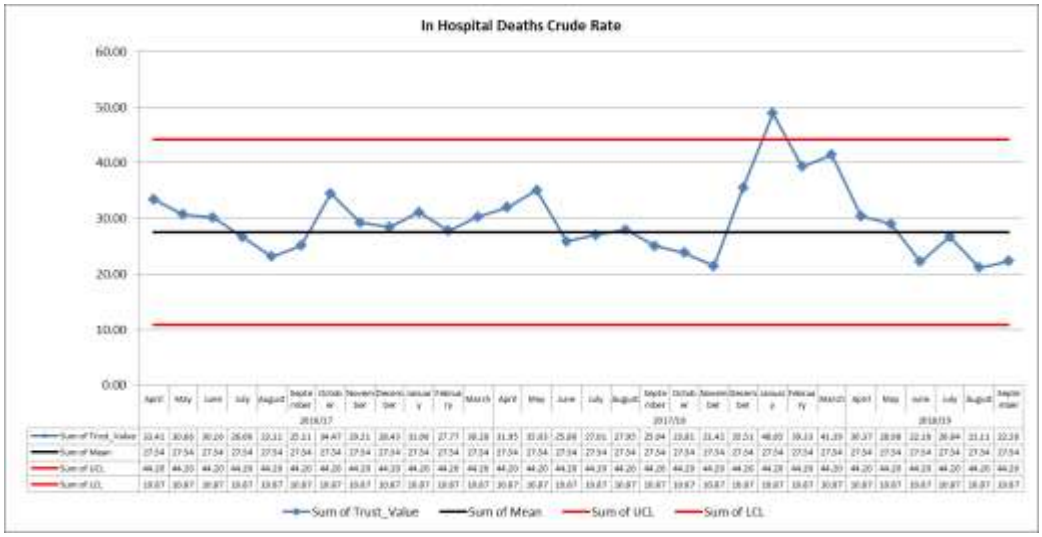
3.2.5 Acute Kidney Injury

The 12 month rolling SMR in June 2018 for AKI was 107.5



3.3 Crude Mortality:

The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for September was 22.26 which was attributable to a total of 72 deaths.

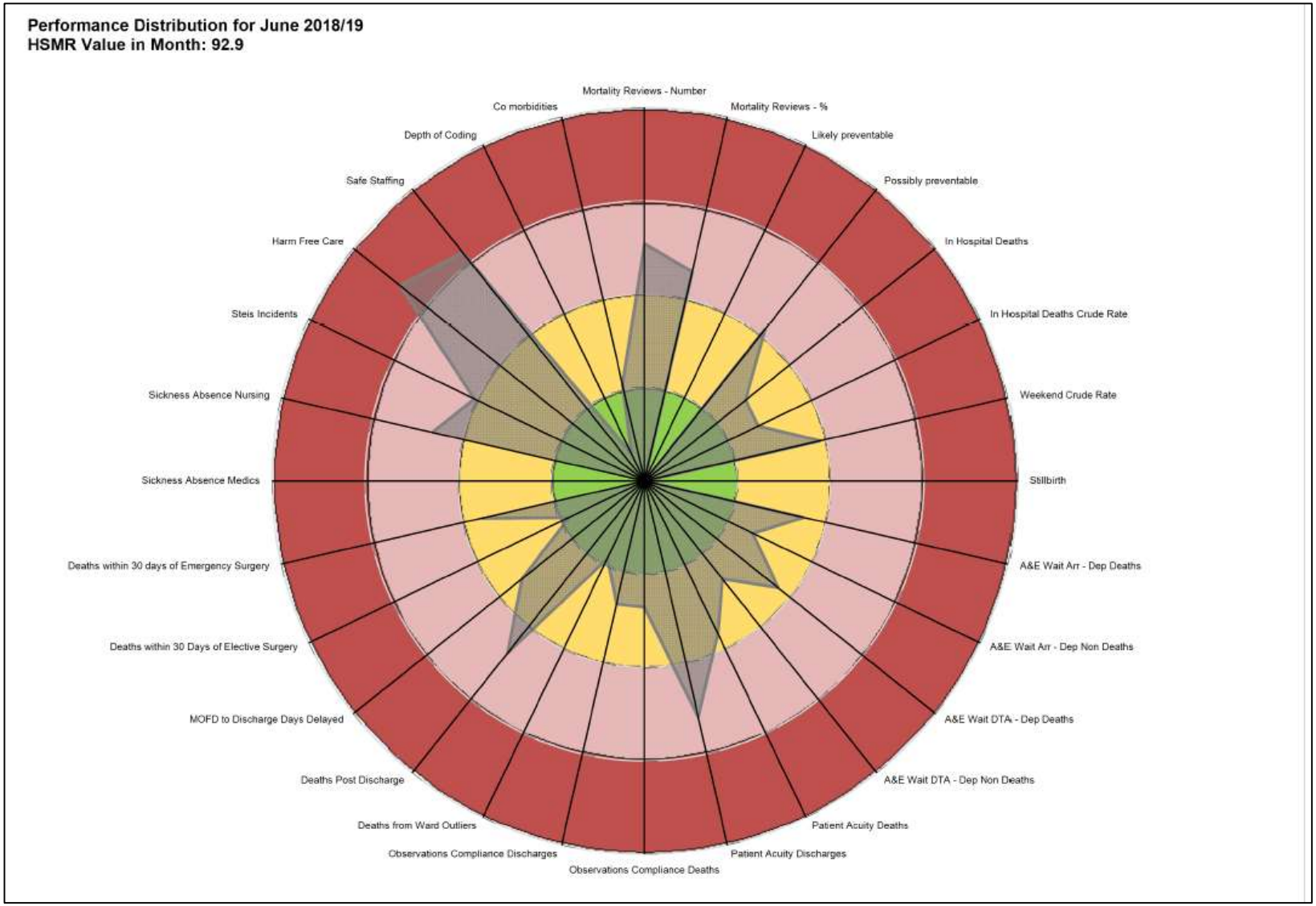


3.4 Performance Distribution – June 2018

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 June are Harm-free care and safe staffing. Safe staffing is a regular concern which is escalated and has been a contentious issue. The Mortality Operational Group wish to understand the principles underpinning this figure in more depth and will be examining this in future meetings. Harm free care deteriorated in June 2018, although the most recent figures for September 2018 show a return to 99.2% harm free care. Deaths within 30 days of discharge and nursing sickness absence remain important areas of work.

Processes to evaluate deaths within 30 days of discharge are being developed.

Performance Distribution for June 2018



4.0 Mortality Dashboard Highlights – September 2018

4.1 To date the SJR process has classified 16 unavoidable deaths, 1 with slight evidence of avoidability and 2 with a chance of avoidability of less than 50%. Four cases have been referred for second review due to quality of care aspects, none of which have been considered potentially avoidable deaths. Overall quality of care has been considered Excellent (2), Good (5), Adequate (9) and Poor (3). There have been no Very Poor judgements made to date.

4.2 Deaths from ward outliers continues to reduce from the high of 2017 in May 18 to 2 in September 2018. This is attributable to better hospital flow and work around improved senior ownership of outlying patients. This will continue to be monitored as we enter winter.

4.3 Learning Disability Deaths remain low, now SJR has been launched; the process of bringing in LeDeR review data to the Mortality Operational Group can begin.

4.4 Observation compliance remains an area of concern. Performance here remains inadequate and stable. NEWS2 is scheduled to go live in January/February 2019; this presents an opportunity for revision of the observation protocols and a re-launch of track and trigger (observation and escalation) with clear guidance for acceptable and unacceptable deviation. The delivery group for NEWS2 have met; progress will be reported to MOG.

4.5 Deaths after elective and emergency surgery on internal figures remain within acceptable limits and compare well nationally. External agencies have reported concern for fractured neck of femur mortality, which is now being examined by Planned Care. The Trust will be participating in the regional Emergency Laparotomy QI programme run alongside the National Emergency Laparotomy Audit (NELA). In the proposed revision to the MOG discussed at the last meeting, quarterly reports of NELA and the National Hip Fracture Database (NHFD) will be received.

4.6 Deaths of patients admitted for less than on day has increased to 19% of all deaths in the last monthly report. These cases have been identified and will be reviewed to examine the issue further. This will be reported to the December MOG.

4.7 Dr K. Groves (Consultant in Palliative Medicine) has reviewed deaths within 30 days of discharge. 88% were known to palliative care services. Anticipatory Clinical Management Plans and Advanced Care Planning (were used) were effective at allowing patients to achieve their preferred place of care. If not used, patients were re-admitted and died in hospital. This cohort will be monitored and a mechanism devised with community to review a subset of these cases for quality of care.

4.8 In September 2018, patients registered on the gold standard framework spent a total of 215 days in hospital after having being Medically Optimised for Discharge; this continues to be a challenge for the Trust with work being undertaken by the Patient Flow Improvement Board and the Length of Stay Project.

4.9 Palliative care coding appears to have stabilised at round 20-25% of all deaths.

5.0 Reducing Avoidable Mortality Project (RAM) – November 2018

Updates on the six work streams of the RAM project are provided below along with a reviewed list of milestones and risks. From next month, the update on project activity will be briefer with a single BRAG rating against each work stream.

5.2 Reducing Avoidable Mortality Project – Update by Workstream:

Project Highlight Report

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

Project Manager	**Rachel Flood-Jones**
Quality Portfolio Lead	**Donna Lynch**
Project Reports to	Mortality Operational Group & Quality & Safety Committee
Report Date	19th November 2018
Report for	Quality & Safety Committee

Key	
Blue	Activity is complete (100% delivered)
Green	Highly likely to deliver benefits as planned
Amber	Some risk the project will not be delivered on time / will not deliver the benefits
Red	Activity is behind schedule against plan, high risk that the benefits will not be realised

Project Objectives

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	**Comments**		**Status Update**	**Status**	**% Completion**
1. CARE PATHWAYS: To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care and produce evidence to assure quality of delivery, by August 2018.	**Deteriorating Patient Trolleys**		Deteriorating Patient Trolleys have been rolled out on all wards on the Southport site. A Deteriorating Patient box is in place on the Medical Day Unit / there is a Deteriorating Patient cupboard in A&E. Four trolleys are still to be rolled out at Ormskirk. *The trolleys have been updated with shorter checklists, first antibiotics for sepsis, first fluid bags for sepsis, equipment for taking blood samples, pots and cathatar urometres for AKI testing.*	G	70
	Care Pathway Compliance		Compliance levels against required activity for Sepsis, AKI and Pneumonia to be reported in the new mortality reports to the Quality & Safety Committee and the Trust Board in the new year.	A	10
	Pneumonia Pathway		The Pneumonia Pathway has been revised and has been sent for approval for the second time to the Clinical Effectiveness Committee (CEC) Group 21/11/2018. *The aim is for the pathway on the wards in time for December with time required for external printing.*	G	60
	UTI Pathway (New Activity)		The RAM Project Group is to support Andrew Chalmers, Infection Control Lead the work that he has delivered under the UTI collaborative to reduce avoidable UTI and associated cases of deterioration. A further consultation is required to scope the next steps (to look into the use of cathetar care plans, the HOUDINI method & a potential Trust pathway document).	G	10
	AKI		The AQUA biannual AKI Collaborative was held on 8th November. The data for the Trust and best practice is to be fed into the AKI Steering Group. PMO are meeting with Henry Gibson, AKI Lead on 22/11 to discuss the new AKI Steering Group and further supporting activity.	A	5
	External Mortality Review: 'Developing Trust Capacity & Approach to Learning from Deaths'- External Mortality Review'		The External Mortality Review Report; highlights and recommendations were presented to the Trust Board on 7th November alongside a draft Trust Action Plan. Presentations were also given to 1. Senior nursing staff, clinical audit and members of the Coding Team and 2. A small group of consultants from the Trust & Queenscourt Hospice. ***This item will close and be replaced by 'EMR Action Plan'***	B	100
	VitalPac Upgrades (3.5 & 3.6)		Testing has commenced, the third cycle of testing started on 12th November. The initial planned date for go live was November 30th, but this is dependent on six show stopper issues being fixed by then. Version 3.6 will be deployed as like for like (so using NEWS). NEWS2 will be switch on at a later date to be agreed by the Trust. Sepsis will NOT be included, the trust current Sepsis pathway will continue to be used. Work is ongoing towards an A&E go live but is slow due to availability of the department The AKI module is dependent on OCRR being rolled out Trust wide which is currently in progress so far we have Ormskirk Outpatients & Wards and Southport Outpatients live with OCRR. Therefore, due to the resource v3.6 will require AKI is planned in for completion in May 2019.	G	20

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	Comments		Status Update	Status	% Completion
2. EFFECTIVE ESCALATION (IT, Safety Hub & Comms)	**Board Round Design/ IT / Safety Hub Reporting**		Scoping Session to confirm IT requirements for Board Rounds (to inform Safety Hub Reporting) taking place 23/11/18; outputs will be fed into the second 'Effective Escalation - IT/ Comms' Subgroup.	R	60
	Pathways for Escalation		Escalation, Recording Observations and Track and Trigger Policies are all to be developed/revised in line with the roll out of NEWS2 (December 18 /January 19).	G	10
	Policy for the Policy for the Clinical Ownership and Review of Outlying Patients		To be returned to the December Clinical Effectiveness Committee with amendments for final approval. Upload and promotional activity then required.	A	70
	Ensure **optimum use of Careflow / VitalPac** to improve patient safety.		Meetings are being coordinated with Ted Adams, the Safety Hub Team and VitalPAC Team for July and August to discuss opportunities for improvement and maximised used of the system functionality once Board Round functionality is in place.		0
3. LEARNING CULTURE	**Screening Deaths with Structured Judgement Review Method (Embedding phase)**		SJR method compliance dropped slightly in October to 51%, the deadline for the end of paper mortality reviewing was 1st November 2018 which should further drive compliance. Associate Medical Directors gave follow up briefings to junior doctors w/c 12th November. Consideration is being given to the training of nursing staff to undertake the review of nursing documentation, (this links into the feedback from the External Mortality Review).	A	70
	Link Risk and Mortality Data: Formal process for triangulation of SJR method, Serious Incidents and Mortality Data		The triangulation of mortality data, SJR findings and incidents/complaints/ inquests will be operationalised through a revised governance structure. Discussions have started to understand the best way to deliver this requirement through Clinical Business Unit Mortality & Morbidity / Audit Meetings. This is a new solution/approach from that initially discussed at the start of the project. Activity to be expedited from December 2018.	A	10
	Lessons Learned and Learning from Excellence		New approaches are being looked into for effective communication with clinicians and nursing staff. Use of social media platforms Whats App groups being considered alongside research into methods used by other Trusts. To be taken to the next RAM Project Communications Subgroup Meeting in December 2018.	A	10

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	Comments		Status Update	Status	% Completion
4. FUTURE CARE PLANNING: Implement care planning for those patients identified as approaching end of life (GSF) that encourages appropriate levels or intervention and enables communication with the patient and their families by April 2019	**Anticipatory Clinical Management Planning**		Dr Fraser Gordon (Lead Consultant Geriatrician) has created a ACMP model which is in place on the Frail and Elderly Short Stay Unit (FESSU). The next stage of project is to review and implement this though an education session to help others to begin to have similar conversations with patients and their families and develop similar plans. This is to be rolled out across the health economy. Timeframes to be discussed.	A	20
	Advance Care Planning: training and awareness is to rolled out across the Trust.		Training sessions were run by the NW Learning Collaborative Network out of Queenscourt Hospice August to October. On-going activity to be confirmed.	A	70
	Alternatives to admission: to be developed as part of a second stage of project: to involve Clinical Commissioning Group partners.		The Trust's Length of Stay Project has identified 4 workstreams including Alternative to Admission - Project meetings commenced in November - updates will be fed through into the RAM Project. In September it was reported NWAS Community Paramedics are now attending MDT Meetings with the Specialist Palliative Care Team to monitor patients who have Anticipatory Clinical Management Plans or who are on the Gold Standard Frameworkand have been admitted.	G	10
	Rapid End of Life Transfer		Queenscourt Hospice are in dialogue with the NWAS Paramedics to find ways to facilitate ambulance transfers home for those at end of life.	A	70
	Reduce time to discharge for patients Medically Fit for Discharge for patients already on the Gold Standard Framework (GSF) Registered.		Updates on hospital activity to come from the Patient Flow Improvement Board, next meeting 22/11/18.	A	10
5. INFORMATION: Produce one version of reporting on mortality by October 2018 that provides clear and consistent information to inform different groups of leaders and clinicians	**Understand and Communicate Mortality Data:** Mortality Reporting to QSC and Trust Board to be reviewed and updated		SJR Reporting is now being pulled through into the Information Mortality Dashboard and into the Mortality Reports to QSC and the Trust Board. Conversation with Dr Foster regarding the Frailty Algorithm.	B	100
	Increase depth of coding		Work continues to ensure a more thorough review of coding, clinical input to this work is yielding positive results. In the long term, work to establish data sharing arrangements (including intermediate work around solutions) are being sought by the Trust and the CCGs. (Next meeting 18th September). A fuller picture of the patient's medical history and comorbidities will provide the required information for increased depth	A	10
WORKFORCE: Establish the proposed workforce model to deliver agreed clinical outcomes which will include a tangible 24/7 Outreach Team by September 2018	**Establish a 24/7 Outreach Team**		All interviews for new posts will have been completed by the end of November - new starters to be in place by the beginning of March 2019. Delays in the HR process have led to a delay in recruitment.	A	70
	Embed Full Utilisation of Safe Staffing Tools		Improvement work to fully optimise the use of safe staffing tools will recommence once the CCOT 24/7 Team / the Ward Boards and Safety Hub Reporting is in place.	A	30
	Increase Access to & Prioritisation of Skills Training		Strategy to be developed with Training and Development and key stakeholders for access to training to support and inform a strategy to ensure managerial prioritisation and release of staff for training. Discussions to recommence with L&D.	A	10

Reducing Mortality Project - Milestones and Risks

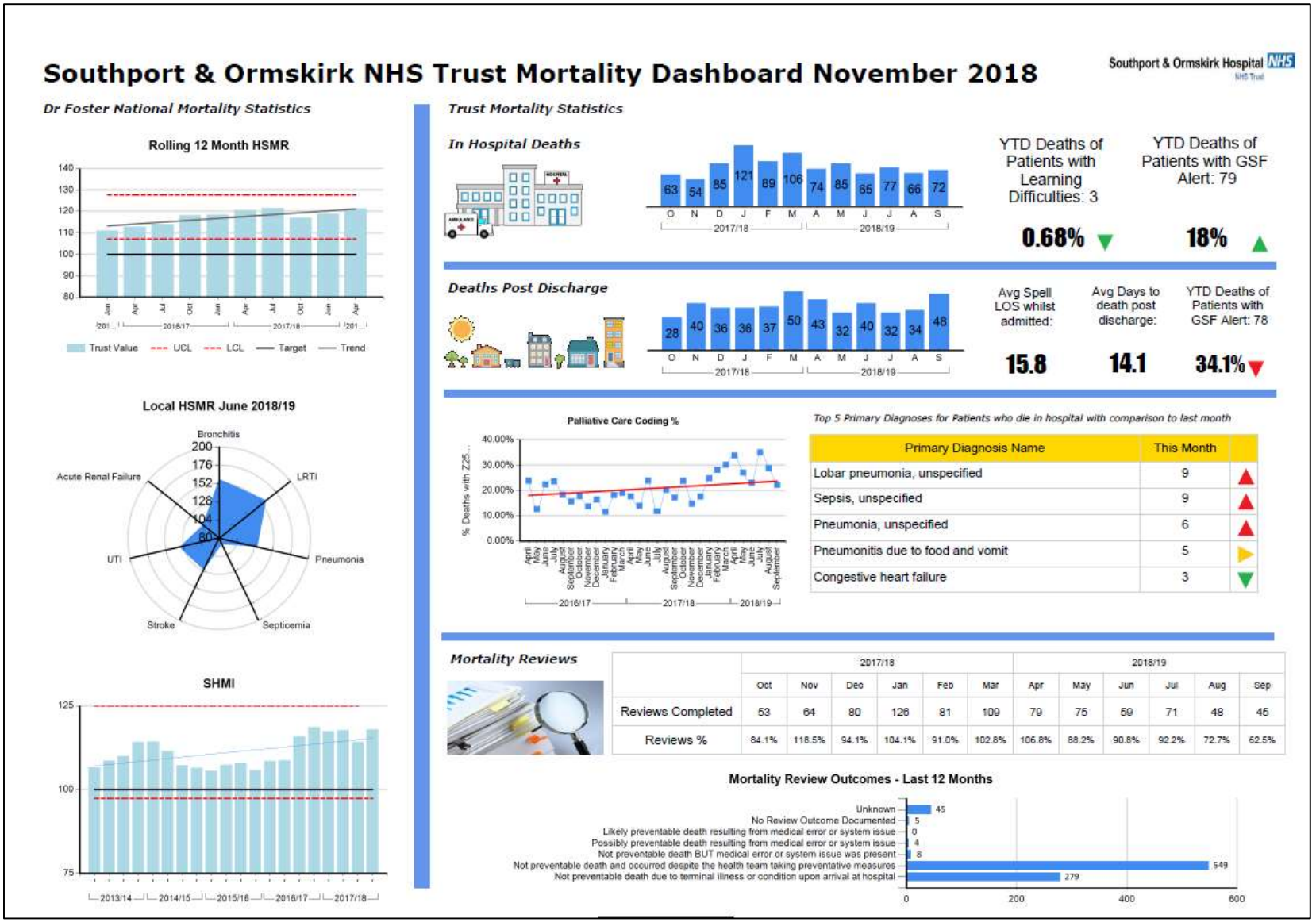
Key Milestones

Key Milestones	Start date	End date	BRAG	Comments
Redesign of Electronic Board Rounds (to populate Safety Hub Reporting Modes)	18/09/2018	31/12/2018	A	Scoping meeting was delayed due to resourcing issues. Revised dates for delivery to be confirmed in meeting 23/11/18
Revision of Patient Escalation, Track & Trigger and Observations Policies	01/12/2018	31/01/2019	G	To support the best practice roll out and implementation of NEWS2
Roll out of NEWS2 (VitalPac V3.6)	30/11/2018	28/02/2019	G	Part of the deployment of VitalPac V3.6
SJR Method - Full adoption	3rd July 2018	31st January 2019	A	Levels of complaince for October 2018 were 51%. The final switch over from paper was completed on 1st November which will support the universal move to the SJR method. Further embedding work is required. (The compliance level for the paper method was around 80%).
Triangulation of Serious Incident, SJR Outputs & Mortality Data	1st June 2018	30th August 2018	R	Preliminary work has begun but the mainstay of activity has been rescheduled to commence December 2018.
Communicating Lessons Learned and Learning from Excellence	1st June 2018	29th September 2018	R	Work has been rescheduled to commence December 2018. Resource issues are impacting the organisation of the Communications subgroup to deliver this.
Relevant workforce trained in: Advanced Clinical Management Planning and Advanced Care Planning discussions with Patients &	1st August 2018	31st March 2019	G	This activity is ongoing, more detail required to confirm the requirement going forward.
Established 24/7 Outreach Team	1st March 2018	30th September 2018	A	Recruitment was delayed by two months; interviews to be completed by the end of November. Additional team to be in place by the beginning of March 2019.

