NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10.50 – 13.15 on Wednesday 9 January 2019
Seminar Room, Clinical Education Centre, Southport

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
TB001/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**10.50**
TB002/19 (D)	**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**		
TB003/19 (D)	**Minutes of the Meeting held on 5 December 2018** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB004/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB005/19 (P)	**Patient/Staff Story: Waiting Times-In/Out Patient Areas** To **receive** the presentation and **note** lessons learnt	**Michelle Kitson**	**15**	**11.00**
STRATEGIC CONTEXT				
TB006/19 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**10**	**11.15**
QUALITY & SAFETY				
TB007/19 (D)	**Quality Improvement Plan Progress Report** To **receive** the monthly report	**DoN**	**10**	**11.25**
TB008/19 (D)	**Monthly Mortality Report** To **receive** the monthly report	**MD**	**10**	**11.35**

TB009/19 (D)	**Monthly Safe Nursing & Midwifery Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**10**	**11.45**
TB010/19 (D)	**Guardian of Safe Working** To **receive** the quarterly report	**Dr Ruth Chapman**	**10**	**11.55**
PERFORMANCE				
TB011/19 (D)	**Integrated Performance Report –Introduction followed by presentaions from:** ***a. Quality Indicators*** ***b. Operational Indicators*** ***c. Financial Indicators*** ***d. Workforce Indicators*** To **receive** the monthly report.	**DoF** **DoN/MD** **COO** **DoF** **DoHR**	**20**	**12.05**
TB012/19 (D)	**Director of Finance Report** To **receive** the current financial position at Month 8 and progress on Internal Sustainability.	**DoF**	**10**	**12.25**
GOVERNANCE/WELL LED				
TB013/19 (D)	**Risk Management:** **Board Assurance Framework –Introduction followed by presentations from:** **a. Risk 1-** ***Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*** **b. Risk 2-** ***Poor clinical outcomes and safety records*** **c.** ***Risk 3-*** ***Failure to live within resources leading to increasingly difficult choices for commissioners*** **d. Risk 4-** ***Failure to meet key performance targets leading to loss of services*** **e. Risk 5-** ***Failure to attract and retain staff*** **f. Risk 6-** ***Inability to provide direction and leadership*** **Risk Register:** To **receive** the monthly report on the Corporate Risk Register	**CoSec** **DoS** **DoN** **DoF** **COO** **DoHR** **DoHR** **DoN** ***(With input from other Directors)***	**15**	**12.35**
TB014/19 (D)	**Annual Report, Annual Accounts and Quality Accounts 2018/19** To **receive** outline of timeframe and key responsibilities in preparation and submission of end of year documents	**CoSec**	**5**	**12.50**
TB015/19 (D)	**The 2017/18 Charitable Funds Accounts** To **approve** the accounts	**DoF**	**5**	**12.55**
TB016/18	**Items for approval/ratification** • To **ratify** the decision taken under Emergency Powers Section 4.3 of the Standing Orders on 19 December 2018 to **approve** application for	**CoSec**	**5**	**13.00**

	an Uncommitted Revenue Support Loan for January 2019			
TB017/19 (V)	**Questions from Members of the Public**	**Public**	**5**	**13.05**
TB018/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**5**	**13.10**
TB019/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**		
TB0120/19 (V)	**Date and time of next meeting** **Wednesday 6 February 2019, 09.00am** Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**	**5**	**13.15** **CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

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Register of Interests Declared by the Board of Directors 2018/19 AS AT 3 December 2018

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 July 2017** **Updated 25 September 2017**
BRICKNELL, Dr David	Non-Executive Director	**Pilkington Family Trust** **St Joseph's Hospice** **The World of Glass** **Pilkington Glass Collection**	**Nil**	**Nil**	**Director, St Joseph's Hospice** **Director, Pilkington Family Trust**	**Director, St Joseph's Hospice**	**Nil**	**Nil**	**Nil**	**9 April 2018**
CHRISTIAN, Mr Steven	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**28 June 2018**
CLARKE, Mr Ged	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Kinsella Clarke Chartered Accountants. A number of Trust's Medical Consultants are clients.**	**1 May 2016**

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COSGROVE Ms Juliette	Director of Nursing, Midwifery & Therapies	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 May 2018**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director, Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GORRY, Mrs Julie	Non-Executive Director	**Catalyst Choices C.I.C.**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**2 August 2017** **Updated 14 March 2018 & 4 May 2018**
MAHAJAN Dr Jugnu	Interim Medical Director	**Nil**	**Director of M&M Professional Consultancy Services**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**22 January 2018**

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MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB** **NDLM Ltd**	**CQC Holdings Ltd** (manufacturer of textile products) **WYG Plc**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**3 December 2018**
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 April 2018**
PATTEN, Ms Therese	Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Director of Human Resources	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**30 May 2017** **Updated 25 September 2017**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother, Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust.**	**Nil**	**Nil**	**Nil**	**25th January 2018**

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SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**	**Nil**	**9 April 2018**

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 5 December 2018

Family Life Centre, Southport, PR8 6JH
(Subject to the approval of the Board on 9 January 2019)

Members Present

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

In Attendance

Steve Christian, Chief Operating Officer
Jane Royds, Director of Human Resources
Audley Charles, Company Secretary
Caroline Griffiths, NHS Improvement
Jitka Roberts, Turnaround Director
Samantha Scholes, Interim PA to the Company Secretary

Observing

Neil Masom, Chair Elect
Deborah Lindley, Care Quality Commission (CQC)

Apologies:

Pauline Gibson, NED Designate

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB276/18	**Chairman's Welcome and Note of Apologies**	
	Mr Birrell as Chair of the meeting, opened by welcoming Board members and members of the public. He welcomed Ms Lindley from CQC and Mr Neil Masom as the Chair Elect who would be observing the Board and invited him to introduce himself.	