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.	G	Interviews to be completed by end of November 2018.
The release of clinical staff for training (to ensure that 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.	A	This issue requires a more robust mitigation strategy, this is to be escalated to the December Mortality Operational Group. *Training funding is also an issue which is to be addressed in the same forum.*
Resources to organise the Board Ward / Safety Hub and Project Communications subgroups.	A	Some resource has been provided and some additional resource is due late December to support the project, (neither are dedicated admin support).	G	A lack of administrative support is having an impact on the pace and timeframes for delivery and is threatening to delay the end date of the project. The current impact is on the Redesign of Ward Rounds and Communication of Lessons Learned activity.

Appendix 1 – Highlights from the Trust Mortality Dashboard November 2018 reporting on September 2018



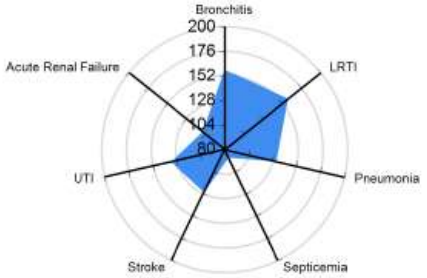
Southport & Ormskirk NHS Trust Mortality Dashboard November 2018

Southport & Ormskirk Hospital NHS

Dr Foster National Mortality Statistics

Rolling 12 Month HSMR

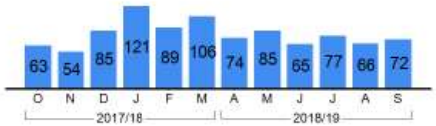
Local HSMR June 2018/19



SHMI

Trust Mortality Statistics

In Hospital Deaths



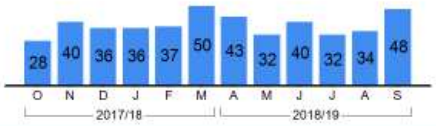
YTD Deaths of Patients with Learning Difficulties: 3

0.68% ▼

YTD Deaths of Patients with GSF Alert: 79

18% ▲

Deaths Post Discharge

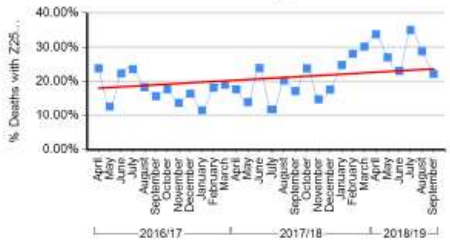


Avg Spell LOS whilst admitted: **15.8**

Avg Days to death post discharge: **14.1**

YTD Deaths of Patients with GSF Alert: 78 — **34.1%** ▼

Palliative Care Coding %



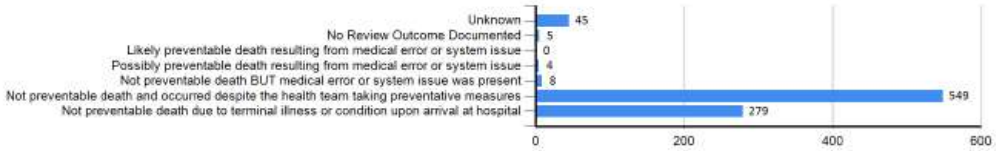
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Lobar pneumonia, unspecified	9	▲
Sepsis, unspecified	9	▲
Pneumonia, unspecified	6	▲
Pneumonitis due to food and vomit	5	▶
Congestive heart failure	3	▼

Mortality Reviews

	2017/18						2018/19					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Reviews Completed	53	64	80	126	81	109	79	75	59	71	48	45
Reviews %	84.1%	118.5%	94.1%	104.1%	91.0%	102.8%	106.8%	88.2%	90.8%	92.2%	72.7%	62.5%

Mortality Review Outcomes - Last 12 Months



NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	**TB284/18**	**Report Title**	**Monthly** Safe Nurse & Midwifery Staffing Report
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Fiona Barnes, Deputy Director of Nursing Carol Fowler, Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ 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 presents the safer staffing position for the month of October 2018.

The Trust Board is advised that the current nurse staffing risk reports as extreme (Major -4 x Likely – 4 RR =16) via the risk register (ID 1862).

For the month of October 2018 the Trust reports safe staffing against the national average (90%) at 93.25%.

Within the report there is an update on the gap analysis undertaken of the Trust compliance with National Institute Care Excellence (NICE, 2014) and National Quality Board (NQB, 2018).

Recommendation:
The Trust 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	☐ 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)*

Executive Leads (Risk Owners) should update their Risks on Datix as assurances and controls are received and ensure timely reports to Committees and the Board

Previously Presented at:

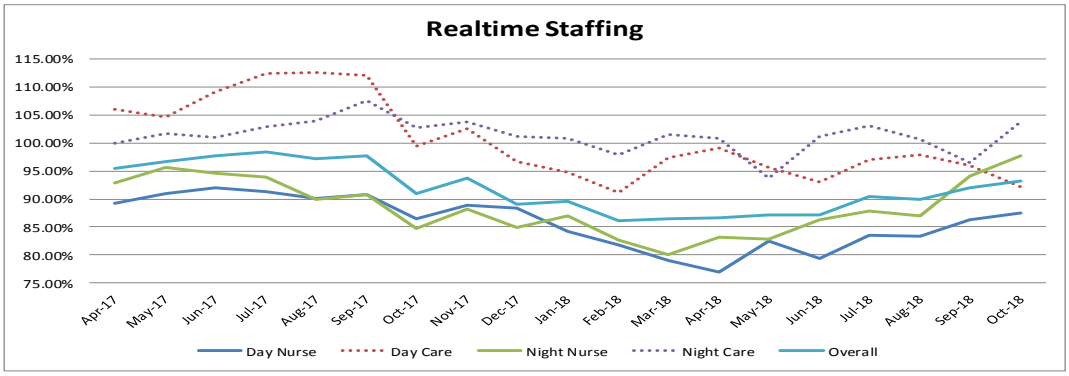
☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	✓ Workforce Committee

1. Introduction

This report provides an overview of the staffing levels in October 2018 and highlights the mitigation put in place to address any gaps in fill rate and addresses the rationale for gaps that have been identified.

Overall fill rate for October 2018 was 93.25% compared to September 2018 that was 91.99%, compared to 89.97% in August (appendix 1).

- 87.51% Registered Nurses on days
- 97.65% Registered Nurses on nights
- 92.11% Care staff on days
- 103.64% Care staff on nights



In line with the national guidance our Care Hours per Patient Day (CHPPD) data has been calculated as part of the 'Safe Staffing' metrics on the Trust monthly return to NHS England and is shared with the Workforce Committee and Trust Board as part of this report (appendix 2). From November 2018 the CHPPD will be divided up by clinical specialty to allow more understanding and scrutiny of the data.

2. October Safe Staffing

Trust whole time equivalent (wte) funded establishment versus contracted:
October 2018 data:

	Funded WTE	Contracted WTE	Oct Total Vacancy
Registered	869.33	774.71	94.62
Non-registered	377.98	343.69	34.29
Total	1247.31	1118.40	128.91

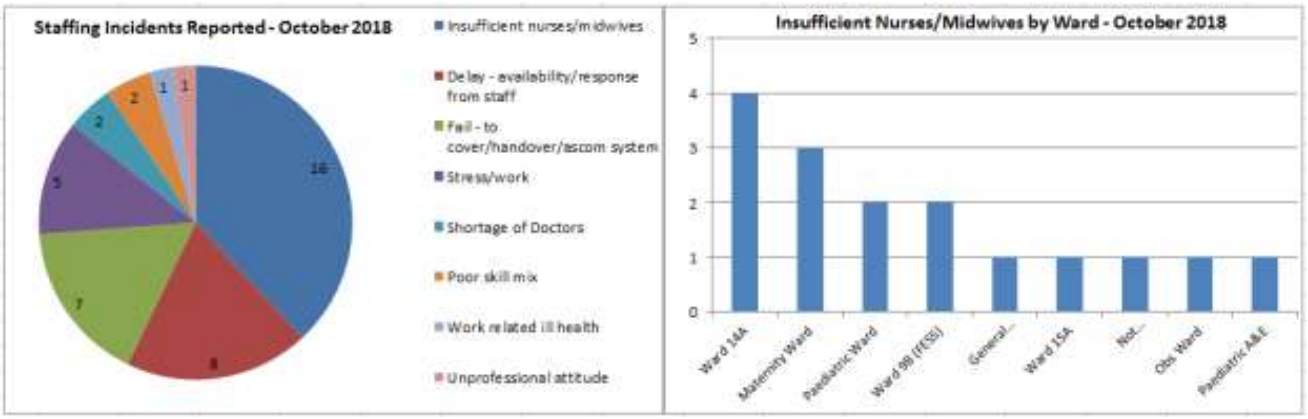
Registered nurse vacancy has reduced in month by 12.59 wte.

The Trust remains engaged with the NHSI Recruitment and Retention pilot focusing its key deliverables over the next 3,6,9,12 months. Further to this the Trust remains engaged at local and overseas recruitment opportunities with presence in October at the HealthSector jobs fair in Dublin leading to 77 contacts to the trust, 3 Registered nurse conditional offers of employment. The Trusts next local recruitment event is 24th November 2018.

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

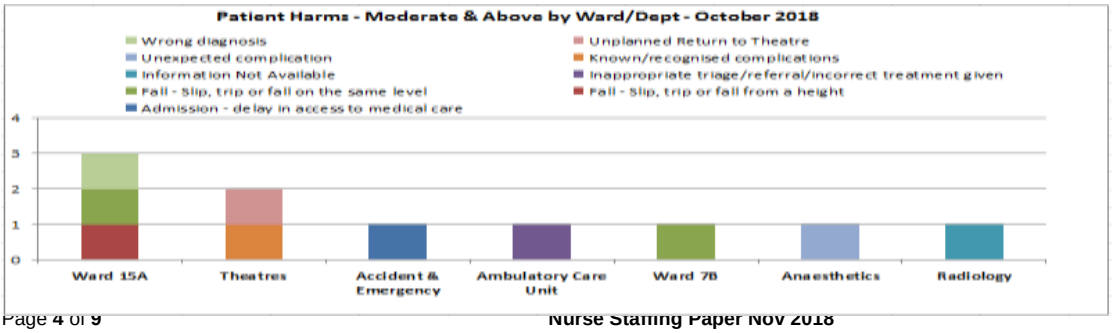
All senior nurses are currently taking action in completing rosters to a fully approved position to 13th January 2019. This provides all staff with a clear roster position over the festive period, clarity on flexible staffing requirements, timely release of these shifts to bank to reduce high cost agency requirements. The roster management exercise further advises on annual leave authorized over the festive to support and assure equity of staff leave during this roster period.

3. Staffing Related Reported Incidents October



42 staffing incidents were reported in October, 2 less than the previous month. 16 of these incidents highlight insufficient nurses/midwives, 6 less than the previous month. Out of the 16 incidents reported there were no patient harms. The highest reported numbers were on Ward 14A with incidents highlighting insufficient nurses to manage the acuity of patients. There were 4 reported incidents related to insufficient staffing on 14A; from these reported incidents no harm was caused to patients due to the staffing posiiton. The Ward Manager and Matron for 14A have developed a comprehesive action plan to address the current vacancies and have ensured that clinical shifts are covered by staff from other wards, NHS Provider (NHSP) bank shifts or Agency shifts. This is monitored on a daily basis at the Safe Staffing Huddle.

4. Inpatients experiencing moderate harm or above in October 2018



10 moderate or above incidents were reported in October, of which 3 were on Ward 15A and 2 were in Theatres.

5.1 Trust compliance with relevant & recent NICE & NQB guidance

A gap analysis of recommendations from the following national guidance has been completed and was shared with Trust Board in early November 2018.

- Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, July 2014)
- Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals (NQB, January 2018)

A combined improvement plan has been developed (appendix 3). The bi-annual nurse staffing establishment review is currently in progress including the first data collection using Safer Nursing Care Tool. The implementation of the 'Red Flag' events will be in December 2018 and will be reported upon in January 2019. This will form part of this report to provide the Workforce Committee and Trust Board with data to correlate with our staffing data.

5.2 Model Hospital Benchmarking

As part of the Establishment Review the Trust will be using the Model Hospital data as a 'benchmark'. Initial interrogation of the Model Hospital data for the Trust shows a number of anomalies.

Currently our CHPPD (Care Hours per Patient Day, see appendix 2 for a definition of CHPPD) is 7.9 which is the same as our 'peer' group and just below the national median of 8.0.

However, our costs per Weighted Activity Unit are greater than our peer group and national median. Our WAU is £951, peer group is £811 and the national median is £718. The anomalies for this reference cost could be related to the data being based on 2016/17 information, which may include the Community services that were part of the organisation at that time and includes our NHSP & agency expenditure. Currently our sickness for nurses, midwifery & CSW are each above our peer group and national median which is contributing (negatively) to the use of NHSP and agency costs.

Over the next month senior members of the PMO & Finance team are attending a 'master-class' on Model Hospital so in the near future the Trust will have a better understanding of the Model Hospital to enable the Trust to proactively address the anomalies and understand our true efficiency opportunities.

6. Recommendations

The Trust Board is asked to note the content presented in this paper.

Carol Fowler
Assistant Director of Nursing – Workforce
Fiona Barnes

Deputy Director of Nursing
Appendix 1:

			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Main 2 Specialties		Registered		Care Staff		Registered		Care Staff									
Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Ward 7A-SDGH	300 - GENERAL MEDICINE		1,443.50	1,854.98	943.50	1,294.60	1,079.00	893.00	713.50	643.00	75.1%	137.2%	82.8%	90.1%	839	2.3	2.1	4.4
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	770.75	770.75	366.00	818.50	718.00	692.00	366.50	342.50	100.0%	114.1%	96.4%	93.5%	254	5.8	3.0	8.8
E A U	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	1,674.25	1,538.00	1,094.17	1,227.17	1,095.00	1,103.50	733.00	771.50	91.9%	113.1%	100.8%	105.3%	569	4.6	3.5	8.2
FESS Ward	300 - GENERAL MEDICINE		1,545.00	1,156.93	1,354.92	1,158.25	1,104.50	945.25	741.00	682.00	74.9%	85.5%	85.6%	92.0%	852	2.5	2.2	4.8
Ward 11B SDGH	300 - GENERAL MEDICINE		1,347.75	1,883.65	1,082.75	1,317.42	1,111.00	804.00	735.00	928.00	76.9%	121.7%	72.2%	126.1%	805	2.3	2.8	5.1
Ward 14B SDGH	300 - GENERAL MEDICINE		1,607.25	1,656.00	1,424.83	1,123.32	1,104.50	1,098.25	737.00	750.75	103.0%	78.8%	99.4%	101.9%	888	3.1	2.1	5.2
Short Stay Unit	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	1,514.75	1,897.75	1,079.75	1,550.25	715.25	986.75	728.00	1,007.50	72.5%	143.6%	138.0%	138.4%	866	2.4	2.9	5.3
ITU/CCU	192 - CRITICAL CARE MEDICINE		4,707.83	4,174.83	1,117.77	1,000.77	4,075.00	2,752.75	1,116.00	890.75	88.7%	89.5%	92.1%	79.8%	253	11.2	7.5	18.8
Ward 15a General Med	300 - GENERAL MEDICINE	410 - RHEUMATOLOGY	1,126.25	1,075.50	755.92	1,030.15	1,090.50	915.75	734.75	1,351.25	95.5%	205.3%	84.0%	183.9%	715	2.8	4.2	7.0
Stroke Ward	300 - GENERAL MEDICINE		1,438.48	1,385.57	959.75	1,116.73	1,101.17	963.17	724.50	672.50	83.8%	116.4%	87.5%	92.8%	576	3.8	3.1	6.9
Rehab & Discharge Lounge	314 - REHABILITATION		989.50	1,198.67	991.58	1,614.23	734.50	686.25	733.50	769.50	121.8%	175.1%	93.4%	104.9%	700	2.7	3.4	6.1
Delivery Suite	501 - OBSTETRICS		1,652.17	1,702.00	408.25	309.58	1,485.50	1,456.50	372.00	325.50	104.5%	75.8%	98.0%	87.5%	48	65.8	13.2	79.0
Maternity Ward	501 - OBSTETRICS		1,130.50	1,188.17	723.50	654.50	746.50	790.50	369.02	623.02	97.3%	90.5%	106.3%	168.8%	275	6.9	4.6	11.5
MAU	501 - OBSTETRICS		1,221.75	1,341.00	354.25	399.75	742.00	719.00	370.50	347.00	109.8%	112.8%	96.9%	93.7%	62	33.2	12.0	45.3
Neonatal Ward - ODGH	420 - PAEDIATRICS		1,038.75	1,027.00	369.00	312.00	1,105.00	1,045.00	180.00	0.00	98.9%	84.6%	94.6%	0.0%	148	14.0	2.1	16.1
Paediatric Unit	420 - PAEDIATRICS		4,165.00	3,816.00	1,109.75	1,187.75	2,228.50	2,084.00	740.00	880.00	88.8%	107.0%	93.5%	91.9%	428	11.3	4.4	17.7
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	1,527.25	1,106.23	1,967.25	1,798.00	743.00	878.50	740.50	1,388.50	83.3%	91.4%	118.2%	187.2%	911	2.2	3.5	5.7
Short Stay Surgical Unit	100 - GENERAL SURGERY		1,812.75	1,367.23	1,772.75	1,146.25	728.25	644.75	370.50	509.00	75.4%	64.7%	88.5%	137.4%	491	4.1	3.4	7.5
Ward H	110 - TRAUMA & ORTHOPAEDICS		742.50	551.50	741.50	476.00	743.50	491.50	369.00	153.00	74.3%	64.2%	66.1%	41.5%	117	8.9	5.4	14.3
Surgical Ward	106 - GENERAL SURGERY		1,325.50	1,139.75	1,110.00	1,049.50	741.50	754.50	741.50	465.50	85.7%	94.5%	101.8%	62.8%	536	3.5	2.8	6.4
Spinal Injuries Unit	400 - NEUROLOGY		1,955.73	1,357.57	1,686.25	1,271.25	2,841.33	2,612.58	1,487.00	1,318.00	84.9%	88.7%	91.9%	88.6%	1320	4.5	3.5	8.0
Ward G	101 - UROLOGY	502 - GYNAECOLOGY	1,659.00	914.00	1,108.50	499.00	1,112.00	728.00	758.50	355.50	49.2%	41.4%	65.5%	48.1%	290	5.7	2.8	8.5

Appendix 2: **Care Hours per patient Day (CHPPD)**

'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (2016)

Lord Carter's report gave clear direction in regards to aspects of staffing across the hospital setting. The report focused on optimising resources and the development of new metrics to analysis staff deployment, to ensure right teams, right place, and right time thus delivering high quality efficient patient care.

Care Hours per patient day
The report details how to eliminate unwarranted variation in nursing & care staff deploys by the use of 'Care Hours per Patient Day (CHPPD) which is to be used as the single metric for nursing/care staffing.

CHPPD can be used to describe both the hours of care required and staff availability in relation to the number of patients.

CHPPD is calculated by adding the hours of registered nurses to the hours of care workers (healthcare assistance/maternity care workers) and dividing the total by every 24 hours of in-patient admission.

$$\text{Care Hours per Patient Day} = \frac{\text{Hours of registered nurse + Hours of care workers}}{\text{Total number of patients}}$$

The figure that is produced gives the number of hours of care that one patient within that ward / department is receiving in 24hour.
For example: If a surgical ward over a month has a CHPPD of 6.5 then this represents that in 24 hours of a patient stay in that ward 6.5 hours of care is given.

It was proposed by Lord Carter that CHPPD would be used at different levels of the organisation from 'ward to board' and will be reported nationally. In 2016 NHS England collated data from over 1000 wards which demonstrated a significant variation in staffing levels of 144%, from 6.3CHPPD to 15.48 CHPPD.

Over the past two years the Model Hospital data has been 'cleansed' and is reported to be more representative of organisations across the country, therefore an appropriate benchmark for Trusts to review their own CHPPD against.

Southport and Ormskirk Hospital NHS Trust

Appendix 3:
Safe Staffing Improvement Plan

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
Development of an Establishment Review – Standard Operating Procedure (SOP)	Ratified SOP through Nursing, Midwifery and Therapies (NMT Group)	DDoN	January 2019	Currently in draft format awaiting outcome of 'Developing workforce safeguards' NHs Improvement October 2018	A
Implementation of the 'Red Flag' system on Data	Red flag summary as part of monthly safer staffing report	DDoN	December 2018	Shared with Matrons & Ward Managers. Datix format to facilitate Red Flag	A
Review & update of the Health roster Policy	Ratified health roster policy available on trust intranet	Assistant director of workforce	January 2019	Draft format	A
Development of the Enhanced Levels of Care guidelines	Ratified SOP through Nursing, Midwifery and Therapies (NMT Group)	Head of safeguarding	February 2019	First meeting to review scope of project completed	A
Development of the Clinical Metrics	Clinical metrix dashboard	DDoN/quality matron	February 2019	Draft clinical metrics formatted	A
Consider ward co-ordinator SOP	Discussion with HoN & Matrons regarding this requirement	DDoN	February 2019	Planned for December Matron meeting	
Professional Learning Communities for Ward Managers– to include training opportunities in regard to budget setting & workforce planning	PLC to be set up in the new year	DDoN	February 2019	Not due to commence until New Year	

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
Update SafeCare module 'criteria' in line with SNCT	SafeCare criteria reflects SNCT	DDoN/ Assistant director of workforce	March 2019	To commence when Nurse Staffing review completed	
Review needs of students and any other 'trainee' posts within the clinical setting	Safe staffing report that reflects the outcome of the establishment review will incorporate dedicated support for students	DDoN	January 2019	This will form part of the Staffing Review and will not commence until December 2018	
To convert the Task & Finish group to a permanent meeting to address Recruitment & Retention. ToR to be ratified by NMB / Workforce Committee.	R&R meeting set up with ToR	DDoN	January 2019	Current T&F group in agreement. ToR to be drafted and shared.	A

RED	Little or No Progress Made
AMBER	Moderate Progress Made
GREEN	Actions Almost Completed
BLUE	Completed

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	TB285/18	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 performance management framework and are discussed with the relevant teams in monthly performance forum meetings.

The report contained the following components:

- Performance Dashboard
- Executive Assurance
- KPI Graphs and Narrative

Please note that in order to streamline the report and exclude the action plans as requested, this has reordered the KPIs in the main report. It has not been possible to ascertain the cause for the Board and will be remedied for the next paper.

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 ✓ 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)*

This is a dynamic document and its structure and content may be updated as necessary.

Previously Presented at:

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

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Integrated Performance Report

Trust Board December 2018

NHS
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Board Report - October 2018

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	0	6	0			
Never Events	0	0	2	0			
VTE Prophylaxis Assessments	95%	96.9%		150			
Harm Free (Safety Thermometer)	94.99%	98.1%	96.9%	7			
Falls - Moderate/Severe/Death	1	3	0	3			
Patient Safety Incidents - Low, Near Miss or No Harm		619	3927	619			
Safe Staffing	90%	93.3%		N/A			
Fractured Neck of Femur	90%	61.3%	71.8%	19			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
SHMI (Summary Hospital-level Mortality Indicator)	100.1	118		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	117.7	117.2	N/A			
WHO Checklist	99.9%	99.9%		0.9986			
Stroke - 90% Stay on Stroke Ward	80%	73.5%	78.7%	9			
Sepsis Screening & Antibiotic Administration	84.99%	94.7%	81.5%	4			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	4	68	4			
Written Complaints	44	17	150	17			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	91.1%		68			

REGULATORY	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
CQC Registration	-						
Monitor Governance Rating	Green	-	-			-	-

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Accident & Emergency - 4 Hour compliance	94.99%	88.4%	91%	1210			
Accident & Emergency - 12+ Hour trolley waits	1	4	11	4			
Ambulance Handovers <=15 Mins	99%	41.5%	41%	846			
Diagnostic waits	1.01%	4.2%		124			
14 day GP referral to Outpatients	93%	95%	94.5%	39			
31 day treatment	96%	97.9%	98.1%	1			
31 day treatment (Surgery)	94%	100%	96%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	68.9%	77.9%	14			
62 day GP referral to treatment	85%	70.9%	80.4%	12.5			
Referral to treatment: on-going	92%	96%	96%	396			
Bed Occupancy - SDGH	93%	98.1%		N/A			
Bed Occupancy - ODGH		29.3%		N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	88.9%	75.8%	1			
Duty of Candour - Evidence of Letter	100%	44.4%	74.2%	5			
I&E surplus or deficit/total revenue	-1%	-18.3%	-19%	N/A			
Liquidity	-23	-42	-42	N/A			
Distance from Control Total	0%	0.3%	-7.9%	N/A			
Capital Service Capacity	-2.423	-2.623	-3.559	N/A			
% Agency Staff (cost)	5.6%	7.1%		N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	24.4%	-5.6%	N/A			
Staff Turnover	0.76%	1%	6.8%	N/A			
Vacancy Rate - Medical		8.1%	12.5%	N/A			
Vacancy Rate - Nursing		10.4%	11.2%	N/A			
Sickness Rate	3.9%	6.3%	5.6%	N/A			
Personal Development Review	85%	71.2%	71.2%	N/A			
Mandatory Training	85%	84.1%	84.1%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.2		N/A			

Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Post MOFD (Medically Optimised for Discharge) - Number of Beds lost per month		25		25.1			
DTOC - Number of Beds lost per month		6		6.13			
Length Of Stay		6.7		N/A			
New:Follow Up	2.64	2.5	2.4	N/A			
DNA (Did Not Attend) rate	8%	6.9%	7.3%	1722			
Cancelled Ops	0.61%	0.1%	0.2%	3			
Theatre Utilisation - SDGH	90%	63.6%	66.4%	N/A			
Theatre Utilisation - ODGH	90%	82%	81.1%	N/A			

Reporting Frequency is monthly except for SHMI which is quarterly.

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Executive Assurance

Executive's Assessment Of Overall Position	Executive: Chief Executive/Company Secretary	GREEN

Overview

Vision 2020

To develop the Trust's leadership capacity and capability and approach to Governance and Quality Improvement to become 'Good' (Well Led) by 2020

Delivery of the Well Led Review as part of the Secretary of State for Health & Social Care priorities is on track.

Significant developments include substantive appointment to executive and non-executive roles.

Assured/Most Improved

Board Leadership & Development and Fitness to Govern
The Board Development Plan was agreed by the November Trust Board. There is a schedule of masterclasses up to May 2019
The annual board self-assessment and board observation has been undertaken.

Well Led Self-Assessment and Action Plan
The CQC Action Plan is reported to the Quality and Safety Committee and Trust Board
The Performance Management Framework is drafted and will go to the next Hospital Management Board. This is being developed further to include an accountability framework
The internal Hospital Improvement Board held its first meeting in November.

Board Governance
A quarterly review of board assurance has taken place
Corporate Risk Registers are reviewed monthly at the board and assurance committees

Governance Framework
The following boards have been established with terms of reference and programme:
Hospital Management Board
Performance Review Boards for Clinical Business Units.
The Programme Management Office (PMO) is now established and resourced.

Integrated Reporting
The format for the Integrated Trust Board Report is agreed. The format continues through the three committees for Finance, Performance and Investment, Quality and Safety and in January for Workforce. The same format has been adopted for Hospital Management Board, Hospital Improvement Board and the Southport and Ormskirk Improvement Board. Next steps will incorporate this reporting into the Performance Review Boards.
KPIs relevant to each Board/Committee have been agreed by the relevant executive and non-executive board members

Not Assured/Most Deteriorated

Executive's Assessment Of Overall Position	Executive: Director of Nursing, Midwifery & Therapies	AMBER

Overview

Vision 2020

2. To develop and implement a Quality & Safety plan which will address CQC 'inadequate rating' by the next 'Well Led' Inspection (est. March 2019) and establish an improvement trajectory for exiting CP status for Quality and a Good rating in core services

Please refer to details included in Quality Improvement Action Plan paper.

Performance in Harm Free Care, VTE, sepsis screening, Care Hours Per Patient Day and Harm Free Care is positive.

The number of complaints received continues to reduce although the response time to complainants still exceeds the 40 day target in a number of cases

Assured/Most Improved

Low and no harm incident reporting is increasing and bringing us more in line with peers.
Duty of Candour reporting is improved. Not all incidents had the apology within the correct timescale, however processes have been reviewed to continue to improve compliance.
Safe staffing levels have remained above 90%, however registered nurse levels are below 90%

Not Assured/Most Deteriorated

Three category three pressure ulcers have been reported however two will be classified as present on admission, the other is undergoing an investigation at present.
Delivering single sex accommodation breaches are improving, this was due to improving occupancy rates within the Southport site, however this is likely to come under further pressure during the winter period.

Patient falls still remains a concern. An action plan for improvement is being developed, drawing upon best practice both regionally and nationally.

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Executive's Assessment Of Overall Position	Executive: Dr Jugnu Mahajan	AMBER

Overview

Vision 2020
To develop and implement a Quality & Safety plan which will address CQC 'inadequate rating' by the next 'Well Led' Inspection (est. March 2019) and establish an improvement trajectory for exiting CP status for Quality and a Good rating in core services

Meet or exceed the national standards for patient mortality.

SHMI & HSMR: Trust is actively working to reduce both HSMR and SHMI values to bring them within acceptable parameters by 2020.Clincal pathways to improve quality of care are being developed and rolled out. Structured Judgement reviews methodology for Learning from deaths is now being used and compliance is improving.. Work streams under Reducing Avoidable Mortality project are being progressed.
Improvements have been made in Sepsis management with reduction in Sepsis related deaths.
Pneumonia pathway has been approved by the Clinical Effectiveness Committee and will be rolled out in December.
Acute Kidney Injury pathway is being led by the AKI steering group.
Crude mortality rate is showing a downward trend
Interviews are being held for recruitment to the Critical care outreach team.

Assured/Most Improved

High SHMI and HSMR remains a risk for the trust. Action plans are in place to improve care and reduce SHMI & HSMR . The actions are being monitored at the board level via the Quality Safety Committee and monthly Reducing Avoidable Mortality report to the board.
A full report on Mortality is presented to the board monthly by the Medical Director

Not Assured/Most Deteriorated

External Mortality review was presented to the board on 7th November 2018.
Action plan is being developed to address areas of improvement.

Executive's Assessment Of Overall Position	Executive: Chief Operating Officer	AMBER

Overview

4 Hour Performance: The Trust failed to meet its performance trajectory in October by 2.4%.performing at 88.4%. It was however 2.9% better than October last year which demonstrates a good improvement. For October the Trust was ranked 25th out of 44 for the North region and 69th out of 135 for the nation. The Trust anticipates delivery of the trajectory set for November (88.9%). ED attendances remain significantly higher than the average and above the first control limit.

Winter planning: The Trust continues to progress the internal winter plan schemes with a prime focus in reducing Length of Stay. The Trust has identified 10 high impact actions that will support the delivery that are drawn from national best practice. Each high impact action has individual clinical and managerial leads identified and has established delivery plans with milestones and KPIs set out. Additional finances required for delivery of schemes has been outlined in individual business cases which have been approved and signed off via the Hospital Management Board and in line with financial governance arrangements. Capacity and demand modelling work was delivered by Ernst Young (EY) in June 2018 for Winter 2018/19. The work demonstrated that the Southport & Ormskirk (S&O) health and care system would have a gap of 36 beds in winter 2018-19 (November – February).

1) Workforce: Workforce is currently a significant issue within the Trust with high volume across medical and trained nursing professional groups. The majority of these vacancies being in the urgent care CBU, and is highlighted within the Trust risk register.
2) Whole system engagement: The Trust has requested a whole system approach to support the bed capacity deficit (36 beds) through additional step-down and transitional care beds (agreement in summer 2018). The commissioners (CCG) have however opted for alternative winter initiatives (confirmed in October 18) which currently have not been quantified in terms of impact. The Trust has raised concerns to system regulators regarding the overall bed capacity deficit and the potential risks associated in patient safety and experience. Discussions remain on-going for a whole system resolution and based on whole system schemes to date the likely bed gap going into winter is between 10 – 15 beds (from the original 36) as determined by NHS England. The CCGs have confirmed that "spot purchasing" beds at times of escalation will be the mitigation to bridge the 10 – 15 bed gap. The Trust has formally highlighted concerns in this strategy as high risk.

Assured/Most Improved

18 week RTT: The Trust is performing against the ongoing RTT target of 92%. Our main areas of concerns are:

- Community pediatrics: Additional funding for clinicians has been sought from the West Lancs CCG to address the current issues within this service however sustaining performance remains a challenge.
- Oral Surgery: The Consultant element is provided by Aintree via an SLA. The Trust has been working with Aintree to provide additional Registrar support to help clear the current day case backlog which in turn would assist with our RTT position. The additional core activity should start in November 2018.
- Ophthalmology: The service has been affected by the staffing issues in theatre and we have lost 13 theatre lists since July 2018. A substantive part-time Consultant and a Locum Consultant leave on 31st December 2018 and we are currently advertising for a replacement. We are currently in discussion with outside providers to help with our FU backlog and Cataracts as the service remains high-risk in regards to RTT performance delivery.

Ambulance turnaround: The ED reconfiguration has introduced 4 dedicated assessment cubicles in ED for ambulance patients, in addition to the extension and relocation of triage. The improvement has enabled crews to hand over patients timely in an appropriate area whilst improving privacy and dignity. The Trust performance will be monitored to measure impact and ensure operating models are effective however the early signs are encouraging with an overall reduction in the average ambulance turnaround time to 34 minutes. This is the best performance for a week the Trust has delivered for the last 2 years for ambulance turnaround.

Length of Stay: The average length of stay for emergency admissions for September and October improved against previous months and reflects best performance for any September and October across the last 4 years. The key interventions being undertaken to reduce average Length of Stay and improve patient flow are through the following initiatives (which feature as key areas in the winterplan):

- Enhanced and extended working across assessment unit functions
- Roll out the application of Red and Green bed days across every inpatient area ensuring MDT board rounds are action orientated. The Trust has now appointed a full-time clinical lead to oversee the delivery and also introduced Executive and Senior Leader allocations for every ward to support the roll-out programme. The COO and DoN meet with the project team on a weekly basis to review progress and confirm next steps.
- The establishment of a weekly 'system-wide' long LoS review huddle aimed at system partners attending inpatient wards to help inpatient MDTs reduce stranded patients and agree clear actions. This will lead to the Chief Operating Officer having a weekly position of the top 10 long LoS patients with clear actions agreed from each part of the system.

Not Assured/Most Deteriorated

Mental Health: Across October the Trust has experienced a number of 12 hour breaches attributed to mental health pathways (due to waiting admission to a mental health bed). The Trust has requested an ECIST review of the mental health pathways across Southport & Ormskirk which took place in early November. The review will include Mersey Care and Lancashire as well as CCG colleague – we are waiting for the results from the review to inform the required improvement plan. The lack of access to mental health beds remains high risk for the Trust from a quality, safety and performance perspective.

Diagnostic waits (Endoscopy): The current Endoscopy improvement is not formally recorded and concerns have been raised by the Chief Operating Officer on accountability and visibility. This will be addressed through the "Theatre & Endoscopy Improvement Programme" led by a dedicated Programme Director (Jenny Farley) and supported by the PMO. A project plan has been developed (October 2019) which covers 8 high impact actions (derived from a number of recommendations from external visits from nationally acclaimed experts). The trajectory for improvement is being developed however the overall aim should be to offer patients the 3-week Reasonable Notice Rule whilst trying to maintain the 14 day Target.

Executive's Assessment of overall position	Executive: Director of Finance	AMBER

Overview

Vision 2020

Ensure delivery of 2018/19 plan and support development of more sustainable position in 2019/20.
Reduce the monthly deficit down from Month 4 year to date levels Financial Plan

Month 7 financial performance was worse than plan although income was much improved. Expenditure levels have risen marginally as expected due to pay awards and the impact of agreed business cases. There are a number of risks that will impact on whether the Trust will deliver the planned deficit of £28.8M as follows:

- Delivery of £7.5million CIP is at risk although additional schemes are continually being identified.
- The Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) tariffs proposed in the draft independent report will need to be paid in full by CCG's; CCG's have agreed to pay for ACU but not CDU. The total value of ACU/CDU income is expected to be £2 million minimum. The CDU element at risk could be as high as £1.4 million.
- Commissioners will apply sanctions as the Trust could not sign up to its control total; the value of sanctions that could be applied for the first seven month's performance is £1.4 million.
- Pressures from vacancies, sickness, rota gaps and the implication of "safe staffing" in nursing has resulted in increased agency usage again in October.
- CQUIN underperformance could result in reduced income of up to £500,000 for the full year although recent focus could reduce this to £200,000.

Assured/Most Improved

- Clinical income ahead of plan in month and year to date (YTD); All points of delivery (POD) have exceeded plan in October with the exception of electives where the adverse YTD performance has slowed.
- The Trust continues to receive cash support from DHSC on a monthly basis to support the planned deficit.
- Income for CQUIN schemes forecast to improve following increased focus.

Not Assured/Most Deteriorated

- CIP plan has under-delivered. Although further CIP schemes have been identified the CIP target of £7.5 million has a projected shortfall of £1.5 million at the year end.
- Agency spend has risen over the last five months and is at the highest level (£782,000 in October) in over a year; the year to date agency spend of £4.5 million will result in the Trust breaching the year end agency cap set by NHS Improvement.
- Expenditure run rate needs to reduce for the remainder of the year from the impact of CIP in order to deliver the year end deficit plan.
- CDU tariffs have been challenged by CCG's and are at risk; CCG's also challenging the average unit price charged for non elective activity.
- October's sanctions rose again to previous month's levels due to due performance against the 4 hour A&E standard and ambulance handovers.

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Executive's Assessment of overall position	Executive: Turnaround Director	AMBER

Overview

Vision 2020
Ensure delivery of 18/19 plan and support development of more sustainable position in 19/20.
Reduce the monthly deficit down from Month 4 year to date levels Financial Plan

Assured/Most Improved

Discretionary spend policy is becoming embedded with all requisitions requiring approval by Associate Director of Finance. Further work is required regarding the rollout of full purchase order compliance to provide full assurance.

Introduction of petty cash policy and reduced limits has resulted in a significant reduction in requests and improved assurance regarding compliance with ordering processes.

CIP check and challenge work continues, a number of CIPs have been removed or amended to reflect a more accurate position on deliverability.

People and Activity Group (PAG) is operating successfully with compliance with documentation and communication of intentions significantly improved.

Not Assured/Most Deteriorated

PAG has received a number of retrospective approval requests in month. The causes of non-compliance have been reviewed and corrective action is in place to reinforce the process to all staff and to ensure all are aware of their delegated responsibilities. All retrospective requests and incidences of non-compliance reported weekly to Executive Team.

Executive's Assessment of overall position	Executive: Director of Human Resources and Organisational Development	AMBER

Overview

Vision 2020
To develop and implement a Workforce Strategy and Staff Engagement Strategy which will enable the Trust to deliver Well Led and 2020 objectives

HR continues to provide full support to CBUs and Corporate services to improve their current position regarding sickness, mandatory training, PDR rates etc. This includes HR Essential Skills training.

Whilst there is evidence of improvement in some areas, sickness absence remains a significant concern.

Assured/Most Improved

Personal Development Reviews
PDR rates have increased to 71.17% in October which is very positive. The increase in rates has been continuous for 6 months in a row. However, there is still much work to be done to achieve 85%, and ultimately beyond this target. CBUs and Corporate Services are currently reviewing their compliance trajectories to ensure an ongoing increase which will continue to be challenged at Performance Review meetings. All areas of the Trust are over 82% compliant, with Corporate and Specialist Services over 85% and Planned Care just short of 85% compliance.

Since October 2018 the Trust has provided Quality Appraisal Conversation training to managers and this has been well received with the number of attendees increasing. This will continue to be delivered regularly until March 2019. Along with the new documentation which will be launched in the next few weeks, we should see a continued improvement.

Mandatory Training
Mandatory training rates continue to steadily increase and improve each month. In October the overall Trust rate was 84.14%. Work is ongoing to support managers to ensure rates are monitored and staff encouraged and given the opportunity to undertake mandatory training. In order to ensure there is a continuous focus, especially in terms of content and delivery, Mandatory training will now be discussed on a regular basis at the Risk and Compliance Committee.

Work continues to build the Trust Bank and reduce agency usage. AHP's have been included in TempRE bank resourcing system from September 2018, with plans to grow the number of staff on the bank in this staff group. The People and Activity Group, which meets weekly, ensuring there is an action plan and trajectory to remove all temporary/interim posts across the Trust.