	Mr Masom thanked Mr Birrell and commented that he had now met or spoken with each member of the Board. He had been a Non-Executive Director for a health Trust and also a Council, however, his background related to aerospace, defence and security, all of which had complex regulatory frameworks. Quality and safety in those sectors were fundamental, which was parallel to the work the NHS undertakes. In addition, the significant financial challenges British Aerospace faced were similar to those of the NHS. Mr Masom had been light heartedly asked if he was looking to 'weaponise' the NHS, given his background, and whilst that was not his aim, he would look to bring good commercial practice and an external perspective to the organisation. He was looking forward to working with the Board. The Chair observed that the meeting was Dr Mahajan's final one as she would be leaving at the end of December and formally thanked her for her hard work and commitment. She had moved the in-patient agenda forward amongst other achievements and that would be built upon by her successor. He wished Dr Mahajan well and that she would have the same positive impact in her next organisation Apologies were received from Mrs Gibson.	
TB277/18	**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 or additions made to the Register.	
TB278/18	**Minutes of the Meeting Held On 7 November 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 7 November 2018. Amendments made included: **Board Attendance** Mr Fraser to be marked as absent for the November Board. **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendments.	
TB279/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn:	

	TB256/18 Quality Improvement Plan Progress Update: the BRAG status reported to Board to be defined and consistent and the Standard Operating Procedure to be updated accordingly.	**CoSec**
STRATEGIC CONTEXT		
TB280/18	**Chief Executive's Report**	
	Mr Nicholls presented the report and welcomed Mr Masom as Chair Elect. **Red2Green** The Red2Green programme focused on preventing "red days" for patients; those were days when blockages and obstacles stop a patient moving closer to going home. In that way as many days as possible became "green days". Those teams which had embraced the concept had seen very promising results. The entire executive team was sponsoring the roll out of Red2Green across the Trust and the intention was for it to be fully operational by the New Year. **Allegations of Bullying in the Trust** The allegations of bullying at the Trust published in the Liverpool Echo last month was concerning. Since becoming Chief Executive, both he and the Executive Team had made it clear they took accusations of bullying and harassment extremely seriously. It would not be tolerated, and they would do what it took to address it and change the culture. Mr Nicholls was very sorry that the individuals who had spoken to the Echo did not feel confident to raise their concerns with the Trust. He urged them publicly to come forward either directly or in confidence to the Trust's confidential Freedom to Speak Up Guardian, Martin Abrams. Their concerns, and those of any other colleagues who felt the need to speak up, would be fully investigated and appropriate action taken where necessary. Letters outlining those principles had been sent to each member of staff with their payslips in November. The Trust was also working with junior doctors and staff representatives to improve the reporting of any behaviours that ran counter to the Trust's values. Mrs Royds would be looking further into those issues and it was expected that more noise would be generated as people felt	

	assured that they would be listened to, which would be welcomed. The Chair added that the Board was fully supportive of that initiative and Mr Singh further commented that bullying was not part of the Trust's vision and values. Mrs Gorry suggested that a response to the Liverpool Echo story be made and Mrs Royds replied that two journalists had been invited to receive the response of the Trust. ***It was agreed that a response should be published on the Trust's website.*** **RESOLVED:** The Board **received** the report.	**DoS/DoN**
QUALITY & SAFETY		
TB281/18	**Quality Improvement Plan**	
	Ms Cosgrove presented the report which provided an update on the development of the Quality Improvement Action Plan and progress made in relation to actions and recommendations 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 outlined the Trust's preparation plan for future regulatory visits and a programme of work up to March 2019. **Emergency Department (ED)** 17 actions had moved to Green (Action completed) with seven 'On track to deliver', one action was completed and no actions were identified as 'No progress/Not Progressing to Plan'. Areas which had improved were: • Medicines management • Caring for patients nursed in corridor • Privacy and dignity • Access and flow • Infection prevention control In the week commencing 10 December a Core Service Inspection (Mock Inspection) would take place facilitated by NHS Improvement and an independent Chair, identified as Dr Vince Connolly, North Regional Medical Director, NHSI. **CQC NATIONAL UPDATE** The report showed that most people were still receiving good care - when they could access it. Overall good quality had been maintained, but there were still significant workforce pressures as	

	all sectors struggled to recruit and retain staff. The CQC found that people's experiences of care often depended on how well local systems work together where they lived. Some people could easily access good care, while others could not get the support they needed. They might experience disjointed care, or only had access to providers with poor services. The Chair commented that there was some comfort that the challenges the Trust faced were not unique. Mrs Gorry stated that the number of actions which had moved to Green was encouraging. An Assurance Panel would review if that test of strength would assure an expected delivery of March 2019. Ms Cosgrove responded that the test would be clear evidence of practice. Some, but not all, would be delivered by the end of March 2019. For those which would not, the risks would be examined. Collectively there was value in the evidence for assurance and working with staff to build evidence as business as usual. The Chair added that the range of progress was significant and evidence of heading in the right direction was clear. Ms Cosgrove replied that her focus was on Vision 2020 when CQC could rate the Trust as *'good'* and until that was realised, she would remain cautious as to the level of evidence of the actions undertaken and would continue to drive it. Mr Singh commented that Ms Cosgrove and her team were taking all the right steps with the right structure to make a difference. They should not sell themselves short. As a Non-Executive he was reassured that all the right decisions were being taken and that time would evidence the improvement. Ms Cosgrove added that in addition to the mock inspection, there would also be a Quality Summit at the end of January 2019 which would evidence improvements achieved and identify any gaps. Mr Christian commented that the Trust's Business Plan needed reinforcement by socialising the continual improvement process, to enable a connected, compelling narrative. The Chair added that the move to hold a Quality Summit was positive and indicative of the progress made and would be great publicity for the Trust. **RESOLVED:** The Board **received** the monthly report.	