Health and Wellbeing
HR, nursing colleagues and NHSI continue to work together on the Health and Wellbeing pilot Action Plan with the ultimate aim of improving attendance at work. In addition to managing sickness absence and supporting staff to return to work, full attention is also being given to supporting staff to look after their health and wellbeing, both mental and physical. The launch of the Health and Wellbeing campaign "For you, With You" at the end of October was very well attended and feedback positive. Further events are planned for the coming year.

The Flu campaign is well under way with 73% of staff having obtained the vaccination by week 7 of the campaign.

Not Assured/Most Deteriorated
Sickness Absence Sickness absence has increased in October to 6.26%, from 5.42% in September. Prior to this there had been a slight decrease month on month since July. This is one of the main areas of focused support provided to services by HR. This support includes: • Review and challenge of monthly performance data for sickness • Focused input in “hot spot” areas of the Trust with exceptionally high sickness absence levels. • The sickness absence team ensure compliance with return to work interviews, appropriate correspondence and the policy being followed correctly. • Monthly meetings with HR Business Partners and CBUs to scrutinize sickness and its management • Managing sickness absence training is delivered regularly by HR to managers across the Trust. This will continue on an ongoing basis. The new Supporting Attendance Policy has been agreed and ratified for use. Work is now underway to work in partnership with Staff Side Colleagues to introduce the policy and to review current cases, transition plans etc. A focussed action report of sickness absence will be presented to Workforce Committee in January 2019.

Executive's Assessment of overall position	Executive: Director of Strategy	AMBER

Overview

Vision 2020

To develop a strategy for Acute Sustainability that will secure the quality and financial future of local services for the population and its future needs

Assured/Most Improved

CLINICAL SCENARIOS
Draft models developed for Frailty, Urgent and Emergency Care, Elective Care and Women and Children's services
Yorkshire and Humber Senate visit took place 2nd October final report is now with the Trust for fact checking
Workshops to mobilise each of the workstreams for Frailty, Urgent and Emergency Care and a launch event for GIRFT with Professor Briggs have taken place
Women and Children's workshop in November with further scheduled for December. Approval for Community hub received from the Vanguard mobilisation meetings in December.
ESTATES SOLUTIONS
Hot/Cold Site Strategy Group established
Regional Elective Care Centre development programme in development alongside the Elective Care Optimisation programme
Estates development control plan currently being produced and a strategic estates review for the Sefton Health and Care Transformation programme is underway
FINANCE SOLUTIONS
Tariff modelling and risk sharing principles are being tested through the Frailty workstream
Further stress testing around the economic modelling (base case and worst case) underway

Not Assured/Most Deteriorated

Maturity of Out of Hospital solutions to inform acute demand modelling continues to be a concern
National approval process for capital bid approval off target which is likely to put back our timescale for consultation

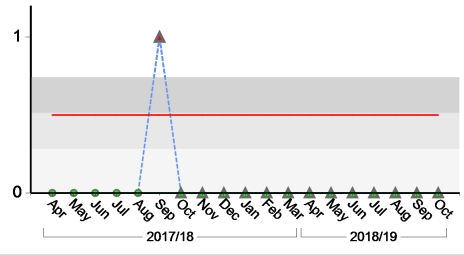
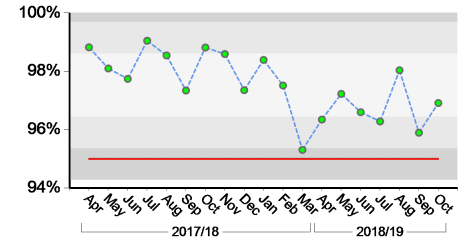
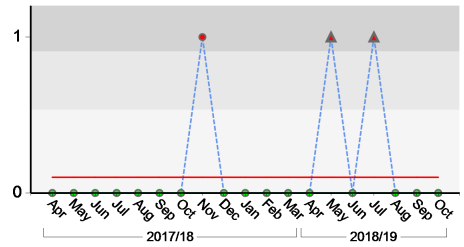
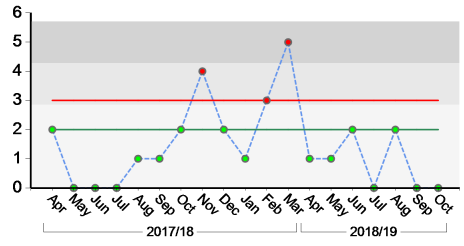
Southport and Ormskirk Hospital
NHS Trust

KPI Graphs and Update

Board Report - October 2018

NHS 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.	There has been zero MRSA bacteraemia since September 2017 - There is continued provision of training/education on the importance of cannula maintenance. Cannulation Stickers are now in cannulation packs for completion and insertion into case notes.	
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	Performance remains above threshold in October and remains compliant -	
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.	There have been three never events in the last 12 months, 2 were in the current YTD, in November, May and July. There were no never events in October. - Never Events and Serious Incidents are reviewed at the Serious Incident Review group (SIRG)	
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year.	There was no hospital acquired C diff in October - This year the target set by NHSI is for the Trust to have no more than 35 hospital acquired C diff infections; the Trust also has an internal stretch target of no more than 20 infections (this is because in 2017/18 our actual cases were 21). The above targets allow for 2.9 cases per month if using the NHSI target or 1.7 if using the stretch target, hence the Trust is under trajectory by either 14 cases (based on NHSI target) or 6 (based on Trust stretch target).	

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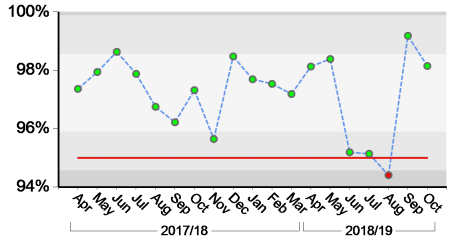
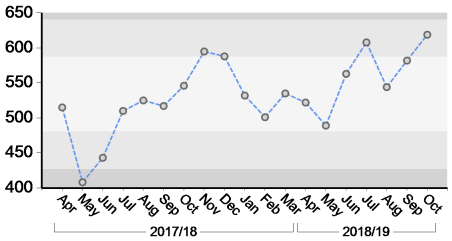
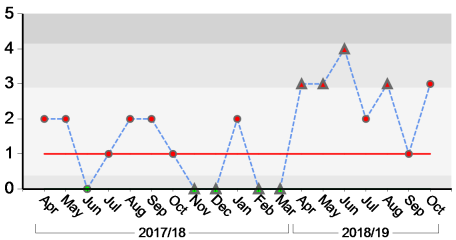
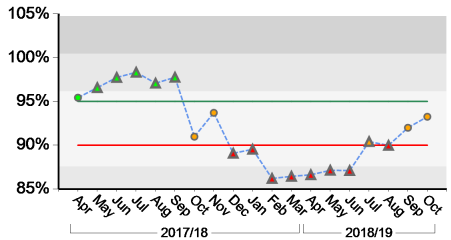
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance compliance continues to exceed the national benchmark - National benchmark of 95% reached for month of October. During the census period of data collection (n=378 the Trust reported 7 new patient harms which were made up of: 1 new HAPU (Grade 2 or above) – 14A (1 x Grade 2) 3 x falls – 2 x moderate harm on 14a and ward 10a plus 1 x low risk on ward 9a 3 x CAUTI – 9a x 1 plus NWRSIC x 2	
Patient Safety Incidents - Low, Near Miss or No Harm	The number of incidents relating to patients where the severity was Low, Near Miss or No Harm caused. A lower number is good.	New KPI for this report - no target set - There were 619 reported incidents in October. This is slightly higher than the normal variation for this indicator, although similar to the previous 3 months, and the highest number reported in the last 12 months.	
Falls - Moderate/Severe/Death	The total number of falls within the Trust were the severity of the harm was either moderate, severe or resulted in death. Threshold:0	Performance remains higher than the Trust target for the 7th month in a row. In October 3 falls were classified as moderate/severe/death - Monthly falls report now will be produced to break down falls per 100 bed days and per CBU this will be circulated trough Q&S and Mortality Review.	
Safe Staffing	The ratio between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts. Threshold: 95%, Fail 90%.	Performance improving against safe staffing through robust daily reviews of fill requirements - Safe staffing reporting shows improvement against the national targets (90%). The Clinical Business Unit (CBU) and corporate nursing and midwifery leads continue with daily safe staffing huddles to monitor, manage and ensure that the nursing and midwifery workforce is safe. The daily morning safe staffing huddle acts as a 'confirm and challenge' forum focusing on ensuring safe staffing levels whilst highlighting roster efficiency. It is recognised the supportive actions require continued collaborative work to monitor flexible workforce requirements and expenditure.	

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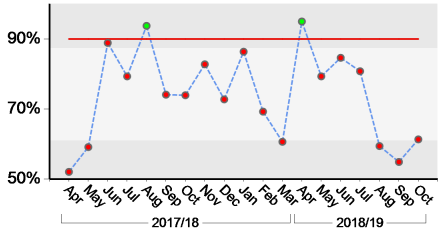
NHS
Southport and Ormskirk Hospital
NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance remains below target for the sixth consecutive month and for the eleventh time in the last year. - pathway redesign is underway as part of the Length of Stay improvements and GIRFT work looking at specialty pathways to enable a strong non-elective pathway.	

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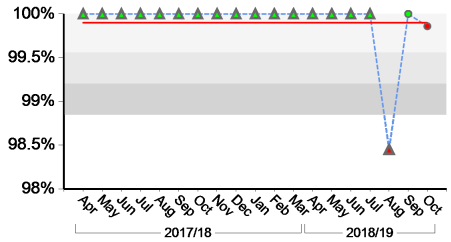
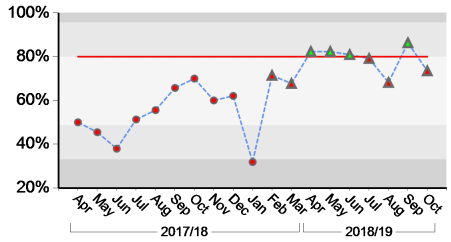
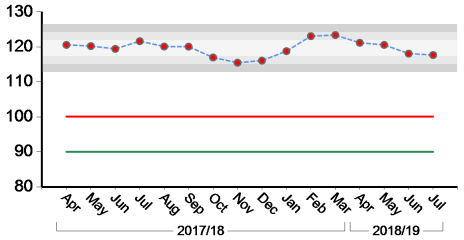
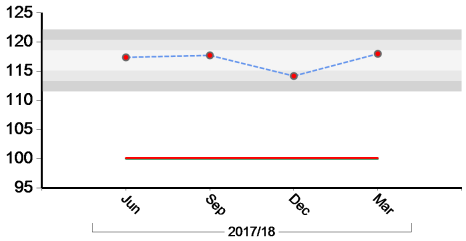
NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
WHO Checklist	WHO Checklist.	WHO Checklist compliance narrowly missed the target in October.There are monthly audits of compliance and data quality. -	
Stroke - 90% Stay on Stroke Ward	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.	Validated data now shows achievement of the 80% stroke target at 86.36% in September 2018 and underperformance of 73.53% in October. October data could be subject to correction. - Stroke data has now been validated and Ward 7B included as a Stroke Ward. YTD performance is as follows: Apr 82.35% 14/17 patients May 82.35% 28/34 patients Jun 80.95% 17/21 patients Jul 79.17% 19/24 patients Aug 68.18% 15/22 patients Sep 86.36% 19/22 patients Oct 73.53% 25/34 patients	
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.	HSMR 12 Month Rolling Total to June 2018 - HSMR is reducing. This is believed to be due to improved coding of palliative care, better recording of patient comorbidity, and potentially improvements in the quality of clinical care.	
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 (rolling 12 months) and is 6 months behind due to when Dr Foster publish the data. Good performance is 100 or less.	SHMI Quarter 4 2017/18 - SHMI increased in the Quarter up to the end of March 2018 to 118, while this is an increase on the previous quarter, when compared to the same period last year the SHMI has reduced, despite an increase in patient acuity and increase in total patients treated. Therefore this represents an improvement on the previous year.	

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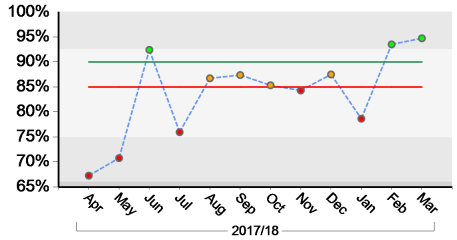
Effective

Indicator Name	Description	Narrative	Month Trend
Sepsis Screening & Antibiotic Administration	Sepsis Screening & Antibiotic Administration.	This KPI is being replaced with two separate KPIs and will be reported in future reports - In Q2: The percentage of patients who met the criteria of the local protocol on the National Early Warning Scores (usually NEWS2 greater than or equal to 5) for sepsis screening and were screened for sepsis and for whom sepsis screening is appropriate WAS 100% The percentage of patients who present with suspected sepsis to emergency departments and other units that directly admit emergencies, and were administered intravenous antibiotics within 1 hour was 81.6%	

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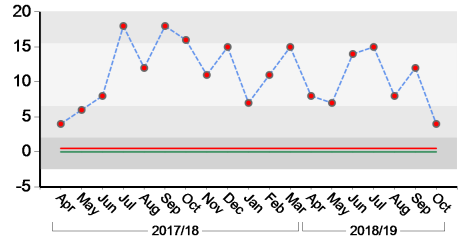
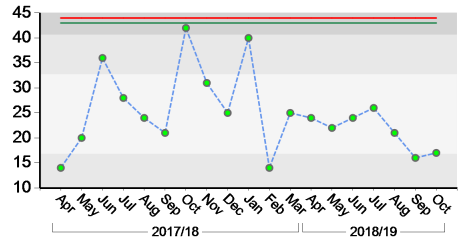
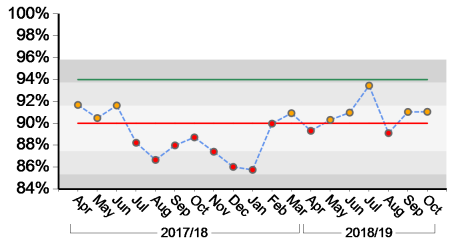
NHS Southport and Ormskirk Hospital NHS Trust

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.	Whilst the Trust failed to achieve target in October, DSSA breaches are the lowest since April 2017 with 4 patients. This is significantly lower than in previous months. - Increased focus and surveillance is now in place at the daily bed management meeting which ensures a discipline is put in place to step patients down within the required timeframe. In addition, the operational leadership team is assessing estate to determine any opportunities to redesign to support performance improvement.	
Written Complaints	The total number of complaints received. A lower number is good.	The complaint numbers are 17 for the month of October, this is 1 more than the month of September. - The number of complaints received suggests that patients are aware of the complaints procedure. The complaints continue to be reported in the Quality and Safety reports for each Clinical Business Unit. Please refer to the Integrated Governance Report for Q2 presented at Q&S Committee for complaints analysis such as trends, themes and responsiveness.	
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Trust performance shows maintained performance when compared to the previous months report at 91.05%. - Ongoing work continues to support the Trust patient experience strategy. A+E refurbishment improvements now 60% completed and are expected to be finished mid-December which will provide an improved patient experience in the department. Developments to improve patient flow and discharge processes continue as red 2 green is implemented across the Trust, and 'Long Stay Tuesdays' have recently been implemented to identify and review patients who have occupied a hospital bed for more than 20 days. Picker attending the Trust on the 28th November to support action planning in response to the 2018. National Maternity Survey Results. Trust volunteer support has enabled FFT comments to be visually shared with wards/depts. This has been initiated in response to staff requests and provides qualitative data for staff regarding the patient, family and carer experience in their own areas.	

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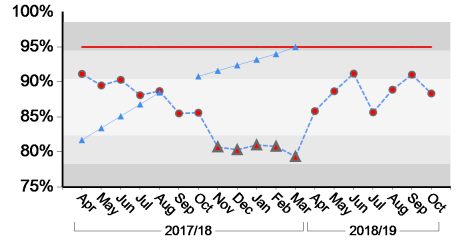
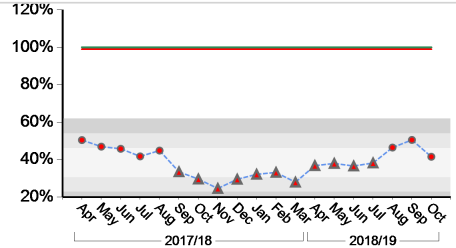
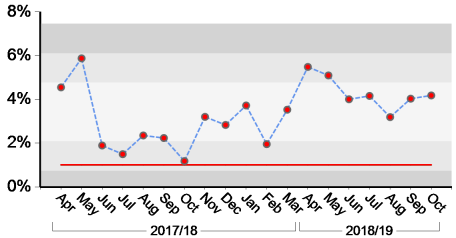
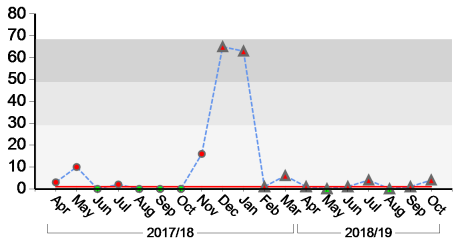
NHS Southport and Ormskirk Hospital NHS Trust

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.	Overall 4-hour performance in October 2018 fell to 88.36%. Reassuringly though, performance on the Southport site alone improved from 67.1% in October 2017 to 81% in October 2018. - This was against a backdrop of 523 additional attendances (11.5% increase), the majority of which were majors category, and restricted clinical space available whilst the rebuild is underway. Admissions via ED were 4% lower than October 2017. The business case for the expansion of Ambulatory Care has been approved and recruitment is underway to develop the service to stream appropriate patients away from ED. Collaboration is also underway with primary care pursue the use of GPs in ED.	
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.	The Trust failed to meet the target in October at 41.45%, although performance remains significantly higher than the same period in the previous year. - October was a significantly challenging month in terms of high attendances, pressures in inpatient flow, along with the temporary reductions in clinical space whilst the refurbishment of ED was underway. Disappointingly only 41.45% of patients were handed over within 15 minutes of arrival in ED. The department saw an increase of 523 patients across the month of October; this increase was in patients who self presented as opposed to brought in by ambulance. Phase 3 of the rebuild opened on 5 November with 4 dedicated ambulance bays, in addition to an ambulance triage room and extended triage capacity for walk in patients. The Ambulance handover screen has been moved to the front of the department and there is a drive to ensure that accurate handover time is captured. The remainder of the rebuild is due for completion by Christmas 2018. We continue to work with NWAS considering 'fit to sit' where appropriate, acknowledging the patient demographics compared to other areas.	
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.	Diagnostic wait performance continues to fail target . Performance is 4.18% for October compared to 1.18% for October 2017 - Audiology 1.8% - 4 patients breached - Senior Audiologist was off for 3 weeks from 20/08/2018 resulting in the cancellation and re-booking of approx 60 patients. Cardiology - on target. Colonoscopy - 5.8% - 8 patients breached - due to patient choice - not given 3 weeks reasonable notice. Computed Tomography - 0.3% - on target. Flexi Sigmoidoscopy - 0% - on target. Gastroscopy - 0.6% - on target. MRI - 1.1% - 4 patients - patient choice. Non-obstetric Ultrasound - 84 patients - 7.1% - lack of capacity. Urodynamics - 8.5% - 4 patients - 3 due to patient choice - offered appointments with less than the three week reasonable notice. The Theatres and Endoscopy Improvement Programme aims to increase productivity and utilisation.	
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.	Disappointingly there were 4 x 12 hour breaches during the month of October. - 2 patients required side rooms which, due to bed pressures and ongoing management of infection control, were unavailable within timescales. 2 were patients who were awaiting admission to mental health beds. A number of meetings have been held regarding mental health with both CCGs and, more recently, with other local acute Trusts. ECIST are also undertaking a deep dive into mental health service on 8 and 9 November with representation from all stakeholders to drive improvement recommendations. The continued roll out of red to green will support improved daily flow, facilitate earlier discharge from acute beds to ensure timely access for patients requiring side rooms on admission.	