TB282/18	**Quality Summit Proposal**	
	Ms Patten presented the report. It was proposed that there be 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 & Lessons Learnt Day – including departments showcasing their work in their own areas including audit, risk, complaints, FTSU • Day 4 – FAB (Academy of Fabulous Stuff) 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. **RESOLVED** The Board **received** the proposal.	
TB283/18	**Monthly Mortality Report**	
	Dr Mahajan presented the monthly report. An overview of the new Structured Judgement Review (SJR) method was given along with the headlines from the External Mortality Review. Learning from Deaths data for Quarter 1 (April to June 2018) was 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. **Structured Judgement Review (SJR)** Levels of screening tool use had been lower than anticipated, due to the roll-out of training on its use. **Summary Hospital-level Mortality Indicator (SHMI)**	

	A reduction was expected to be evidenced for the next quarter **Crude Mortality** A reduction in the last 12-18 months had been seen. Ms Cosgrove stated that the Red2Green initiative had seen fast track discharges for those patients with an Advanced Care Plan, whose preferred place of death was not in hospital, reducing from two to three weeks to one week, which had also resulted in improved reporting. Mr Clarke questioned why 45 deaths were defined as unknown, to which Dr Mahajan replied that she would check the criteria but it was potentially due to the deaths not fitting into other defined categories. The Chair stated that it was agreed at the Quality & Safety Committee that ***the report would be refined and Dr Mahajan commented that the next Board report will follow a different format.*** **RESOLVED:** The Board **received** the monthly report.	**MD**
TB284/18	**Monthly Safe Nurse & Midwifery Staffing Report**	
	Ms Cosgrove presented the report. The Board was advised that the current nurse staffing risk reported as extreme (Major -4 x Likely – 4 RR =16) via the risk register (ID 1862). For the month of October 2018, the Trust reported safe staffing against the national average (90%) at 93.25%. Within the report there was an update on the gap analysis undertaken of the Trust compliance with National Institute Care Excellence (NICE, 2014) and National Quality Board (NQB, 2018). Overall fill rate for October 2018 was 93.25% compared to September 2018 that was 91.99%, compared to 89.97% in August . • 87.51% Registered Nurses on days • 97.65% Registered Nurses on nights • 92.11% Care staff on days • 103.64% Care staff on nights **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

Ms Cosgrove was pleased to report that registered nurse staffing had improved. Improvements had also been seen due to the flexible workforce and a greater interest in the Trust by potential staff.

The Chair noted that staffing was at its highest level for 18 months which was commendable. It was also noted that planned budget levels for agency staff were being achieved.

Ms Cosgrove added that a flexible Bank opportunity was being considered which would reduce levels of agency spend further.

The Chair commented that the experience of the winter of 2017/18 should not recur with the Trust being bullied into opening extra wards, without appropriate staffing. Mr Nicholls responded that the regulators and commissioners were clear that no unsafe beds or wards would be opened.

Mrs Gorry asked if contingency plans for staffing had been considered and enquired if beds be closed if necessary. Mr Nicholls replied that daily staffing huddles were taking place and the clinical/operational decision will be managed as and when they occurred.

Mr Christian added that a Command and Control arrangement had been put in place with Gold, Silver and Bronze commanders to manage Winter and re-deploy staff where needed. In addition Urgent Care Outpatient clinics could be cancelled, releasing senior consultants onto wards.

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

PERFORMANCE

TB285/18 **Integrated Performance Report (IPR)**

Mr Shanahan introduced the report, details of which were in the Board pack. Each Director Lead followed giving brief summaries relating to their areas of responsibility.

The report highlighted indicators which required discussion by Trust

Board. Some of these indicators required corrective action to be taken. A brief narrative was provided in order to provide assurance that corrective measures were in place.

Mr Shanahan stated that the report had been further revised, with updated dashboard, Key Performance Indicators (KPIs) and graphs and the removal of actions, which were now addressed by the appropriate sub-committees. The report had also been shared with the Southport and Ormskirk Improvement Board (SOIB). The Chair commented that he was satisfied with the information supplied in the report.

Quality Indicators

Dr Mahajan congratulated the Infection Control Team and staff on the fact that the Trust had been meticillin-resistant Staphylococcus aureus (MRSA) free for 12 months. Fractured Neck of Femur was of concern and the mortality rate in relation to that was high. The Quality & Safety Committee (Q&S) had developed and agreed an action plan and pathway redesign which was underway as part of the Length of Stay improvements and Get It Right First Time (GIRFT) work, looking at speciality pathways to enable a strong non-elective pathway. Ms Patten added that GIRFT would be culminated with consultation in January 2019.

Ms Cosgrove commented that the numbers of complaints had reduced and Clinical Business Units (CBUs) had assured that the backlog was being worked through with appropriate prioritisation. Patient Falls performance remained higher than the Trust's target. The monthly falls report would be produced to break down falls per 100 bed days and per CBU this would be circulated via Q&S and the Mortality Review. Stephen Cooper, Head of Nursing, Urgent Care)and Meg Langley, Head of Older Peoples Care & Directorate Manager for Urgent Care (Cardiology, Haematology, Oncology, MDU and Frailty) were examining the work to understand what was required to improve it. Patient Safety Incidents were a new Key Performance Indicators (KPI), with the data showing a higher than normal variation, although similar to the previous three months. Themes were being identified and daily incident meetings were taking place. Duty of Candour was evident with apologies and letters and in some instances face to face with families.

Operational Indicators

Mr Christian noted that Performance in October 2018 had been 88.4% and had risen to 89.4% in November 2018, which was an 8.7% improvement against the same period in 2017. He was pleased to report that the Trust was currently ranked second of

eleven Trusts in Cheshire & Merseyside which was a significant improvement from ninth to eleven for the same month in 2017 which was good to recognise. The trajectory for December 2018 was the same as it had been for November 2018. Ambulance turnaround had seen equally significant improvement, from 278 waiting for over an hour in November 2017, to 30 in November 2018. That had been achieved with improved teamwork and standard operating practices.

Length of Stay (LoS) had improved in the last six months and reflected best performance for any September and October in the past four years. A weekly 'system-wide' long LoS review huddle aimed at system partners attending inpatient wards to help inpatient Multi-Disciplinary Teams (MDTs) reduce stranded patients and agree clear actions had been established. That would result in the Chief Operating Officer having a weekly position on the top 10 long LoS patients with clear actions agreed from each part of the system, which also demonstrated rigour.

Workforce was a significant issue to which staff members were responding positively. Every effort was being made to maintain a good run rate, however, that remained a fragile position in light of potential winter pressures.

Risks relating to diagnostics and endoscopy remained with action plans in place to work with the CBUs to address.

Mr Christian was pleased to inform the Board that the Trust was in the upper quartile of the performance tables for 18-week Referral To Treatment (RTT).

Mr Shanahan observed that agency costs had risen for the fourth month which equated to 7.05% of the pay bill. NHS Professionals (NHSP) was focusing on ensuring framework rates were adhered to.

Workforce Indicators

Mrs Royds commented that improvements had been seen in Personal Development Reviews (PDRs) rates had increased due to the delivery of training to managers with Mandatory Training rate also continuing to rise. The Flu campaign had been well supported and 73% of staff had obtained the vaccination by week seven. It was noted that Sickness Absence had increased, which was one of the main areas of focused support provided by HR, including, review and challenge of monthly performance data; ensuring compliance with return to work interviews and monthly meetings

	with HR Business Partners and CBUs to scrutinise sickness and its management. **Financial Indicators** Mr Shanahan stated that the Director of Finance Report would cover all the financial elements in the IPR report. Mrs Gorry commented that the Executive Assurances within the IPR had significantly improved and was much better, to which the Chair added there was now consistency of presentation which was reassuring. Mr Singh stated that 62 day GP referral to treatment had been 'red' for a long time, with little progress, which would have impacted on both lost money and potentially the quality of care. He asked if any themes were identified including staffing and/or beds. Mr Nicholls responded that the strategy was for the Trust to get the Ormskirk site fit for purpose. Referral to Treatment for the Trust was one of the best in the country; however the intention was to improve even further. The Chair added that the beginnings of improvement were being seen, however, winter may impact on that progress. Mr Nicholls further responded that the focus would not only be on Urgent Care but would include elective and planned care. **RESOLVED** The Board **received** the report.	
TB286/18	**Director of Finance Report**	
	Mr Shanahan presented the current financial position at month 7. At month 7 the Trust's financial performance was a deficit of £17.81 million which was £173,000 worse than plan. That included £933,000 income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. The Trust continued to see over-performance in A&E attendances and non-elective activity. Elective activity was still behind plan at the end of October. The CIP programme was forecasted to be £1.4 million lower than the £7.5 million plan although additional schemes were expected to mitigate. Expenditure run rate had been fairly consistent but there were signs of increasing cost pressures as the cumulative pay budget overspend increased significantly from £368,000 (month 6 Year to Date (YTD)) to £779,000 (month 7 YTD). While there had been an increase in substantive staffing, agency spend increased for the fifth consecutive month; YTD spend was £4.5 million which means	

	that the Trust would breach NHSI agency cap set at £5.6 million. CIP delivery and agency spend were two of a number of risks to delivering the year end deficit of £28.8 million. The others being: • Commissioners applying contract sanctions; Trust had not made any provision at this stage as discussions had been taking place around reinvestment; at month 7 total value to date was £1.38 million. • Contract challenges on non-elective activity and CDU tariffs. • Mitigation of additional business case costs from reserves. The Chair asked if the year-end deficit of £28.8 million was the best case scenario and what the worst-case scenario would be, to which Mr Nicholls replied that the outcome of the tariffs and sanctions would determine that. The Chair further commented that whilst agency costs were of concern, they remained within the required parameters. Mr Shanahan agreed that the Trust had the grip and significant work was taking place, however, a tangible reduction had not yet been evident. Mrs Royds added that work was taking place regionally with agencies to standardise rates. Ms Patten commented that business plans for 2019/20 were being developed for examination at the Executive Team meeting and would encompass a four year plan, with the aim of no in-year surprises. **RESOLVED:** The Board **received** the report.	
TB287/18	**Communications & Marketing Strategy**	
	Ms Patten presented the report. Previously the Trust had been reactive in relation to Communications & Marketing and the plan was for a pro-active strategy to be initially approved. The Communications and Marketing Strategy would: • 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. The Strategy described the communications and marketing activities the Trust would use to deliver its corporate objectives. The themes were drawn from Vision 2020, the Trust's Strategy. They were:	

	• Internal communications and engagement • Enabling Vision 2020 • Building the Trust's reputation • Supporting the recruitment, retention and recognition of staff To facilitate those, a new website was being invested in and would be launched by 31 January 2019. The Chair commented that the Board must demonstrate the same values as the Trust and take decisions in line with those. Dr Bricknell observed that the public consultation of plans must be included in that Strategy and a programme of building towards that would help create a more conducive climate. Ms Patten agreed, stating, however, that consultation would be led by the commissioners instead of the Trust. She made reference to the Quality Summit Week scheduled for 28 January to 1 February 2019 would include partners such as Healthwatch, Age Concern. Dr Bricknell concurred, adding that the building of hearts and minds in anticipation would be valuable. The Chair added that the internal element of the Strategy would be of paramount importance. **RESOLVED** The Board **approved** the report	
GOVERNANCE/WELL LED		
TB288/18	**Risk Management:** **Risk Register**	
	Ms Cosgrove presented the report. No new risks had been added to the register since the last report in November. **Risk 1917: Quality of Older People's Care** A post implementation review of the revised documentation which was released in 2018 identified that Bank and agency staff were unfamiliar with those and that further training needed to be provided. Mrs Gorry asked if that could be provided at induction for any incoming staff, to which Ms Cosgrove replied that that was possible, and they were already incorporated in the Nursing and Midwifery Council (NMC) Code of Practice and Responsibilities; however it was evident that the Trust needed to do more work to ensure that was embedded.	