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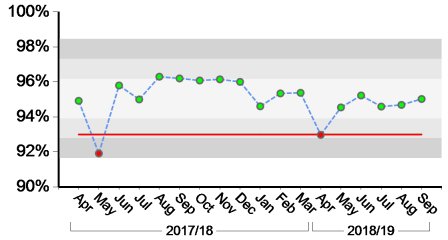
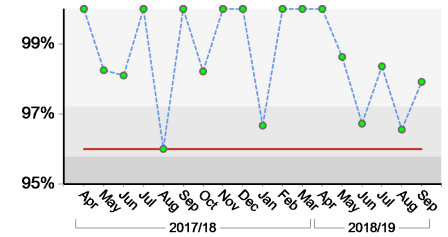
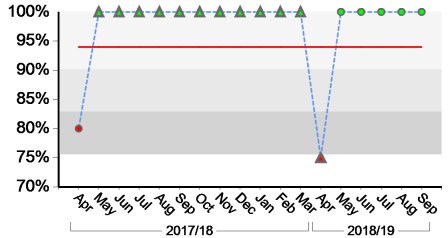
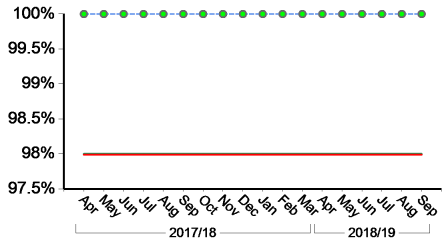
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
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.	Performance remains on target for September 2018 - Focused work beginning on 7 day pathway. The objective is to reduce the wait for the first appointment to less than 7 days. RAS implemented in Lung, Urology and moving to Gyane in Dec 2018	
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.	Performance remains on target in October at 97.92% -	
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').	Performance remains on target in October at 100% - No change	
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').	Performance remains on target in October at 100% - No Change	

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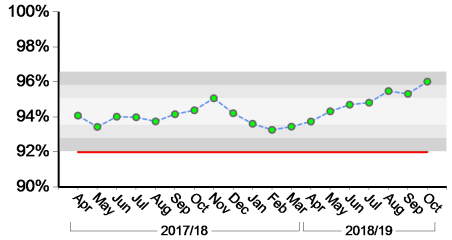
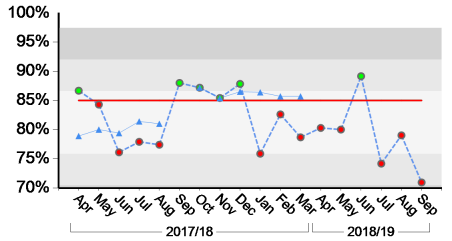
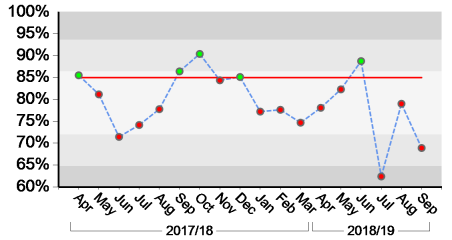
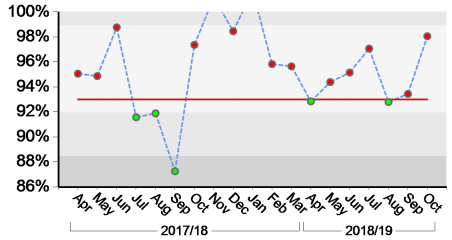
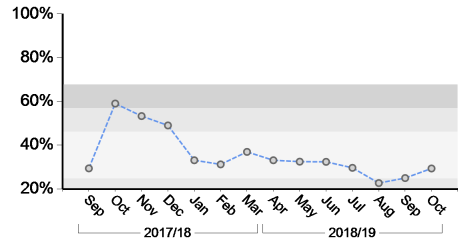
Responsive

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.	Trust Performance has again met the 92% threshold for October 2018 which was recorded at 96.02%. This is the highest performance since April 2017 and 18mths of steady compliance, demonstrated by the improvement in performance. - This overall Trust figure does not reflect the challenges faced in some of the smaller sub-speciality areas i.e. Paediatric Ophthalmology 86.3% and Paediatric Resp 75%. Patients are still being booked in chronological order	
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.	Performance remains under target in August at 79.01% although this is an improvement on July at 74.16%. - New 7 day pathway project implementation underway. Cancer Improvement Group looking at over arching projects that have a direct impact on Cancer Targets including work underway in Endoscopy, Radiology, Theatres Access & Booking and ERS work streams. Until project work undertaken in these areas it is anticipated that Cancer Performance will not show significant signs of improving although every effort is made to avoid any breaches by the way of weekly/daily PTLs and robust escalation policies.	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	The Trust has not achieved the target of 85% in August as performance was 79.01%. This is a significant improvement on July which was 62.38% and is within normal variation. - Cancer Improvement Group now implemented looking to ensure we are working towards compliance with the standard by implementing a 7 day standard.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Bed occupancy at Southport remains high in Southport and was at 98.06% in October. This is higher than September which was 93.44% and similar to October 2017 which was 97.37% -	

Board Report - October 2018

Southport and Ormskirk Hospital NHS Trust

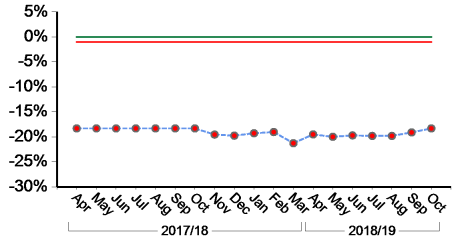
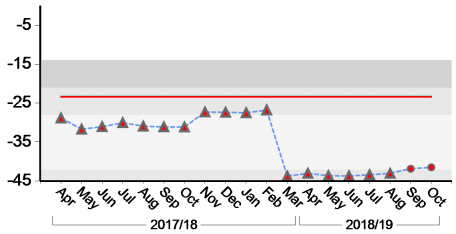
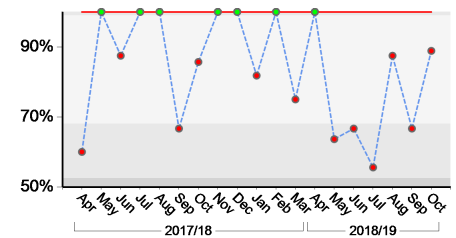
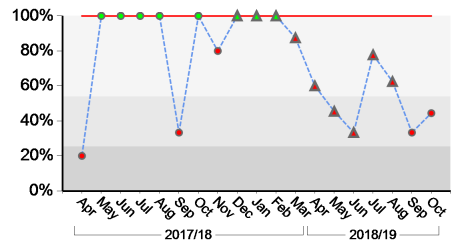
Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site. A lower percentage is good. Threshold is 93%.	Bed Occupancy at Ormskirk was reported as 29.33% in October. This demonstrates a month on month reduction since October 2017, although numbers have been slightly higher in September and October. - Bed Occupancy in the last 12 months is as follows: Nov 2017 53.3% Dec 2017 49.03% Jan 2018 33.09% Feb 2018 31.20% Mar 2018 36.92% Apr 2018 33.09% May 2018 32.45% Jun 2018 32.37% Jul 2018 29.63% Aug 2018 22.65% Sep 2018 24.95% Oct 2018 29.33% The data is currently under validation to ensure correct recording. This will enable an analysis of occupancy on open wards and occupancy of the site as a whole.	

Board Report - October 2018

NHS Southport and Ormskirk Hospital NHS Trust

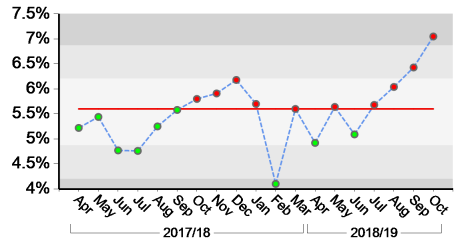
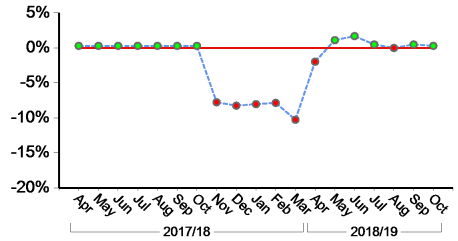
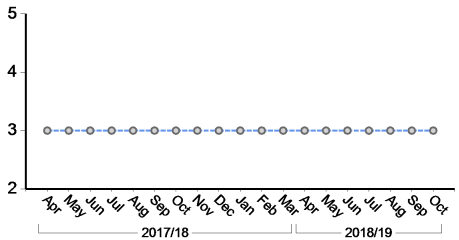
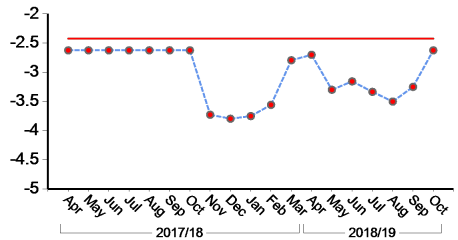
Well-Led

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.	Please refer to the DoF Report for the detail -	
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Metric is relatively static although there is a minor improvement in October - 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.	
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.	Performance remains below target for the 6th consecutive month - Failure to achieve compliance has been impacted by delays in completion of 72hr reviews which verify the level of harm. Another factor can be the appropriateness of a discussion relative to the patient's condition.This has been an issue across all CBU's. The Daily Incident Review meeting reviews now includes Duty of Candour within the incident review and 72hour SIRG also includes this. The Integrated Governance team produce weekly reporting highlighting non-compliance and this is escalated to the CBU Triumverates. The standard for this metric is being queried and the data validated for accuracy. The Trust policy is now being amended and the process, IT system and reporting improved to ensure more timely responses.	
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.	Performance is reported as failure to comply since march 2018. - Failure to achieve compliance has been impacted by delays in completion of 72hr reviews which verify the level of harm. This has been an issue across all CBU's. The Daily Incident Review meeting reviews now includes Duty of Candour within the incident review and 72hour SIRG also includes this. The Integrated Governance team produce weekly reporting highlighting non-compliance and this is escalated to the CBU Triumverates. The standard for this metric is being queried and the data validated for accuracy. The Trust policy is now being amended and the process, IT system and reporting improved to ensure more timely responses.	

Board Report - October 2018

NHS Southport and Ormskirk Hospital NHS Trust

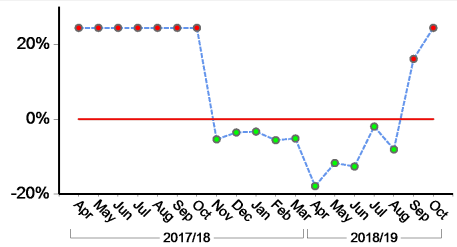
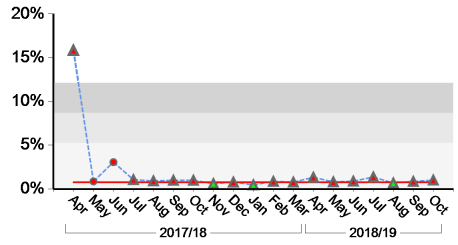
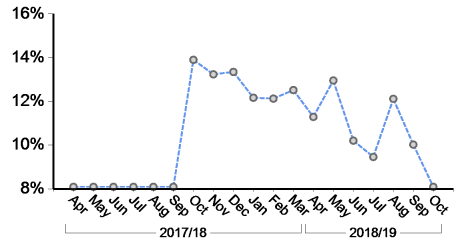
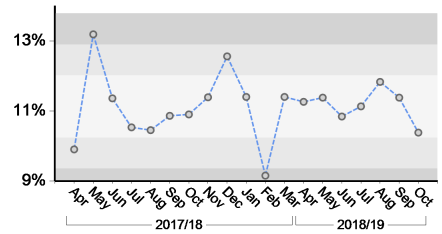
Well-Led

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.	Agency staff cost has increased for the 4th month in succession and was 7.05% in October. -	
Distance from Control Total	Distance from Control Total.	The Trust is ahead of its financial plan in terms of the I&E margin metric - The planned I&E margin metric (deficit divided by turnover) was -18.6% cumulatively at October. However, the Trust delivered -18.3% so it is 0.3% better than planned. Although the deficit is slightly more than planned it is the turnover which is £2.6m better that is driving this positive metric.	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Overall score remains static at 3 (A score of 1 is best and 4 is the worst) - The unrounded rating is 3.0 and this is the same as last month. 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 delivering the financial plan (on target rated at 1) and achieving the agency cap target (adversely away from plan with a rating of 2).	
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.	A significant improvement in October - The metric has improved from -3.25 last month to -2.62 this month. The driver for change is that the Trust has been able to service its finance lease payment on the second modular building and also pay off more of its DH capital loan.	

Board Report - October 2018

NHS Southport and Ormskirk Hospital NHS Trust

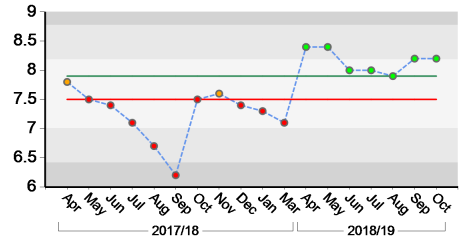
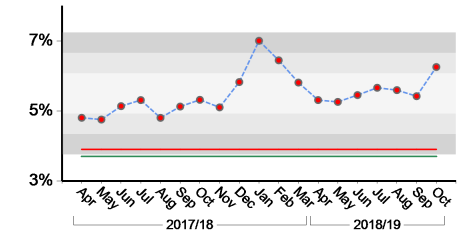
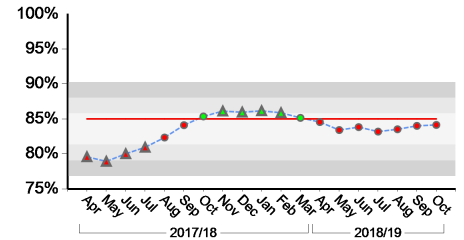
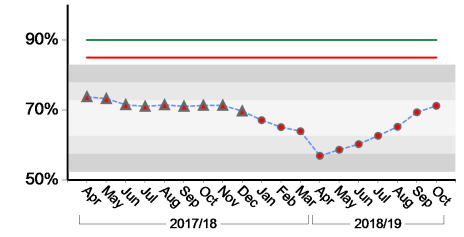
Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Please refer to the DoF Report for the detail -	
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.	Staff turnover has increased slightly in month. YTD turnover is 6.73%. Rolling 12 month turnover is 10.83% - The Trust is participating in the NHSI Nursing Workforce Retention Pilot, in order to increase the Trust's nursing retention. This is a 90 day pilot.	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The vacancy rate is showing a decline in the last 12 months. - Initial meeting has taken place between the Director of HR, Head of Resourcing and the Medical Director. A task and finish group will be scheduled in November 2018 to develop a comprehensive medical workforce strategy.	
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Trajectory shows an improving position aligning to ongoing recruitment actions - Vacancies are under stringent review through Nursing and Resource recruitment leads aligning to ongoing local recruitment events and supportive actions required with recruitment team leads.	

Board Report - October 2018

NHS Southport and Ormskirk Hospital NHS Trust

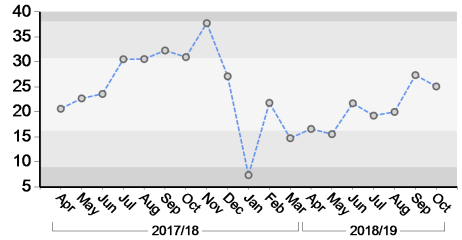
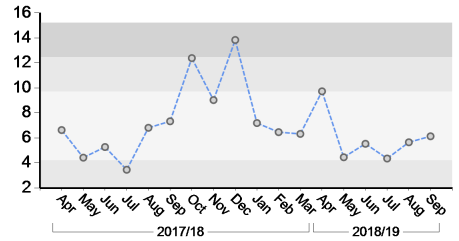
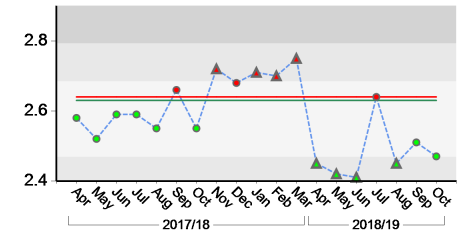
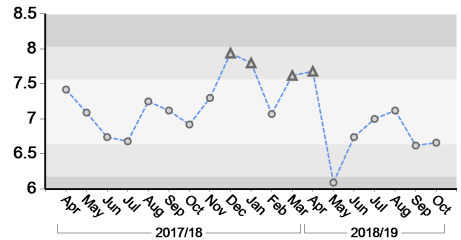
Well-Led

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.	Data reports a positive trajectory - Whilst the data reports a positive trust position this requires further scrutiny to assure a robust CHPPD is reported going forward.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	The Trust continues to fail the 4.2% target. Whilst performance has been stable over the summer months, and was 5.42% in September, performance for October was 6.26%. - Sickness absence had been reducing slightly month on month from July 2018. However, it has now increased from 5.42% In September to 6.26% in October 2018. The rolling year to date percentage has increased to 5.68% from 5.55% in September 2018 and remains significantly above target. Sickness absence had been reducing slightly month on month from July 2018. However, it has now increased from 5.42% In September to 6.26% in October 2018. The rolling year to date percentage has increased to 5.68% from 5.55% in September 2018 and remains significantly above target.	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	The Trust has seen a steady improvement in compliance since May 2018. October performance was 84.14%. - Hand hygiene has seen a 4.05% since September, this in part will be due to concentrated effort by the Infection Control team and their Bug Bus. Last month's spotlight was on Local Fire Training and this has shown a 0.64% rise since September. When Subject Matter Experts own and drive their compliance rates through increased training provision, communications and by monitoring their own compliance reports to target non compliant areas, this generally results in % increase. Recommendation: SME's should be supported with time and resources by their Executive Leads to promote, monitor, train and target non compliant areas/groups to achieve the Trust target. The Consultant/SAS Mandatory Training Days have also been reinstated and will be held 4 x per year. These groups also have access to monthly "You Choose" days held at both sites and alternatively they can access eLearning modules via My ESR.	
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance has improved for the 6th consecutive month. - PDR compliance is 71.17% in October 2018 which is a 6th month consecutive improvement. Overall, to meet the Trust target of 85% there needs to be a further improvement of 13.83% in PDR compliance. All CBU's have been asked to review and update their improvement trajectories to ensure that they have a realistic plan to deliver the required improvement.	

Board Report - October 2018

NHS Southport and Ormskirk Hospital NHS Trust

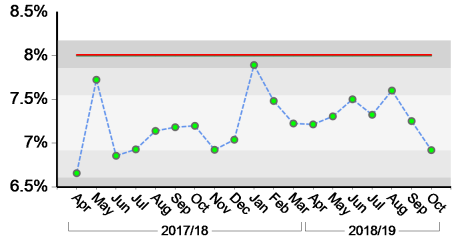
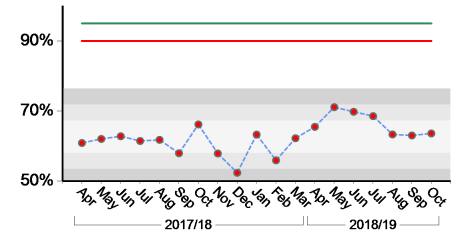
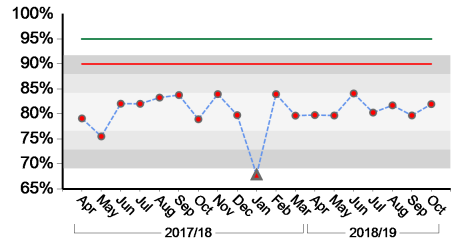
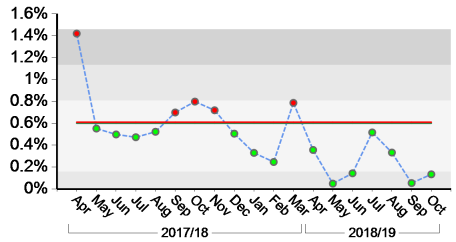
Efficiency

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.	The number of bed days lost in October was 25.1 which is within normal variation, although slightly lower than September which was 27.37. - Implementation of #longstaytuesday - working alongside ECIST and system partners, new review of patients with LOS 20+ days commenced weekly. The introduction of D2A beds in community has also seen a big impact, using trusted assessment document developed by community following PDSA with all parties.	
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).	The number of bed days lost in September was 6.13. This is slightly higher than August which was 5.65 but is within normal variation. - Working alongside ECIST and system partners, a new review of patients with LOS 20+ days commenced weekly. The introduction of D2A beds in community has also seen a big impact, using trusted assessment document developed by community following PDSA with all parties. system wide week long review planned. Improvements should be seen in the October data.	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	The Trust continues to achieve the new to follow up ratio target in October. Performance is consistent at 2.47. -	
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.	Average LOS remains stable at 6.66 days. - There is a re-launch of LOS reviews with support from ECIST- ward based reviews of all patients 20+days with system partners. The appointment of a red2green lead on a 3month secondment supports the review and further rollout. Exec and operational support is identified for all inpatient areas.	

Board Report - October 2018

NHS 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.	The DNA Rate has decreased in October to 6.92% and remains within threshold - The OPD Project Board has commenced and will need to undertake a deep dive and develop an action plan to address the current DNA rates.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Theatre utilisation in Southport continues to fail to achieve the target of 90%. - Theatre utilisation data is under review for accuracy. Utilisation on the SDGH site is dependant on availability of beds.	
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Theatre utilisation at Ormskirk continue to fail to meet the target of 90%. October performance was 81.96%. - Theatre utilisation data is currently under review between the Operation and IT teams. The theatre efficiency programme looks to increase utilisation.	
Cancelled Ops	Percentage of Operations Cancelled.	The Trust continues to achieve the target of 0.6% for the seventh month in succession. October performance was 0.05% -	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	TB 286/18	Report Title	Director of Finance Report - October 2018
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ☑ To Receive	

Executive Summary

The Trust did not sign up to its 2018/19 control total of £13.681 million (£6.9 million including Provider Transformation Funding (PSF)), and set a deficit plan of £28.8 million.

At month 7 the Trust's financial performance is a deficit of £17.81 million which is £173,000 worse than plan. This includes £933,000 income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. Trust continues to see over performance in A&E attendances and non-elective activity. Elective activity is still behind plan at the end of October.

The CIP programme is forecast to be £1.4 million lower than the £7.5 million plan although additional schemes are expected to mitigate.

Expenditure run rate has been fairly consistent but there are signs of increasing cost pressures as the cumulative pay budget overspend increased significantly from £368,000 (month 6 YTD) to £779,000 (month 7 YTD). While there has been an increase in substantive staffing, agency spend increased for the fifth consecutive month; YTD spend is £4.5 million which means that the Trust will breach NHSI agency cap set at £5.6 million.

CIP delivery and agency spend are two of a number of risks to delivering the year end deficit of £28.8 million the others being. .