	The Chair queried if an external review of Older People's Services had taken place and Ms Cosgrove responded that an Emergency Care Intensive Support Team's (ECIST) review had been planned with Gateshead as part of a 'buddy' arrangement. That had been changed to work with Leeds Teaching Hospital instead once greater understanding of the risks was evident. Mr Nicholls added that NHSI had originally suggested buddying with Gateshead, however, it was not found to be feasible and negotiation to move on had taken some time. **RESOLVED** The Board **received** the report.	
TB289/18	**Items for assurance and information: AAAs Highlight Reports from the Trust's Statutory and Assurance Committees**	
	In the interests of the time available to the Board the AAA reports for the Finance, Performance and Investment Committee, Quality & Safety Committee and Workforce Committee were briefly discussed in the Private Board and presented to the Public Board for assurance and information. **RESOLVED** The Board **received** the reports.	
TB290/18	**Questions From Members of the Public**	
	Mr Ryan wished the Board a Merry Christmas and suggested that ***members of staff should be invited to attend the Public Board, without loss of pay, to promote an inclusive and transparent environment.*** The Board agreed that that was a useful suggestion.	**CoSec**
CONCLUDING BUSINESS		
TB291/18	**Any Other Business**	
	In the absence of a Patient Story, Mr Clarke related the recent experience of a friend who had attended the Southport site. They had had excellent experiences in the Acute Care Unit each time they attended, under the care of Dr Beth Glackin. Appointments were made, consultation was professional, and Dr Glackin was kind, informative and reduced the stress they were experiencing at a difficult time. ***Dr Glackin to be thanked on behalf of the Executive Team and the Board and Mr Clarke would get in touch with her to convey that directly.***	**Mr Clarke**
TB292/18	**Items for the Risk Register/changes to the BAF**	
	There were no additional items or changes. It was acknowledged that winter pressures and staff sickness might impact on the risks.	

TB293/18	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • Merry Christmas to all staff and patients • Bullying was being taken seriously • Quality Summit in the last week of January • Winter plans • Safe staffing had improved Mr Masom, as Chair elect, thanked Mr Birrell for chairing the meeting and the previous one. The Board packs had contained a lot of data and information which having read them and observing the Board, he then understood. The Executive summaries were very good and the meeting was well chaired and he enjoyed Mr Clarke's annotated patient story. He looked forward to working with the Trust in 2019.	
TB294/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 9 January 2019, 10.50am Seminar Room, Clinical Education Centre, Southport District General Hospital	

There being no other business, the meeting was adjourned

Board Attendance 2018/19

Members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Richard Fraser	✓	✓	✓	✓		✓	✓	A				
Neil Masom									✓			
Silas Nicholls	✓	✓	✓	✓		✓	✓	✓	✓			
Jim Birrell	✓	✓	✓	✓		✓	✓	✓	✓			
David Bricknell	✓	✓	✓	✓		A	A	✓	✓			
Audley Charles*	✓	✓	✓	✓		✓	✓	✓	✓			
Steve Christian*			A	A			✓	✓	✓			
Ged Clarke	✓	✓	✓	A		✓	✓	A	✓			
Juliette Cosgrove			✓	✓		✓	✓	✓	✓			
Pauline Gibson*	✓	✓	A	A		✓	✓	✓	✓			
Julie Gorry	✓	✓	✓	✓		A	✓	✓	✓			
Terence Hankin												
Dr Jugnu Mahajan	✓	✓	✓	✓		✓	✓	✓	✓			
Therese Patten	✓	✓	✓	✓		A	✓	✓	✓			
Jane Royds*	✓	✓	A	✓		✓	✓	✓	✓			
Steve Shanahan	✓	✓	✓	✓		✓	✓	A	✓			
Gurpreet Singh	✓	✓	✓	✓		✓	✓	✓	✓			

A = Apologies, ✓ = In attendance, - = No response ***** = Non-voting Member

Public Board Matters Arising Action Log
as at 9 January 2019

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
CEO Report	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	Sep 2018	**December 2018** ADHR was TUPEd and appointed as Director of HR in November 2018. **January 2019** Work continues to transfer other services back to the Trust by March 2019.	**GREEN**
TB283/18	Dec 2018	**Monthly Mortality Report**	The report would be refined and Dr Mahajan commented that the next Board report will follow a different format.	**MD**	Jan 2019	Jan 2019	**January 2019 Update** The updated format of the report is in the Board Pack	**GREEN**

Public Board Matters Arising Action Log
as at 9 January 2019

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**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB290/18	Dec 2018	**Questions from members of the public**	A member of the public suggested that members of staff should be invited to attend the Public Board, without loss of pay, to promote an inclusive and transparent environment**.**	**CoSec**	Jan 2019	Jan 2019	**January 2019 Update-COMPLETED** An invitation was extended via Communication and Marketing	**BLUE**
TB291/18	Dec 2018	**Any Other Business**	Dr Glackin to be thanked on behalf of the Executive Team and the Board and Mr Clarke would get in touch with her to convey that directly.	**Chair/CoSec**	Jan 2019	Jan 2019	**January 2019 Update-COMPLETED** A letter was sent by the Chair on behalf of the Board	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB006/19	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

This report highlights the following:

- Preparations for winter
- Appointment of Medical Director
- Getting it right first time
- Nurse leadership programme

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 ✓ 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 – JANUARY 2019

1 Preparations for winter

Last winter was very challenging for the NHS, particularly the first two weeks of January following the holiday season. Performance against the four-hour A&E standard to treat, admit or transfer patients dropped significantly, including here at Southport and Ormskirk.