- Commissioners applying contract sanctions; Trust has not made any provision at this stage as discussions have been taking place around reinvestment; at month 7 total value to date is £1.38 million.
- Contract challenges on non-elective activity and CDU tariffs.
- Mitigation of additional business case costs from reserves.

There is no plan at this stage to amend the forecast outturn from £28.8m deficit; the Board will need to consider this position ahead of Quarter 3 reporting to NHSI.

The Board is asked to **receive** the month 7 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)*

Risks, mitigating actions and forecast outturn to be discussed with NHS Improvement.

Previously Presented at:

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

Committee	

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 7 (the financial period ending 31st October 2018).

2. Executive Summary

2.1. The Trust did not sign up to its 2018/19 control total of £13.681 million (£6.9 million including Provider Transformation Funding (PSF)), and set a deficit plan of £28.8 million.

2.2. At month 7 the Trust's financial performance is a deficit of £17.81 million which is £173,000 worse than plan. This includes £933,000 income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. Trust continues to see over performance in A&E attendances and non-elective activity. Elective activity is still behind plan at the end of October.

2.3. The CIP programme is forecast to be £1.4 million lower than the £7.5 million plan although additional schemes are expected to mitigate.

2.4. Expenditure run rate has been fairly consistent but there are signs of increasing cost pressures as the cumulative pay budget overspend increased significantly from £368,000 (month 6 YTD) to £779,000 (month 7 YTD).

2.5. While there has been an increase in substantive staffing, agency spend increased for the fifth consecutive month; YTD spend is £4.5 million which means that the Trust will breach NHSI agency cap set at £5.6m.

2.6. The table below is the I&E statement for October:

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	148,922	86,940	88,064	1,124	12,909	13,304	395
PP, Overseas & RTA	1,383	805	652	(154)	116	98	(18)
Other Income	14,378	8,325	8,538	214	1,218	1,242	24
Total Income	**164,683**	**96,070**	**97,254**	**1,184**	**14,243**	**14,644**	**401**
Operating Expenditure							
Pay	(129,202)	(75,947)	(76,726)	(779)	(10,691)	(11,102)	(411)
Non-Pay	(53,115)	(31,153)	(31,725)	(572)	(4,375)	(4,695)	(320)
Total Expenditure	**(182,317)**	**(107,100)**	**(108,451)**	**(1,351)**	**(15,066)**	**(15,797)**	**(731)**
EBITDA	**(17,634)**	**(11,030)**	**(11,197)**	**(167)**	**(823)**	**(1,153)**	**(330)**
Non-Operating Expenditure	(11,217)	(6,543)	(6,549)	(6)	(935)	(914)	20
Retained Surplus/(Deficit)	**(28,851)**	**(17,573)**	**(17,746)**	**(173)**	**(1,758)**	**(2,067)**	**(310)**
Technical Adjustments	63	37	(64)	(101)	6	7	1
Break Even Surplus/(Deficit)	**(28,788)**	**(17,536)**	**(17,810)**	**(274)**	**(1,752)**	**(2,060)**	**(309)**

2.7. CIP delivery and agency spend are two of a number of risks to delivering the year end deficit of £28.8 million the others being

2.7.1. Commissioners applying contract sanctions; Trust has not made any provision at this stage as discussions have been taking place around reinvestment; at month 7 total value to date is £1.38 million.

2.7.2. Contract challenges on non-elective activity and CDU tariffs.

2.7.3. Mitigation of additional business case costs from reserves.

2.8. There is no plan at this stage to amend the forecast outturn from £28.8 million deficit; the Board will need to consider this position ahead of Quarter 3 reporting to NHSI

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

2.10. The Trust continues to require cash support as it is trading with a deficit each month and provides rolling 13 week cash forecast to NHSI to support the monthly application for revenue support loans.

3. Income Performance

3.1. The Commissioning income budget has overperformed in month due to additional activity levels in non-elective, A&E and outpatients as well as a further £133,000 (YTD £933,000) income accrual for ACU/CDU activity.

3.2. Based on activity going through these assessment units it is likely that the full year value could be in the region of £2.0 to £2.5 million.

3.3. 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 emergency tariff (@70%) for activity above the agreed baseline; this reduction of £791,000 still gives the Trust an income over performance of £1.880 million (inclusive of £933,000 ACU/CDU).

3.4. A&E attendance total 48,577, up 4.82% against plan; resulting in a financial impact of £317,000

3.5. CQUIN income was reduced by £326,000 in month 6 for non achievement of antibiotic review and advice & guidance in Quarters 1 and 2.

3.6. No further reduction has been applied in month 7 as progress is being made on CQUIN performance. It is now expected that CQUIN underperformance will be less than the original £500,000 forecast and could be as low as £200,000.

3.7. Elective activity continues to underperform by 11.0%; resulting in a financial impact of £784,000, although there has been improvement in the last two months. The Trust's forecast outturn assumes the elective shortfall is brought back to plan and, therefore, it is vital that a significant improvement is delivered in the second half of the year.

3.8. Outpatient activity performance has improved but remains 1.77% below plan. However, the case mix continues to generate a YTD favourable variance of £211,000.

3.9. 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.

3.10. This issue forms part of a presentation on financial system risks prepared for the regulators who met on 20th November. All parties awaiting feedback from the regulators.

4. Expenditure

4.1. Underlying expenditure levels for both pay and non-pay have increased compared to previous months with agency expenditure still increasing due to the increased use of Thornbury nursing.

4.2. Pay expenditure in October has increased compared to previous months. The pay award for medical staff has been actioned in month with only a minor effect on pay, the biggest increase is nurse agency again (£367,000 in month of which £146,000 relates to Thornbury).

4.3. Non consultant medical staff and nursing staff continue to overspend which is a reflection of the high level of vacancies and the necessity to fill shifts at premium rates.

4.4. The key areas of nurse overspend are medical and surgical wards and theatres.

4.5. The key areas of non consultant medical staff overspend are medicine, surgery and paediatrics.

5. Non pay spend has increased again in October with a YTD overspend of 1.9% (before reserves and CIP).The Turnaround Director continues to hold budget reviews with all budget holders to bring this back into balance.

6. Agency spend

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

6.2. The Trust has spent £782,000 on agency staff in October (8.2% of the substantive payroll) which is above the planned expenditure profile submitted to NHSI.

6.3. The monthly profile of the plan reduced considerably in July, however spend has increased with more Thornbury agency nurse shifts being used to cover the increasing nurse vacancies, holidays and sickness. Fill rate has also increased.

6.4. The reduction in agency spend required to achieve the £5.6 million NHSI agency cap is no longer possible.

6.5. Nurse agency spend is £367,000 in October which continues on an upward trend as reported at last month's Board with high usage continuing in A&E, general medicine and general surgery.

6.6. Bank fill remains constant; the focus continues to be on recruiting to substantive posts.

6.7. Nurse vacancy levels have reduced in month to 10.3% (11.3% September) without any improvement on nurse bank and agency spend.

6.8. The cost of providing cover for nurse sickness in October was £147,000 (bank £111,000; agency £36,000) based on the information provided by NHSP.

6.9. Thornbury nurse agency spend has increased month on month: June £24,000; July £45,000; August £122,000; September £132,000; October £146,000.

6.10. With regard to medical staff required on short notice (less than 7 days) a revised escalation procedure has now been fully implemented.

6.11. This procedure speeds up decision making but also take into consideration the required executive authorisation (as per NHSI rules) before shifts are booked.

6.12. Any requests to fill vacant medical shifts which are at least 7 days away must go through the Trust's weekly Performance and Activity Group (PAG)

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

6.14. The cost of providing cover for medical sickness in October was £1,000 for bank only based on the information provided by TempRE.

7. Cost Improvement Plan (CIP)

7.1. The Trust's I&E plan assumes an in year £7.0 million CIP is delivered in 2018/19 from both increased income and reduced expenditure.

7.2. Overall the Trust is required to deliver £7.5 million CIP, to take account of the balance to FYE of 2017/18 schemes.

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

	Annual	YTD			In Month		
	Plan £000	Plan £000	Actual £000	Var £000	Plan £000	Actual £000	Var £000
18/19 Plan	7,006	3,660	1,920	(1,740)	760	379	(381)
17/18/ balance to FYE	535	268	268	0	45	45	0
Total	7,541	3,928	2,188	(1,740)	805	424	(381)

7.4. CIP delivery continues to underperform and is contributing materially to the adverse expenditure budget performance in month.

7.5. The Turnaround Director reviewed the CIP plans and revised the CIP forecast down.

7.6. Additional schemes have been identified and £1.6 million has been added in September for the additional income expected for ACU and CDU. As highlighted this figure could be higher taking into account the additional activity through the winter period.

7.7. This along with the revision of other schemes has increased the CIP forecast to £6.1 million, a shortfall of £1.4 million.

8. Cash

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

8.2. 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 (October's cash flow was sent on 6th September).

8.3. The Trust borrowed £2.618 million in October against the original plan of £4.937m million. This included an additional £3.2 million to settle prior year CCG invoices. This additional cash requirement was drawn down in November.

8.4. Note that as the Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

8.5. Performance against the cash target in October was as follows:

Description	Target £'000	Actual £'000	Comments
Opening balance	1,300	1,033	Brought forward balance.
Cash inflows	16,673	17,054	Two VAT refunds received in month totalling £499k against a target of £250k.
Cash outflows	(16,973)	(16,860)	Immaterial difference <1%

Closing balance	**1,000**	**1,227**	

8.6. Cash is monitored daily and plans are adjusted for any changes in month to ensure the Trust does not breach its loan condition to have £1 million cash balance at the end of the month.

8.7. As highlighted last month agreement has now been reached with the CCGs around settlement of prior year invoices in mid-November and to facilitate this November's loan request was £5.196 million.

8.8. December's cash flow has just been submitted and the loan requirement is forecast to be £2.09 million.

8.9. The Board is asked to note that there is a potential cash risk building over the next few months. This is around the fact that in delivering the £28.8 million deficit plan, the Trust is reliant on additional income being paid for by Commissioners rather than CIP savings.

8.10. Discussions so far indicate a reluctance to pay for this activity and if this continues then the Trust will start to face difficulties with managing cash due to non-payment for this activity.

9. Capital

9.1. Total spend in month was £962,000, largely driven by equipment installed as part of the GE radiology managed service (total value of this equipment was £606,000 with £350,000 relating to the replacement CT scanner at Southport).

9.2. Year to date spend is £2.713 million with ccommitments of £1.513 million which includes approved tenders on A&E phase 3, new sexual health accommodation and the Theatre UPS.

9.3. An additional appendix has been included this month (previously presented to FPI in October) which provides a narrative for all capital schemes this year.

9.4. National funding of £735,000 has been awarded; £280,000 for the Surgical Assessment Unit, opened in October 2018, and £455,000 for implementation of Strata Health a real time patient access and flow system to community health and social care.

9.5. Capital Investment Group is fully sighted on being able to spend the full capital allocation including the additional monies highlighted in 9.4.

10. Commissioning for Quality and Innovation payments (CQUINS)

10.1. The full 2.5% CQUIN income of £3.2 million has been included in the 2018/19 Financial Plan.

10.2. Most of the CQUIN targets are "national" targets and are a continuation of 2017/18.

10.3. In September, the Trust has recognised the non achievement against specific milestones and reduced ncome by £326,000.

10.4. Additional resource has been targeted at ensuring CQUIN targets are delivered and an improvement on the original £500,000 shortfall projections is expected.

11. Risks

11.1. Following an assessment by the Turnaround Director there is a significant risk of delivering the CIP of £7.5 million (£7 million 'in year'). There is a current gap of £1.4 million but run rate schemes (£600,000) and additional CIP opportunities (£1 million) are forecast to mitigate the shortfall.

11.2. Agency spend has been increasing each month and is now beginning to create an overspend on the cumulative pay budget.

11.3. Contract sanctions have not been deducted from the income position; to date at month 7 this totals £1.38 million.

11.4. Current non-elective activity performance will lead to CCG payments exceeding their contract value. The risk is contract challenges for non-elective activity and the tariff for CDU.

11.5. Potential further business cases or pressures (including winter) may not be fully covered by reserves.

12. Forecast Outturn 2018/19

12.1. The Trust forecast outturn with NHSI remains at £28.8 million deficit. However, this is the “best case” and further discussions are planned with regulators in order to resolve the Local Health Economy financial deficit.

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

13. Recommendations

13.1. The Board is asked to receive the month 7 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	148,922	86,940	88,064	1,124	12,909	13,304	395
PP, Overseas & RTA	1,383	805	652	(154)	116	98	(18)
Other Income	14,378	8,325	8,538	214	1,218	1,242	24
Total Income	**164,683**	**96,070**	**97,254**	**1,184**	**14,243**	**14,644**	**401**
Operating Expenditure							
Pay	(129,202)	(75,947)	(76,726)	(779)	(10,691)	(11,102)	(411)
Non-Pay	(53,115)	(31,153)	(31,725)	(572)	(4,375)	(4,695)	(320)
Total Expenditure	**(182,317)**	**(107,100)**	**(108,451)**	**(1,351)**	**(15,066)**	**(15,797)**	**(731)**
EBITDA	**(17,634)**	**(11,030)**	**(11,197)**	**(167)**	**(823)**	**(1,153)**	**(330)**
Non-Operating Expenditure	(11,217)	(6,543)	(6,549)	(6)	(935)	(914)	20
Retained Surplus/(Deficit)	**(28,851)**	**(17,573)**	**(17,746)**	**(173)**	**(1,758)**	**(2,067)**	**(310)**
Technical Adjustments	63	37	(64)	(101)	6	7	1
Break Even Surplus/(Deficit)	**(28,788)**	**(17,536)**	**(17,810)**	**(274)**	**(1,752)**	**(2,060)**	**(309)**

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/10/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	125,808	(982)	406
Other assets	1,382	1,246	(136)	(138)
TOTAL NON CURRENT ASSETS	**128,172**	**127,054**	**(1,118)**	**268**
CURRENT ASSETS				
Inventories	2,454	2,453	(1)	(95)
Trade and other receivables	9,591	9,035	(556)	678
Cash and cash equivalents	1,079	1,227	148	194
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**12,715**	**(409)**	**777**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(24,595)	636	(704)
Provisions	(131)	(162)	(31)	(7)
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)	(173)	298	6
TOTAL CURRENT LIABILITIES	**(32,199)**	**(31,296)**	**903**	**(705)**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(18,581)	494	**72**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**108,473**	**(624)**	**340**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(84,062)	(17,447)	(2,618)
PFI/Finance lease liabilities	(13,807)	(13,764)	43	10
DH Capital loan	(1,400)	(1,000)	400	200
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(99,092)**	**(16,992)**	(2,408)
TOTAL ASSETS EMPLOYED	**26,997**	**9,381**	**(17,616)**	**(2,068)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	97,368	127	0
Retained earnings	(83,484)	(101,227)	(17,743)	(2,068)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**9,381**	**(17,616)**	**(2,068)**

In month material movements are as follows:

Property Plant & Equipment increased by £406k in the month, largely due to new CT scanner under IFRIC12.

Trade and other receivalbles increased by £678k, the majority of this was associated with income accruals together with September's VAT return where the monies were not received until November.

Cash increased by just over £194k and remains above the minimum level set by DH.

The loan received in September was £2.618m.

Statement of cash flows

NHS
Southport and Ormskirk Hospital
NHS Trust

	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual 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)	(2,376)	(1,792)	(1,669)	(1,438)	(2,235)	(1,509)	(2,085)	(1,687)	(23,804)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)	(20)	0					(15)	(160)
Depreciation and Amortisation	523	524	523	524	523	524	518	517	517	509	509	508	6,219
Impairments and Reversals	0	0	0	0	0	0	0						0
(Increase) in Inventories	(50)	59	(83)	0	(39)	19	95			(56)		55	0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818	(805)	(540)			(242)	(250)	(200)	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	(144)	492	(3,785)	1,269	(43)	2,153	(16)	(1,422)
Increase in Provisions	(3)	(3)	(61)	82	0	(3)	7	(25)	(15)		(18)	(1)	(40)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(1,465)	(2,221)	(1,097)	(4,731)	(464)	(1,341)	309	(1,356)	(19,207)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	5	4	2	2	3	2	2	32
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(8)	0	(90)	(167)		(284)	(243)	(1,001)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(214)	(114)	(393)	(984)	(1,006)	(1,022)	(437)	(5,889)
Receipts from disposal of fixed assets	0	0	1	2	0	0	37						40
Receipt of cash donations to purchase capital assets	5	52	30	18	20	20	0				15		160
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(197)	(73)	(481)	(1,149)	(1,003)	(1,289)	(678)	(6,658)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	127	0	280	455				862
Public dividend capital repaid	0	0	0	0	0	0	0						0
Loans received from DH	2,739	2,178	2,479	2,718	2,573	2,142	2,618	5,196	1,764	2,451	1,764	3,378	32,000
Loans repaid to DH	(200)	0	0	0	0	0	(200)						(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(554)	(122)	(8)	(8)	(243)	(7)	(990)
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)	(145)	(150)	(193)	(172)	(199)	(1,024)	(2,957)
Interest element of finance lease	0	0	0	0	0	0	(262)	(5)			(172)		(439)
Interest element of PFI, LIFT	(80)	(80)	(196)	(80)	(80)	(197)	(79)	(80)	(197)	(80)	(80)	(196)	(1,425)
PDC dividend (paid)/refunded	0	0	0	0	0	(77)	0					(32)	(109)
Net Cash Inflow/(Outflow) from Financing Activities	2,338	1,973	1,966	2,512	2,335	1,342	1,364	5,105	1,660	2,177	1,056	1,958	25,786
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**(1,076)**	**194**	**(107)**	**47**	**(167)**	**76**	**(76)**	**(79)**
Cash - Beginning of the Period	1,079	2,531	1,380	1,018	1,446	2,109	1,033	1,227	1,120	1,167	1,000	1,076	1,079
Cash - End of the Period	**2,531**	**1,380**	**1,018**	**1,446**	**2,109**	**1,033**	**1,227**	**1,120**	**1,167**	**1,000**	**1,076**	**1,000**	**1,000**

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	350	260	90	55	97	735	412	323
	Beds / Trolleys	G0060	50	50	51	(1)	0		50	51	(1)
	Sub total MEDICAL DEVICES		**785**	**400**	**311**	**89**	**55**	**97**	**785**	**463**	**322**
IM&T	Electronic Patient Record	F6409	190	135	56	79	6		190	62	128
	Vitalpac	G0007	30	18	3	15	2		30	5	25
	eDMS	F6447	160	94	0	94	15		160	15	145
	Wireless network upgrade	G0073	302	175	174	1	146		302	320	(18)
	Server warehouse infrastructure incl. storage	G0078	75	75	25	50	0		75	25	50
	Telephony system replacement	G0059	95	95	9	86	0		95	9	86
	Cyber security	G0071	50	30	0	30	7		50	7	43
	Fixed network infrastructure	F6498	100	58	10	48	12		100	22	78
	Datacentre	G0075	50	50	5	45	0		50	5	45
	Virtual desktop infrastructure	G0076	25	15	2	13	0		25	2	23
	Equipment refresh	G0077	50	30	4	26	0		50	4	46
	Sub total IM&T		**1,127**	**775**	**289**	**486**	**188**	**0**	**1,127**	**477**	**650**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	200	150	58	92	125		200	183	17
	Southport A&E Redesign	G0068	436	0	301	(301)	62	335	436	698	(262)
	Ward reconfigurations	G0064	280	280	280	0	0		280	280	0
	Medical gasses	G0067	30	30	25	5	11		30	36	(6)
	UPS Theatre	G0053	140	140	0	140	0	143	140	143	(3)
	Waste management storage facilities	G0080	100	100	0	100	0		100	0	100
	Theatre airplant controls		45	45	0	45	0		45	0	45
	Generator connectors		65	65	0	65	0		65	0	65
	Fire compartmentation	G0052	12	12	12	(0)	0		12	12	(0)
	Fire Precautions - Fire Doors	G0019	7	7	7	0	0		7	7	0
	Discharge lounge	G0074	134	134	127	7	0		134	127	7
	Spinal isolation works		200	200	0	200	0		200	0	200
	Additional Car Parking		50	0	0	0	0		50	0	50
	Sexual Health Accomodation	G0079	260	60	2	58	0	193	260	195	65
	Capital team	F6305	155	95	111	(16)	0	69	155	180	(25)
	Aseptic isolator		30	30	0	30	0		30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,144**	**1,348**	**923**	**425**	**198**	**740**	**2,144**	**1,861**	**283**
FACILITIES	Catering equipment	G0026	100	100	0	100	0		100	0	100
	Sub total FACILITIES		**100**	**100**	**0**	**100**	**0**	**0**	**100**	**0**	**100**
	CONTINGENCY	**F6301**	**155**	**155**	**47**	**108**	**0**		**155**	**47**	**108**
	Capital plan excluding donations and IFRIC 12		**4,311**	**2,778**	**1,570**	**1,208**	**441**	**837**	**4,311**	**2,848**	**1,463**

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
OTHER	Donated assets	000000	120	60	145	(85)			120	145	(25)
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,488	1,142	998	144		235	1,488	1,233	255
	Sub total Donations and IFRIC 12		**1,608**	**1,202**	**1,143**	**59**	**0**	**235**	**1,608**	**1,378**	**230**
	TOTAL CAPITAL SPEND		**5,919**	**3,980**	**2,713**	**1,267**	**441**	**1,072**	**5,919**	**4,226**	**1,693**

Actual year to date spend is £2,713k with a further £1,513k committed.

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	Comments	2018/19 £'000 Plan
MEDICAL DEVICES	Medical Equipment fund	Multiple equipment purchases including ophthalmic equipment, defibs, cell savers, orthodontic chair and wright spirometers. Main purchase in 18/19 will be replacing the Trust's anaesthetic machines.	735
	Beds / Trolleys	Scheme complete - specialist beds	50
	Sub total MEDICAL DEVICES		**785**
IM&T	Electronic Patient Record	The scheme is to extend the current EPR coverage, in particular, patient observation recording in more clinical areas, specifically A&E and Paediatrics through Careflow Vitals. This will move the Trust towards the NEWS 2 assessment CQUIN	190
	Vitalpac	End user device refresh	30
	eDMS	The delivery of additional scanning hardware to increase the capacity of the scanning bureau.	160
	Wireless network upgrade	To modernise the wifi provision, increasing the coverage and capacity to handle a greater number of medical devices in use in the Trust. The new service will improve monitoring and maintenance. It will also provide free NHS wifi to patients as per the national mandate.	302
	Server warehouse infrastructure incl. storage	The current storage area network (SAN) has reached the end of its support contract and the most cost effective solution is to replace it to provide additional capacity to deal with our additional data storage requirements. The improvements will be in response times for database heavy activity, in reduced power consumption and storage management	75
	Telephony system replacement	Additional kit to support the implementation of SIP trunking to reduce call costs.	95
	Cyber security	Additional resource to configure, install and train staff on the new firewalls purchased in the last financial year. Scheduled for October. This moves the Trust to a modern, advanced set of firewalls that offer more functions and will be easier to manage.	50
	Fixed network infrastructure	Additional cabling points to support changes in estates use, allowing services to be re-configured properly.	100
	Datacentre	To refresh the end of life servers that power the datacentre, reducing the footprint by using more powerful machines. This will improve performance, add more	50
	Virtual desktop infrastructure	Additional host purchased.	25
	Equipment refresh	To replace broken equipment where existing equipment cannot be reclaimed.	50
	Sub total IM&T		**1,127**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	Works required to install replacement CT scanner. On schedule to have new scanner installed, old one removed by end of November.	200
	Southport A&E Redesign	Clinical Decision Unit complete avoiding corridor waits in A&E. Final phase with new areas for patients and ambulance to improve patient flow due for completion November.	436
	Ward reconfigurations	The Surgical Assessment Unit allows the Emergency Department (ED) to send appropriate patients direct to SAU, avoid delays in surgical treatment and improve the flow of patients from ED. Scheme complete mid October.	280
	Medical gasses	Patient medical gases provided at the bed side. Complete.	30
	UPS Theatre	Uninteruptable power supply Ormskirk theatre. Awaiting installation.	140
	Waste management storage facilities	Legal requirement due to start shortly. Will sort out some of the clutter problems on wards.	100
	Theatre airplant controls	Works required on air plant (medical and surgical air) used in Theatres.	45
	Generator connectors	Replacement of generator parts. Scheme not yet started.	65
	Fire compartmentation	Main Southport works complete to ensure that compartments are fully sealed and can withstand fire for the designated time.	12
	Fire Precautions - Fire Doors	Southport site complete. New fire doors fully compliant.	7

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	Comments	2018/19 £'000 Plan
	Discharge lounge	Discharge and transfer lounge now open. There are three beds and a side-room to accommodate less able or infectious patients. There is also a seating area for up to eight more mobile patients. We can take patients in their own clothes or nightwear. All patients are to be transferred to the discharge lounge if they are unable to go home directly.	134
	Spinal isolation works	Increase the number of spinal isolation rooms from one to six but also maintain the total bed complement of the spinal unit to 43. The benefit is to reduce infection risk.	200
	Additional Car Parking	To increase the number of spaces to alleviate problems for staff, visitors and patients. Scheme not yet started.	50
	Sexual Health Accomodation	Current accommodation not fit for purpose. New accommodation identified, planning permission granted and works have just gone out to tender. Service due to move into new facilities in Feb 19.	260
	Capital team	Support all the above schemes.	155
	Aseptic isolator	Pharmacy extract system to improve staff safety.	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,144**
FACILITIES	Catering equipment	No equipment purchased yet but potentially looking at a suite of heated trolleys on the Southport site.	100
	Sub total FACILITIES		**100**
	CONTINGENCY	Used for unexpected replacements	**155**
	Capital plan excluding donations and IFRIC 12		**4,311**
OTHER	Donated assets	UV control of infection machines, stryker trolleys, maternity partner beds	120
	GE Radiology equipment replacement programme (IFRIC 12)	New CT scanner at Southport together with ultrsounds, spinal imaging and mobile Xray equipment.	1,488
	Sub total Donations and IFRIC 12	**Sub total Donations and IFRIC 12**	**1,608**
	TOTAL CAPITAL SPEND	**TOTAL CAPITAL SPEND**	**5,919**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	**TB287/18**	**Report Title**	**Communications and Marketing Strategy**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Tony Ellis, Communications and Marketing Manager		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The Communications and Marketing Strategy will:

- Enable an engaged, informed and self-confident workforce
- Build and protect the Trust's reputation in the community as a provider of quality services that inspire confidence and pride

This strategy describes the communications and marketing activities the Trust will use to deliver its corporate objectives. The themes are drawn from Vision 2020, the Trust's strategy. They are:

- Internal communications and engagement
- Enabling Vision 2020
- Building the Trust's reputation
- Supporting the recruitment, retention and recognition of staff

Recommendation:
The Board is asked to **approve** the strategy.

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)*

Implement and monitor through Hospital Management Board.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

COMMUNICATIONS AND MARKETING STRATEGY

Tony Ellis Communications and Marketing Manager

November 2018

1.0 Introduction

1.1 Background

Southport and Ormskirk Hospital NHS Trust has had a troubled recent past. A significant financial deficit puts it by percentage of turnover as one of the worst performing hospitals in the country. Two consecutive Care Quality Commission (CQC) inspections found it lacking in terms of the consistent provision of even the most basic care

Strong values-based leadership has been lacking and the removal of the chief executive and other members of the senior team left a vacuum in terms of strategy and purposeful direction.

The Trust was without a substantive chief executive for more than three years during which time a succession of interim appointments filled this and other key positions. Each had their own views of how the Trust should be led and the future direction of the organisation.

A CQC inspection in November 2017 scored the Trust “requires improvement”. It was scored inadequate for safety in urgent and emergency care, inadequate for well-led across medicine, surgery and the Trust overall. An unannounced safe and responsive inspection of the emergency department took place in March 2018 and similar concerns were identified.

The Trust is classed as “challenged provider” by NHS Improvement because of the financial quality concerns and is subject to enhanced scrutiny.

The long-term sustainability of the Trust and its services is being addressed by the Sefton Health and Care Partnership. Delivering a sustainability solution for the Southport, Formby and West Lancashire health economy is seen as a priority for the overarching Cheshire and Merseyside Health and Care Partnership,

1.2 Impact on staff and Trust reputation

Against this background it is unsurprising that both staff morale and the Trust’s reputation with local stakeholders has suffered measurably and anecdotally.

It is also worth noting the malaise extended beyond the challenges of the recent past. The pre-2015 leadership had been in place many years. Staff had become disempowered and were cautious of speaking out of turn. Relationships with external partners were strained, damaging partnership working to the Trust’s long-term detriment.

The effects of this staff behaviour continue to this day despite significant effort over the past 12 months to create a more open, inclusive culture.

The independent Freedom To Speak Up Guardian works across the Trust inviting staff to raise confidentially with him any concerns they have. The Trust is also working with junior doctors and Staff Side to improve the reporting of any behaviour that runs counter to the Trust's values.

May 2017's WannaCry cyber-attack was perhaps the closest the Trust got to a major crisis in the past few years. However, the media headlines obscured the fact a huge, unprecedented team effort restored systems for patients in a safe and timely manner. A lesson of WannaCry was there is a powerful kernel of pride and can-do among staff that effective communications and engagement can help nurture.

Recent instability also led to concerns both among staff and the wider public about the future of the organisation. This has manifested itself in rumours about hospital closures, trust mergers and/or the loss of services to other providers.

Vision 2020, the Trust's roadmap to how we will become a successful and sustainable provider of healthcare for local people, is clear the organisation has a bright future ahead of it. Vision 2020 is the foundation upon which the Trust's reputation will be repaired.

2.0 Strategy objectives

The Communications and Marketing Strategy will:

- Enable an engaged, informed and self-confident workforce
- Build and protect the Trust's reputation in the community as a provider of quality services that inspire confidence and pride

3.0 Strategy themes

This strategy describes the communications and marketing activities the Trust will use to deliver its corporate objectives. The themes are drawn from Vision 2020. They are:

- **Internal communications and engagement**
- **Enabling Vision 2020**
- **Building the Trust's reputation**
- **Supporting the recruitment, retention and recognition of staff**

The "business as usual" activities of the Communications and Marketing team will support these objectives. They include:

- Day-to-day staff, patient and visitor communications
- Media handling and Press office
- Supporting Trust resilience needs and activities
- Managing the Trust's digital and social media channels
- Ad hoc professional guidance and advice
- Partnership communications in the wider health and social care economy

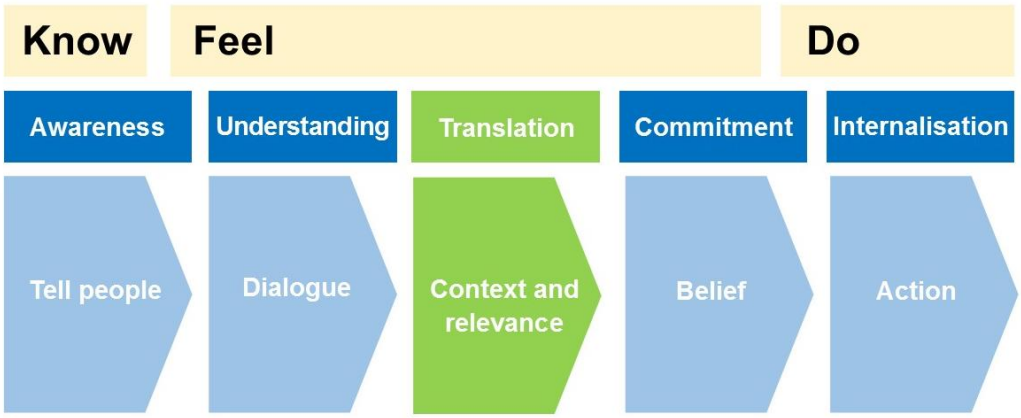
3.1 Internal communications and engagement

Communications is everybody's business. It is particularly managers' and team leaders' business.

The Trust has a variety of internal communications channels. Appendix 1 shows existing internal channels and those planned.

By making staff aware of issues and providing them with the opportunity to question and understand, effective communications gives context and relevance which, in

turn, translates into commitment and action. This applies as much to individual workplaces as it does to wider Trust objectives.



How good communication enables communications

It helps managers be good at their jobs too. US research showed managers benefit from upward and inbound flows of information from staff because it is more likely to contain novel, useful ideas or information. In addition, receiving this information motivates them to act on it for their own team's benefit.

There are five elements to the internal communications and engagement theme:

3.1.1 Research lower banded staff experience/needs/preferences

Anecdotally, staff and managers say there is too much emphasis on email. It is considered difficult to access because many frontline staff don't have the time to read emails or log on. Others, such as some staff working in Facilities roles, don't have regular access to computers.

The Communications Team is embarking on research to understand what kind of communication staff in these sometimes hard-to-reach roles see now, whether it's appropriate to their need and what other channels they would like to see.

From this research we will develop a benchmark to test changes to communications channels against.

Once established it could be used to research the attitudes and needs of other staff groups.

3.1.2 New and refreshed two-way communications channels

The reinvention of the monthly Senior Managers' Meeting in the spring as the Leadership Forum, widening access to all staff at Band 7 above and senior clinicians, has improved attendance and participation.

A Leaders' Briefing, starting in November, will be a weekly email to this staff group. It will replace Trust Brief which is backward-looking and often out of date by the time it comes to be used.

The briefing will provide information specifically for managers which they need to effectively deliver the Trust's objectives.

It will also include a key messages summary of the week's Trust News email newsletter(s). Running to no more than a single page, it will be available to print and share directly with local teams. This will be an additional channel to reach staff without regular access to email.

It will also help "declutter" Trust News, which goes to all staff, of information that is only relevant to managers

3.1.3 Senior manager visibility and engagement

The NHS annual Staff Survey tells us that staff feel disconnected from senior management. This is unsurprising given the instability of the senior team over the past three years.

To address this issue, a visibility plan has been developed to enhance the profile of the Executive Team.

3.1.4 Developing engagement via social media

Launched in April 2018, nearly 800 members of staff have joined The Meeting Place. It is a "closed group", approval for membership of which is by the Communications and Marketing team. Staff are encouraged to share their Trust-related news, events, stories and pictures.

It is an informal space that generates conversations and more personal engagement, and promotes the Trust as a team working together. Corporate messages are kept to a minimum. There is also the opportunity to run instant polls which, now the group has reached sufficient mass, will become a tool for instant feedback on issues of the day.

3.1.5 Induction and self-service

The Communications and Marketing team's "offer" will form part of the materials provided to new starters at Trust induction from 2019.

The Trust intranet now provides similar advice and information. This includes "self-service" tools and collateral to help develop communications capacity and capability within the Trust.

3.2 Enabling Vision 2020

Vision 2020 is the Trust's roadmap to how the Trust will become a successful and sustainable provider of healthcare for local people. The channels and mechanisms described in this strategy will support:

- Sefton Health and Social Care Partnership (HCP)
- Supporting the Quality Improvement Plan with the aim of receiving a Care Quality Commission (CQC rating of "good" overall with no "inadequates") and initiatives such as Red2Green
- Reducing avoidable mortality
- Supporting financial turn around

Sefton HCP has a separate communications and engagement group which the Trust Communications and Marketing Manager sits on.

A key part of its role is to coordinate engagement with stakeholders on the future shape of hospital services in Southport, Formby and West Lancashire. It will also:

- Build and maintain momentum by explaining how the work of the HCP and the transformation of health and care services will benefit the people of Sefton
- Build trust between the partners leading the integration of health and social care with the public
- Generate and gather evidence of communications and engagement activity

3.3 Building the Trust's reputation

We will continue to be opportunistic in putting the Trust forward where the work of the organisation and its staff can be showcased (e.g. such as when BBC Breakfast spent the morning in our kitchens last Christmas).

In the same spirit, the Communications and Marketing team will also continue to support bespoke campaigns and individual endeavours of staff (e.g. the publication of Dr Paula Briggs' book on the menopause in autumn 2018).

More people now get their news and information from digital and social channels rather than traditional print media. We must use these where they are appropriate.

While we need to be conscious that our patient base is more likely to favour traditional sources, these are in long-term decline and our communications and engagement needs to reflect the opportunities these channels offer.

Appendix 2 shows existing external channels and those which are planned.

This strategy focuses on three key elements to build the Trust's reputation:

3.3.1 Trust website

www.southportandormskirk.nhs.uk is the Trust's original website from 2003. Digital media has come a long way since then and social media as we know it almost entirely invented (Facebook was founded in 2004). Our website is looking distinctly long in the tooth.

The Trust agreed to invest in building a new site this year. It will be launched by 31 January 2019.

As well as being a modern, new-look digital shop window, it also opens the possibility of developing other digital platforms for Trust services at relatively low cost.

3.3.2 Key stakeholder communications

The Trust's engagement with GPs should be a key relationship given their role as gatekeepers to secondary care. Engagement has been erratic over the years. At a minimum a regular communication is needed informing them and their practice managers of Trust services and developments.

A GP newsletter will be launched in January 2019 and published every two months.

We will also publish a related newsletter every three months starting in December 2018 for distribution to all our local external stakeholders.

3.3.3 Charitable fund

The Trust is embarking on a relaunch and rebranding of its Charitable Fund. The Communications and Marketing team will support this work which also provides an opportunity to engage staff as well as with external organisations, such as potential sponsors.

4.0 Supporting the recruitment, retention and recognition of staff

4.1 Staff recruitment

Maintaining a sustainable workforce is a key risk for the Trust. This final theme of the strategy is to support the work of the Nursing Workforce Retention Group.

This will include develop a compelling “Trust story”, and supporting collateral, to attract potential recruits.

We will also use the new website and social media as recruitment tool. Initial low-cost targeted tests in autumn 2018 demonstrated the effectiveness of the reach and value of Facebook as a recruitment channel.

There will be also the opportunity to create a professional, more appealing, more dynamic “shop window” using for the Trust as a recruiter and employer.

4.2 Staff recognition

Embedded staff recognition activities have begun to be extended this year from the annual staff awards and dinner. Thanks A Bunch, a peer-recognition scheme, was introduced in September which had the dual role of allowing the Executive team, who present the twice-monthly award, to the winners.

- **Thanks A Bunch** will be opened up to nominations for entire wards, clinics or departments
- **Patient compliments awards.** We will ask patients, or their family, to make an award sourced by the Trust to staff they have complimented. These will be repeated monthly, creating a steady stream of positive staff-focused news for the regional press and our social media channels
- **Southport and Ormskirk Hospital Hero Award.** In the New Year, we will trial a two-month Southport and Ormskirk Hospital Hero Award via our social media channels and the local media. Nominated staff will be profiled on our Facebook page to encourage conversations and engagement. People will vote on the nominated staff members to pick a winner, who will receive an award and/or prize

Appendix 1

COMMUNICATIONS CHANNELS – INTERNAL

CHANNEL	FUNCTION	PURPOSE	FREQUENCY	METHOD
Trust News	Email newsletter of current news and information to all staff	Information	Weekly (Wed)	Email (MailChimp)
Trust News Extra	Ad hoc email newsletter to all staff	Information		Email (MailChimp)
Leaders' Brief	Timely, manager-specific communication previously in Trust Brief and Trust News	Information	Weekly (Mon) Trial Nov 2018 Launch Dec 2018	Email (MailChimp)
Trust News "Need to Know"	A key messages summary of the week's Trust News email newsletter(s) delivered with Leaders' Brief. Running to no more than a single page, available to print and share directly with local teams. This will be an additional channel to reach staff without regular access to email.	Information	Weekly (Mon) Trial Nov 2018 Launch Dec 2018	Email to managers with Leaders Brief for appropriate delivery to staff
Trust Brief	Corporate messages for delivery by managers at team meetings. Limited evidence of effectiveness. Backward looking and content often out of date by time delivered.	Information	Monthly. Withdrawn. Last edition Oct 2018	Email
Intranet	In-house digital portal for Trust news, departmental information, policies, guidelines, etc	Information	Daily	System log in

Chief Executive Blog (video option)	Circa fortnightly message from Chief Executive, or guest blogger, on topic of the moment. We will explore opportunity of videoing this message too from time to time.	Information	Twice monthly	Intranet
Screensavers	Carousel of mainly visual information triggered when desktop PCs lock. Opportunity to use splash screen on Medway system being investigated.	Information	Daily	PCs
Straight to Silas	Dedicated inbox (soh-tr.straighttosilas@nhs.net) for staff to raise issues in confidence with Chief Executive.	Engagement, information	Daily	Email
The Meeting Place	Facebook group open to staff for informal sharing of mostly work-related stories and information. Small corporate input. Launched March 2018, now >750 members and growing.	Engagement, recognition	Daily	Social media
Staff "town halls"	Staff events held at both hospital sites to raise awareness and engage with staff on issues of the moment. Led by Chief Executive/Executive team.	Information, engagement	Quarterly	Meeting
Time to Shine Awards	Staff nominated by their peers in awards presented at dinner event.	Recognition, engagement	Annual (Oct)	Event
Back to the Floor	Staff invite members of Executive team to walk in their shoes for day.	Engagement	Monthly from Nov 2018	Event

Thanks a Bunch	Staff mutual recognition scheme, recognising staff/teams who go extra mile. Plan to extend to teams.	Recognition, engagement	Monthly from Oct 2018	Event
Grapevine magazine	Trust magazine for staff and visitors.	Information, recognition, engagement, reputation	Annually x 3 (first edition Jan 2019)	Publication

Appendix 2

COMMUNICATIONS CHANNELS – EXTERNAL

CHANNEL	WHAT IS IT?	FUNCTION	FREQUENCY	METHOD
Trust website	Relaunched January 2019. See 3.31.	Information	Daily	Internet
Facebook pages	The Trust has three corporate Facebook pages (Southport hospital, Ormskirk hospital and Recruitment). A number of teams operate their own discrete pages (e.g. Maternity, Paediatric Diabetes). We plan to create a Southport and Ormskirk Hospital NHS Trust page as the principle page. The Ormskirk site page will remain but Recruitment will be absorbed into the main Trust page.	Engagement, information, reputation	Daily	Facebook
Twitter @SONHSTrust	Micro-blogging site. Channels for sharing and/or recognising achievements/activity/news. Popular for peer support among staff who use it.	Engagement, information, reputation	Daily	Twitter
Hospital Hero Award	See 4.2.	Engagement, recognition, reputation	Trial Q4	Social media, local media
Patient compliment awards	See 4.2.	Engagement, recognition, reputation	Monthly (start Dec 2018)	Social media, local media
Open Day	Opportunity for local community to meet staff and hear/see the work of the	Recognition, engagement,	Annual (Sept)	Event

	Trust. Alternates between hospital sites.	reputation		
Annual General Meeting and report	Overview of the Trust's year. Opportunity for members of the public to question Board members.	Reputation, engagement	Annual (Sept)	Event, document
Stakeholder Briefing	News and information about the Trust.	Information, reputation	Annually x 2	MailChimp
GP newsletter	Clinical news and information for GPs and practice managers.	Information, reputation	Annually x 6	TBC

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 December 2018

Agenda Item	TB288/18	Report Title	Risk Register
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Senior Information Analyst & Datix Lead Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

Since the last meeting, no new risks have been escalated onto this risk register.