Colleagues across the Trust have worked hard to ensure we are better prepared than ever for winter 2019.

Some of this work is very apparent such as the extension and refurbishment of A&E at Southport. The work is scheduled to be completed this month with the new patient waiting room having opened shortly before Christmas.

Staff have also embraced new ways of working, striven to improve our internal processes and worked on relationships with partners in the community, such as other health and social care providers.

The early signs are that this huge effort is paying off.

In November and December 2017, the Trust was the second-worst performing trust in Cheshire and Merseyside against the four-hour A&E standard. To date, as this report goes to press, we are second best for the same period.

That's good news for everyone but particularly our patients.

Most likely the worst of the winter lies ahead but the foundations to help us meet that challenge are now firmly in place.

2 Appointment of Medical Director

I am delighted to welcome **Dr Terry Hankin** who attends his first Trust Board today as Medical Director. Terry was previously deputy medical director at St Helens and Knowsley Teaching Hospitals NHS Trust for five years.

He was also the trust's Responsible Officer and Medical Director for the Lead Employer Organisation.

In these roles he has extensive experience of supporting and managing clinicians in the workplace. He has a proven record in improving patient care, and as an active critical care physician and anaesthetist has a clear understanding of the challenges of the clinical workplace.

As Medical Director for the Lead Employer, he has worked with the trust's HR team and contributed to the development of a team managing more than 5,000 trainees. He has also developed strong ties with Health Education England North West and the region's educators.

Terry is dedicated to improving patient care and supporting the both the medical, nursing and the wider workforce in delivering such improvements. He has a particular affiliation with Southport hospital having completed some of his training there.

I want also to record my sincere thanks to **Dr Jugnu Mahajan** who made a huge contribution to the life of the Trust over the past 12 months as interim Medical Director.

I was also pleased to announce the appointment of **Dr Ann Holden** as our new Director of Medical Education.

She succeeds **Mr Sanjeev Sharma**, a passionate advocate for education, who has overseen many changes in both undergraduate and post-graduate education during his 10-year tenure. He remains involved in examination work with the Royal College of Obstetricians and Gynaecologists and will continue to work within the Gynaecology department.

3 Getting it right first time

We welcomed Prof Tim Briggs to Ormskirk hospital in November where he launched the Trust's Getting It Right First Time (GIRFT) programme.

Prof Briggs is an eminent orthopaedic surgeon who practices at the Royal National Orthopaedic Hospital, north London. He is chair of GIRFT and national director of clinical quality and efficiency at NHS Improvement.

The aim of GIRFT is to deliver improvements in clinical quality and process by reducing variation in practice and making sure patients get the best care. Implementation to occur at pace, but be sustainable in the long-term.

We are one of a small number of trusts who have been specially selected by Prof Briggs to be part of GIRFT, with a focus on trauma and orthopaedics. Good progress is already been seen, notably in increasing the number of patients we see in a single theatre session.

Trauma and Orthopaedics (T&O) spans both urgent and elective care. If we get T&O right, we can spread the learning to other specialities that will soon be involved in GIRFT. This will have a knock on effect on the whole hospital in terms of flow, quality, safety and finance. Prof Briggs returns to the Trust later this month to assess our progress.

4 Nurse leadership programme

Over the past six months we have a run Leadership Development Programme for senior nurses facilitated by the University of Central Lancashire.

Participants have the opportunity to meet members of the Executive team on the last day of the programme and provide them with feedback.

Overwhelmingly, the groups we have met have said how inspiring and empowering the programme had been and how they felt reinvigorated, motivated and enthused to be our leaders in the future.

5 In brief …

Staff flu vaccinations - More than 80% of health care staff had been vaccinated against flu by December, making the Trust once again one of the best performing in the NHS. Many more non-clinical staff have also been vaccinated.

Christmas fundraising and donations - I want to thank all staff and members of the public who have either made donations to patients, collected gifts for good causes or raised money for local charities in the run up to Christmas. You have all made a fantastic contribution to the life of our community.

Silas Nicholls Chief Executive

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Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	PB007/19	Report Title	Quality Improvement Plan Progress Update
Executive Lead	Juliette Cosgrove, Director Nursing, Midwifery & Therapies		
Lead Officer	Paul Jebb, Deputy Director of Nursing, Quality Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

This paper provides the Board of Directors with an update on the development of 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, including the feedback from the Core Service Quality reviews held in December 2018.

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*
✓ **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)*
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

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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. TRUST PROGRESS

The AQUA Well Led review and preparation for the core service peer reviews has meant that we have been unable to convene the assurance panels over the last month. As with November, 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

4. 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.

Since the March 2018 inspection a number of improvements have been implemented in relation to the environment and the impact on patient experience including the opening of SAU, CDU, additional triage space, and protected clinical cubicles for patients brought in by ambulance. December 2018 saw opening of waiting room, and 2 additional consultation rooms, one of which is an enhanced care needs room

Due to the ongoing work within the department and increasing patient demand there has been an impact on the continued improvement relating to the actions.