There are currently 8 risks on the High Level Risk register. These are:

- **1688** - Inadequate Staffing Levels in Anaesthetic Department
- **1902** - Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC
- **1917** - Quality of Older Peoples Care
- **1901** - Cancellation of elective activity in theatres
- **1314** - Management of mental health pathways
- **1862** - Maintaining safe quality nursing care with current level of nursing & HCA vacancies
- **1367** - Failure to have a motivated and engaged workforce (culture)
- **1329** - Returning to financial balance by 2021: this risk will be closed and a new risk created in readiness for January Board

The Committee is asked to:

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

Recommendation:

The Board is asked to **receive** the monthly 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)*

This is a dynamic document and its structure and content may be updated as necessary.

Previously Presented at:

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

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
13/11/2017	1688	Chief Operating Officer	Mandy Marsh	Inadequate Staffing Levels in Anaesthetic Department				
Description	Staffing Levels of anaesthetic department affecting capacity and safety of emergency/ICU/Maternity cover. Lack of emergency cover for on call / ICU / maternity both sites. This would result in the closure of high risk patients presenting to A&E for both adult and children and the inability to staff ITU. Update - High level meetings with COO and the anaesthetic team to seek solution.							
Controls	Internal/external Locums anaesthetists to cover shortfall caused by vacancies People to work additional hours to fill extra sessions Elective lists cancelled to ensure cover when needed Change to on-call system to ensure full coverage; 1st on call onsite & 2nd on call supporting within core hours Interim support from staff pain management shortfall						**Gaps in Controls**	Availability of staff to cover vacant shifts at a minimum due to burn out/sickness/annual leave Lack of agency staff within capped rate 2.88 vacancies remain in service 1 consultant taken out of core theatre sessions to run pain activity; back filling those sessions with WLI's which has been approved to the end of the year by SS
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	03/11/2018	03/12/2018
Assurance	Monthly Planned Care governance meetings						**Gaps in Assurance**		
Action Plan	Reviewing job descriptions to be inline with national requirements. Continue to advertise to recruit to posts. Workforce strategy meetings set up with COO & MD in support to address. 1st meeting held on 06/11/18 with the next meeting scheduled for 29/11/18. Team are actively seeking solutions to address gaps in the workforce and looking at new ways of working to both the on call rota(s) and staffing establishment.						**Action Plan Due Date**	18/12/2017 31/12/2018	**Action Plan Rating**	Completed Little or No Progress Made

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
19/09/2018	1902	Director of Nursing & Quality	Paul Jebb	Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC				
Description	If we fail to comply with regulatory framework then this will result in breach of the Trust regulation and potential legal action, poor patient experience, unsafe and poor quality of care, and lack of public confidence in the Trust							
Controls	enhanced team to support DoN deliver expectations Improvement plans developed and agreed with trust Board Improvement groups developed across Trusts, including CBUs commitment to run a shadow CQC process over 12 weeks Identified Executive and management leads for Performance, quality, people and use of resources development of a shared drive to enable evidence to be uploaded development of awareness raising and preparation for key leaders at Board and CBU level identified support from PMO with project management						**Gaps in Controls**	CQC identified 97 MUST AND SHOULD DO actions following November and December 2017 inspection Lack of pace and assurance regarding progress of action plan
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	12	High Risk	19/11/2018	31/12/2018
Assurance	committee structure regular engagement meetings assurance at quality and safety & committee CBU monthly governance meetings development of a single quality improvement action plan engage and gain support for validation from HealthWatch, CCG and other regulators						**Gaps in Assurance**	Engagement of key leaders from 'ward to board' reduced understanding of expectations of regulator prior, during and after inspections
Action Plan	work with communications team to engage widely with staff develop training for staff across the organisation Key leaders to access training with lead CQC executive/manager To deliver against the 97 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.						**Action Plan Due Date**	31/12/2018 30/11/2018 01/03/2019	**Action Plan Rating**	Little or No Progress Made Little or No Progress Made Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety							Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**						
19/10/2018	1917	Director of Nursing & Quality	Megan Langley	Quality of Older Peoples Care						
Description	If the limited care of Older People in Southport & Ormskirk NHS Trust continues then harm may be caused to our older patients. The areas of concern relate to specific practices: •Deconditioning of patients •Poor falls assessment and management of bed rails •Poor mouth care •Poor nutrition & hydration management •Poor continence management •Lack of interaction and social/cognitive stimulation increasing confusion and delirium •Limited availability of Geriatricians to provide holistic comprehensive assessment and advanced care management plans for patients •Inability to discharge patients home due to lack of resource to support at home									
Controls	Commenced education and roll out of Red2Green Board Rounds to value and consider patients time Falls assessment in nursing notes Care plans and policies in place. Additional care needs bay on one ward.						**Gaps in Controls**	Care plans not always used appropriately and not all care plans are appropriate Red2Green Board Round not fully rolled out. Work Currently underway to review falls documentation Inability to consistently staff additional care bay Training for staff re: older people risks not currently provided Environment not conducive to reabling patients and maintaining function, social interaction or orientation Environment not wholly adapted for additional/enhanced care needs e.g. dementia Lack of understanding of the impact of patients remaining in bed, in pads, with cot sides, not eating/drinking Lack of pathway/service availability to support patients with enhanced needs returning home- i.e lack of 24hour care in community to step down		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	22/10/2018	30/11/2018	
Assurance	CQC Review planned for March 2019.						**Gaps in Assurance**	Need to develop internal assurance of improved quality around all domains listed in the hazard. Need to develop action plan and RAG rate, identify projects and leads for the improvements which have been identified. Need to commence audits of older people incidents, harm, impact of admission, causes of 'red days' and delays between being fit to leave and leaving hospital.		
Action Plan	Develop a nutrition, hydration and mouth care quality improvement group to deliver identified changes to practice and therefore improve patient/relative/carer experience and outcomes. To improve education, understanding and therefore change practices of those working with patients to manage continence appropriately, identifying when a patient may need support, maintaining the ability of patients to go to the toilet, using catheters and pads which are individually identified as a need for a patient and demonstrating better awareness of patients displaying the need to go to the toilet particularly in areas requiring enhanced care. Business case to be developed to enhance the provision of the geriatrician service at S&O. Patients with						**Action Plan Due Date**	01/01/2019 01/01/2019 01/01/2019 01/01/2019 01/01/2019 31/12/2018	**Action Plan Rating**	Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made

	such high frailty factors must have appropriate care and advanced care management plans with sensitive, individual conversations in order to support the individuals and families with delivering the patients wishes and best quality end of life care possible. Review of wards to take place to establish how to maximise potential of the areas we have to provide better environments for patients particularly with enhanced needs. Particularly looking at signs, colour of objects, orientation devices, tables/chairs to encourage interaction, stimulating activities, getting up dressed and moving. Develop and work up discharge pathways group to rid of unnecessary delays which cause harm to patients who remain in the acute setting. Continue to roll out Red2Green and education across all wards				Moderate Progress Made Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
18/09/2018	1901	Chief Operating Officer	Helen Hurst	Cancellation of elective activity in theatres				
Description	Due to high levels of vacancies and sickness within theatre team at both Southport and Ormskirk sites, elective theatre sessions are being cancelled. This is having both long and short term effects on moral within the team, productivity, efficiency, expenditure and income generation							
Controls	Use of Bank & agency staff short and long term Ask permanent staff if able to do overtime Theatre co-ordinator to go into theatres when to cover short notice shortfalls Clinical manager co-ordinate the theatres Ensuring appropriate skill mix of workforce Continue with extensive recruitment drive Rates of pay agreed with NHSP Daily review of rotas to ensure safety maintained Review to be undertaken to ensure correct workforce establishment						**Gaps in Controls**	Discussion with operational managers to ensure joint decision on moving lists Clinical urgency is reviewed for each patient to ensure correct patients are cancelled with minimal impact to outcomes
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Almost Certain (5)	Moderate (3)	20	15	Extreme risk	6	Moderate risk	20/11/2018	20/12/2018
Assurance	Theatre scheduling group kept informed at weekly meeting. Discussed at CBU meetings Discussed at Theatre Programme Steering Group Planned Care PRB						**Gaps in Assurance**		
Action Plan	Nurse Staffing Establishment Review across the Trust. 2019 To deliver against recovery plan for Theatre recruitment and retention Implementation of the GIRFT/Elective Care project						**Action Plan Due Date**	29/03/2019 31/10/2019 30/04/2019	**Action Plan Rating** Moderate Progress Made Little or No Progress Made Little or No Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services						Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
11/04/2016	1314	Chief Operating Officer	Jane Lawson	Management of mental health pathways					
Description	patients who are admitted with mental health problems are not transferred out of SOHT to a mental health bed timely due to lack of beds. Patients are therefore not in an environment. All patients on a under mental health act section should be risk assessed to ensure any potential of further deterioration of their condition is mitigated and a full assessment is carried out. The delay in transfer then impacts on staff and potentially other patients								
Controls	Full Risk Assessment required to understand the individual needs of the patient and the environment Risk Assessment to be reviewed on a define time (hourly), i.e. changing patient's condition, change in environment, change of patient's location Ensure Mersey Care/ Lancs Care are continually informed, escalate to Mersey Care management, escalate to Trust management and those patients on Section 136, ensure Police support remains in place SLA in place with Mersey Care / Lancs Care Staff attending Conflict Resolution Training CEO support and confirmed that all patients should stay in AED and not transferred to general ward or observation ward 24 hour security presence in SDGH - available to AED if required communication and training LCFT engagement Shared 136 protocol police liaison shared learning to be carried out with Mersey Care re: patient observation (awaiting publication of ECIST metal health deep dive) Full system engagement involving Mersey Care & Lancs Care both CCG, acute trust (regular meeting carried out) news ops manager based onsite for Mersey Care						**Gaps in Controls**	Mersey Care staff not present in the department 24hours 7days a week No RMN's employed within the current Trust nursing establishment Staffing levels can prove challenging Limited availability of AMP to carry out assessments which often leads to delay	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	12	16	Extreme risk	8	High Risk	19/11/2018	19/12/2018
Assurance	Escalation to Commissioners of current shortfalls in mental health beds and delays experienced in A&E Emergency Care Improvement Support Team (ECIS) undertaking full review of mental health pathway Nov 2018 Conflict Resolution training figures Timely Datix Incident Reporting for any incidents						**Gaps in Assurance**		
Action Plan	Establish office space to accommodate merseycare on site Documentation audits are to be scheduled to identify deficits in record keeping Emergency Care Improvement Support Team (ECIS) undertaking full review of mental health pathway Nov 2018						**Action Plan Due Date**	29/01/2018 02/04/2018 23/11/2018	**Action Plan Rating** Completed Completed Little or No Progress Made

Strategic Objective	SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services						Link to BAF	SO2
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
20/06/2018	1862	Director of Nursing & Quality	Carol Fowler	Maintaining safe quality nursing care with current level of nursing & HCA vacancies				
Description	If levels of Nurse & HCA staffing remains below funded establishment due to vacancies then patients may experience poor quality of care (safety & patient experience).							
Controls	Safe Care monitored daily Daily staffing huddles with Matrons & Senior nurse Review Health roster Policy & compliance NHSP contract Continued review of nursing establishments Staffing data reviews See risks 1132 , 278 and high risk 1368 Datix system to identify if there has been a harm of patients due to staffing levels						**Gaps in Controls**	No formal Safety Huddle at w/ends Established budgets in some clinical areas do not meet the clinical needs of the patient group Establishment review not undertaken on a 6 monthly basis with recommendations to the TB Datix system to identify if there has been a harm of patients due to staffing levels in accordance with NICE 'red' flags NHSP contract for review in 6 months T&F group for Retention with a focus on Recruitment, supported by NHSI Workforce Plan to be developed following Establishment review See risks 1132, 278 and high risk 1368.
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	19/11/2018	17/12/2018
Assurance	Workforce data (sickness & AL) Dedicated H roster Lead for N&M CQC inspection Monthly staffing report mandatory training Complaints Incident reporting Quality and safety reports Bi annual staffing reports						**Gaps in Assurance**	Establishment Review Process not consistent Workforce Plan (including retention & Recruitment) Updated E roster policy Matrons dashboard/Clinical metrics needs to be developed Mandatory training not being at Trust required standard Managing Performance Framework process	
Action Plan	Senior nursing staff deployed to identified areas to review current nursing practice and care delivery. Deployment of senior staff to wards identified. Quality improvement approach of the themes to address actions form CQC inspection, complaints and incidents						**Action Plan Due Date**	29/06/2018 31/01/2019 29/03/2019	**Action Plan Rating**	Moderate Progress Made Actions Almost Completed Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF	BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).				
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, high turnover.							
Controls	Leadership Master Classes Annual Shine Awards Workforce Strategy and OD Plan Junior Doctors Survey Friends and Family Test Valuing our People Working Group New post created for support of records system, recruitment process is ongoing. Staff Survey Action Plan						**Gaps in Controls**	lack of OD resource within organisation
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	15/10/2018	31/12/2018
Assurance	Quarterly HRD report to Trust Board Result of Staff Attitude Survey Coaching in the workplace Values based recruitment based on guidance from NHS England PDR Process which includes Trust values Charter for Staff and Managers Review of culture in the Trust completed Progress against action plans for FFT, Staff Survey and Retention						**Gaps in Assurance**	Nil Identified	
Action Plan	Cultural Review as commissioned by the Board						**Action Plan Due Date**	02/02/2018	**Action Plan Rating**	Completed

Strategic Objective		SO3 - Provide care within agreed financial limit					Link to BAF	BAF007
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
10/05/2016	1329	Director of Finance	Steve Shanahan	Returning to financial balance by 2021				
Description	If we do not have a plan to return to financial balance by 2021, then potentially the organisation will not exist in it's current form.							
Controls	Long term financial model and an estate solution based on the sustainability report completed by the Deloitte in 2015. The Care for You programme built on the Deloitte findings. This has now been supported by the Northern England Clinical Senate report. Trust is part of the Cheshire & Mersey Health & Social Care Partnership (STP); the Sefton Transformation Board provides oversight of the Care for You Programme Building on the modelling done by KPMG (funded by STP) the Trust has commissioned MBI group to develop costed clinical options based on Northern Clinical Senate report in more detail						**Gaps in Controls**	The need to model the STP/LDS assumption in LTFM Accuracy of PLICS data and Model Hospital West Lancashire CCG member of Healthier Lancashire & South Cumbria (STP)
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	6	Moderate risk	17/09/2018	17/10/2018
Assurance	Monthly report to Trust Board re Progress of the Sefton Transformation Board Long Term Financial Model (LTFM)						**Gaps in Assurance**	No agreed clinical model for reconfiguration of services	
Action Plan	Development of Estate plan for reconfiguration of services; identification of land sales to support capital development costs Development of a financial revenue plan with savings for the reconfiguration of services. KPMG to produce 'Case for Change' by 20/07/2018. Submission of Trust 2 year operational plans by 23/12/16. Submission of STP plan.						**Action Plan Due Date**	07/01/2019 23/12/2016 16/10/2016	**Action Plan Rating** Moderate Progress Made Completed Completed

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group	Finance, Performance & Investment Committee
Meeting date:	26 November 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)

- both agency expenditure and the number of substantive staff in the Trust have risen. These increased costs together with the likelihood of penalties and sanctions from CCGs are putting significant pressure on the Trust's financial position.
- recent discussions facilitated by the regulators suggest that the local health economy is collectively £9.4m over its planned outturn
- the Trust's internal Winter Plan has been finalised. However, it is anticipated that the economy wide plans may leave a 15-bed gap that CCGs plan to address by spot purchasing beds.

ADVISE

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

- Committee members expressed disappointment at the late despatch of papers and the size of the Committee pack, both of which were felt to impact on the effectiveness of the group
- there is a continuing reluctance to engage in meaningful discussions on the Cost Improvement Programme
- little progress on refining the Service Level Reporting information. Discussions are taking place regarding options for improving the situation.

ASSURE

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

- budget setting principles for 2019/20 have been agreed and the process is underway
- performance on the 4-hour target is much improved but remains challenging
- the additional space for handling ambulance arrivals has opened and there are positive early signs that the handover arrangements have improved
- the Committee was encouraged by the joined-up nature of the discussion on integrated performance information, emergency care performance, the external review of deaths and measures to improve the average length of stay. Hopefully this will be reflected in service and quality improvements over coming months.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

Alert, Advise, Assure (AAA) Highlight Report

COMMITTEE/GROUP:	**Quality & Safety Committee**
MEETING DATE:	**26th November 2018**
LEAD:	**Mrs Julie Gorry**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Despite the significant work programme, there are ongoing concerns with progress in reducing avoidable mortality, including issues highlighted in the recently received confidential external review of learning from deaths. An action plan based around the recommendations of the external review has been developed and is in the process of implementation.
- The response rate on the Friends & Family Test has decreased from an already low base. The Committee recommended that consideration be given to ways of improving the situation.
-

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)

- A report on Fractured Neck of Femur Treatment highlighted a need for immediate action to ensure patients receive treatment within 36 hours and the development of an ortho-geriatric service that will improve post-operative care. The Committee supported the latter but asked that a business case be submitted for consideration.
- The Trust now has an active Falls Group and one of their initial tasks will be to roll out lessons learnt from incident reports.
- The Trust is working with AQUA to hold a week-long quality summit in late January/early February 2019 The event will enable the Trust to showcase best practice tools and share some of the recent quality improvements implemented within the organisation
- whilst serious incidents are being managed more effectively, there are still problems in ensuring that relevant actions are completed in a timely manner.
- Application of the Structured Judgement Review approach is becoming embedded in the Trust. However, the full benefits of the system will only be fully realised when clinicians have had more time to familiarise themselves with the system and they have more accrued data to assist in reaching conclusions.
- A problem with compliance had been identified and assurance was given that remedial actions have taken place; response letters have been sent out to families and patients where Duty of Candour was applicable. It is important that we are complaint with this regulation and plans are in place to address this and raise awareness of Duty of Candour.
- The Acute Kidney Injury (AKI) Pathway has now been rolled out.
- The Pneumonia Pathway was approved by the Clinical Effectiveness Committee at their meeting on 21st November 2018.

ASSURE

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

- The recent gaps in capacity within the Speech & Language Therapy, (SALT), Team as a result of sickness and vacancies have been resolved and all temporarily suspended services will be restored in the near future. In addition, funding has been received to appoint a Consultant SALT on a 2-year contract, which will enable some enhanced services to be provided.
- The diagnostic delays reported in recent STEIS reports will be reviewed at the

Committee's next meeting • The Tissue Viability Team has recently increased in number from 1 to 3 , which should improve the management of pressure ulcers within the Trust • In respect of clinical pathways, it was reported that the Acute Kidney Injury pathway has been updated and, following agreement by the Clinical Effectiveness Group, the pneumonia pathway will be rolled out in the near future.	
New Risk identified at the meeting	• In view of the continuing high SHMI/HSMR figures together with the contents of the external review referred to earlier, the Committee felt that consideration should be given to including a risk covering the need to minimise avoidable mortality.
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	**Workforce Committee Meeting**
Meeting date:	**22 November 2018**
Lead:	**Pauline Gibson**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Sickness Absence

This has risen again and the rise is across the Trust (not any specific CBU). There is some focussed work being done to support the high level of anxiety with the health and well-being programme. Execs are looking at a proactive, holistic approach to tackling root cause (e.g. bullying & harassment, staffing etc) and will bring a comprehensive plan to WFC in January 19.

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)

WFC

Terms of Reference (TOR) are being reviewed in an additional session to be run in January 19. This has been rescheduled at the request of the Chair.

Medical Education

Whilst this remains an extreme risk there has been significant progress made and the committee have recognised this. The original action plan has now been closed and we could be described as 'on an even keel'. Effort and further action is the focus.

Pulse Check & Friends and Family

Whilst the completion numbers are low and this requires action to improve, it is recognised that there is a significant improvement in motivation levels and how supported people feel. There is work to be done on how involved people feel in decision making in the Trust. It is important to reiterate that the sample size is low however the improvements from those who have completed are an early indication of positive movement.

Safe Staffing

Some positive news and ongoing challenges. New guidance on safe staffing was issued by NHSI in October and a gap analysis is underway. 93.25% is an improvement against September 91.99% (national average 90%), however this is still a risk. Daily safe staffing huddles are continuing and we have more clarity on erroneous data sets which need cleansing. Finance are supporting this.

ASSURE

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

CQC

Pro-active preparation is underway so we are more prepared for our CQC

inspection. **Apprenticeships** A good news story! Our apprenticeship levy fund is protected and we are meeting our public sector targets. We are being asked to share our good work as best practice. Well done to all involved.

New Risk identified at the meeting	None

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