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

5. PREPARATION FOR QUALITY VISITS – UPDATE

All three parts of the Quality Visit Preparation plan have been completed, including:

- Provider Information Return (PIR)
- Core Service Review

CBUs were 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. Self-assessment returns are currently being reviewed; they will be triangulated with the outcome of the PIR to identify any gaps areas requiring improvement

The Core Service Review took place on 11 and 12 December 2018, over 30 people took part in the review including Trust staff, NHSI, CCGs, local NHS Trusts, and Student Quality Ambassadors (SQAs) from local universities. The event was chaired by Pete Weller – Senior Clinical Lead, NHSI Greater Manchester and Lancashire. Dr Vince Connolly NHSI Medical Director (North) also attended for one day and led medical engagement with clinical leaders from the Trust.

Six teams were identified to review core services including:

- Medicine and older people
- Emergency care
- Outpatients and Radiology
- Spinal Unit and Critical Care
- Surgery
- Ormskirk (Maternity, Paediatrics, Surgery, Outpatients and Radiology)

The teams based their review on the five CQC domains; Safe, Effective, Caring, Responsive and Well Led.

Key Headlines from Feedback

- Staff were welcoming and supported the review teams
- Staff are caring, compassionate and there were examples of good practice, however not all staff felt valued or looked after
- Recognition of new leadership and contribution from Executives within the improvement journey
- No areas were considered to be 'inadequate'
- No immediate or apparent regulatory or enforcement issues were found, however some high risk areas were identified for improvement including:
    - accuracy and security of documentation
    - infection prevention control
    - uniform compliance
    - out of date policies
    - equipment (cleaning, maintenance and storage)
- Good practice was identified in all areas particularly highlighted especially in Maternity, Medical Day Unit, Critical Care and Radiology
- It was noted that CQC inspectors will focus on detail not strategy.

However, areas for improvement were identified including:

- Need to align values, behaviours, systems and processes
- Poor communications in relation to quality priorities
- Lack of visibility relating to integrated governance and silo working
- Need to consider how enabler services are involved such as Estates and Facilities.
- Patient experience strategy – staff not aware of the strategy or the pledges.
- Staff could describe progress regarding flow
- Incident reporting appeared to be inconsistent with a lot of variation, long backlogs and delays which need to be reduced
- Lack of patient records strategy (including short/medium/long term improvements) and clarity regarding leadership, roles and governance.

- Health and Safety – did not appear high profile across the Trust and little evidence of support for staff safety.
- Signage and notice boards are poor; a review is needed across the estates.
- Medicines management including storage of medicines and PGDs.

We will review the final feedback from the core services review and triangulate with the outcomes from the draft PIR and AQuA Well Led review to identify gaps and priorities. Communications will be developed and shared on a wider level once all the feedback has been triangulated

6. WELL LED WORKSHOP

AQuA facilitated a workshop on 5 December to review the Trust's position and challenges in relation to the Well Led domain / guidance. The workshop reviewed the recommendations from December 2017 well led review, then teams identified improvements and gaps in relation to the key lines of enquiry whilst considering best practices shared from other providers.

The Company Secretary is developing a project plan and further sessions with AQuA are planned for February and March 2019.

7. RECOMMENDATIONS

The Board of Directors is asked to receive the progress identified in this report as assurance that systems and processes are in place to deliver quality improvement and is asked to note the high level feedback and once triangulation is complete develop improvements in specific areas.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB008/19	Report Title	Monthly Mortality Report
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
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.

The report includes the following:

Learning from Deaths
A summary of the initial data from the trusts Structured Judgement review process is presented. This is an initial dataset and will be improved over time with greater data and experience. Some of the clinical developments supported by this process are outlined.

Measuring Mortality

- Summary Hospital-level Mortality Indicator (SHMI) – 12 month rolling up to 30th June 2018
- Hospital Standardised Mortality Ratio (HSMR) – July 2018
- Disease-Specific Mortality Ratios – July 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 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*

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

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

CQC KLOEs	**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)*

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

Previously Presented at:

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

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></tr>
<tr><td>Qtr. 1 2018/19 (paper proc) Oct/Nov 2018 (SJR)</td><td>115.5 Qtr. 1 2018/19</td><td>117.7 July 2018</td><td>July 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 Areas of Work</td><td>Further areas of work driven by mortality data analysis</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>
</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 to sit within statistical norms 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 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, with a phased switch over completed in November 2018. Methodology and process have been outlined previously.

This month the new Structured Judgement Review activity is reported below. The 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 the Structured Judgement Review method.

Table 1. Mortality Screening

Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review
July	77	30	39.0%	18	60%
August	66	39	59.1%	26	67%
September	72	43	59.7%	33	77%
October	59	31	52.5%	22	71%
November	68	40	58.8%	13	33%

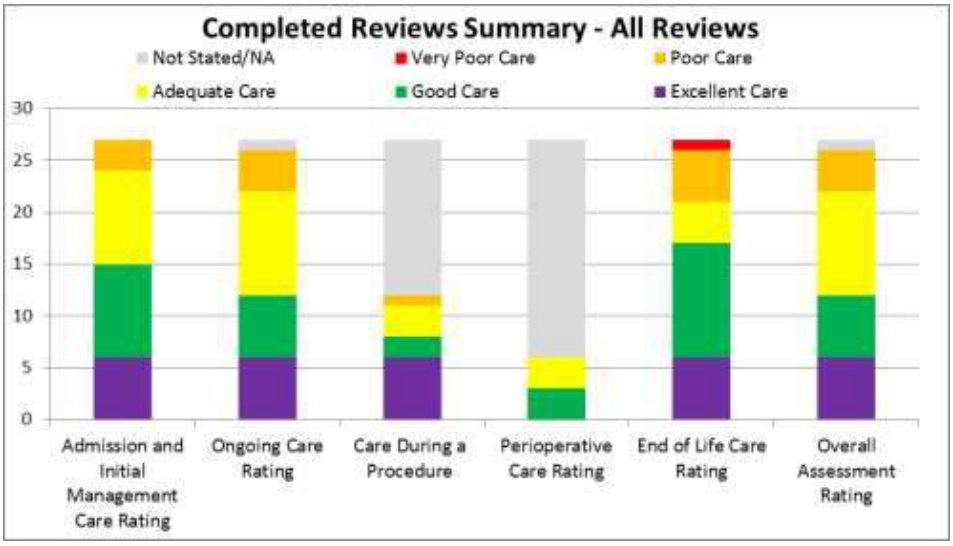
*change of criteria for review

Table 2. Completed SJR reviews to date

Speciality	No of Reviews
General Medicine	9
Intensive Care/Coronary Care/High Dependency	6
Geriatric Medicine	5
Trauma & Orthopaedics	3
Respiratory Medicine/Thoracic Medicine	2
Cardiology	2
Grand Total	**27**

This is 27 of a possible 35 reviews. 77% completion rate at time of writing. Delays to review are being investigated; process changes to the scanning of notes to the Evolve system are implicated in most delays.

Chart 1. Trust – Wide SJR results



To date there has been no 'Very Poor' overall care identified. Two cases of overall 'Poor' care are being reviewed by the CBUs. Case one from T&O has been used as evidence for ongoing revision of the fractured neck of femur pathway. This episode was rated 'poor' overall due to the patient waiting over 36 hours for surgery.

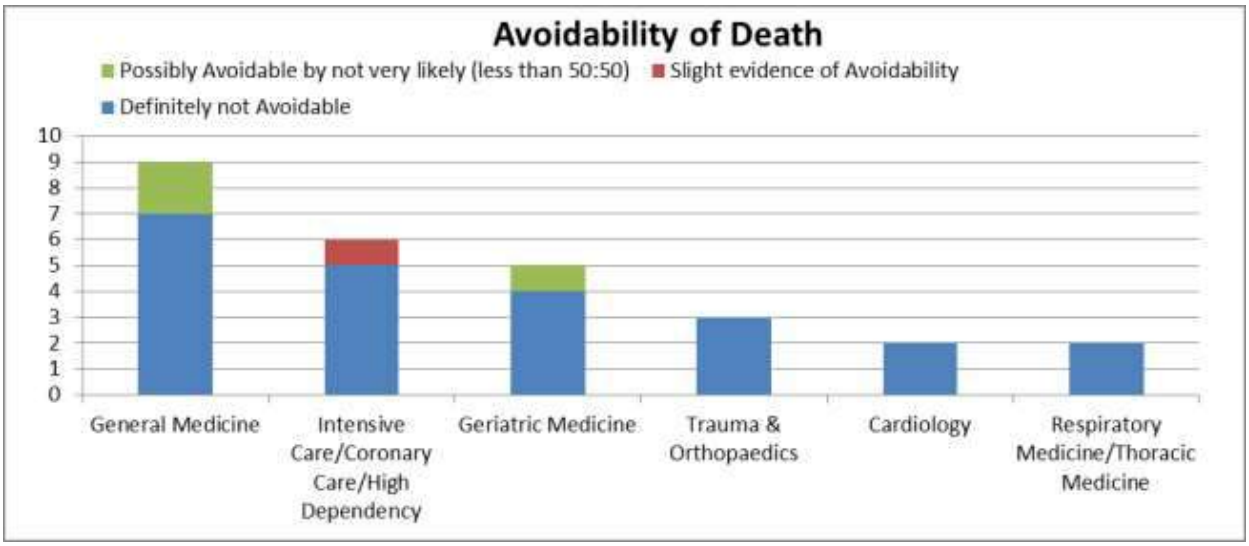
The second case was rated poor overall due to the lack of recognition of dying in a patient with multiple severe medical problems leading to too many medical interventions. Other aspects noted in this review were the lack of access to specialist diabetic advice. The Urgent Care CBU have discussed this in their governance meeting and are using this as a learning opportunity to increase awareness of end of life care. The CBU has appointed a substantive diabetologist and is increasing the establishment of diabetic specialist nurses in response.

The single case of very poor care in the End of Life Care phase is subject to a complaint and the issues have been fully investigated. There was an absence of end of life planning over a course of years by multiple hospitals and community services despite the patient suffering from a chronic, progressive neuromuscular condition. Multiple areas of work are ongoing as a result including a task and finish group on assisted feeding and the sharing of clinical records across organisations.

Chart 2. SJR by specialty

Due to reporting anomalies not all medical SJRs are classified as general medicine. The largest other category is Geriatric Medicine. Graphs for Cardiology and Respiratory account for 4 patients and are therefore omitted for ease of review. Reporting structure is developing and will be clearer in future reports.

Table 3. Avoidability of Death



No definitely avoidable deaths have been found to date. 4 patients have been classified with some evidence of avoidability, but none greater than the 'more likely than not' cut off. These are reviewed based on their SJR scores for learning as described above.

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.

[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.

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. A further focus group to develop the actions was held on the 18th of December. The results of this session have been integrated with the existing action plan and will be submitted for executive approval.

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

Key national and local mortality indicators

	2017/18					2018/19							Target
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Rolling 12 Month HSMR	115.5	116.1	118.8	123.1	123.4	121.2	120.6	118.1	117.7				*100.0*
Monthly HSMR	95.9	115.7	138.6	136.0	124.7	105.0	125.6	95.1	117.7				*100.0*
SHMI		114.2			118.0			115.5					*100.0*
Local HSMR Bronchitis	119.0	133.3	110.5	126.1	165.9	154.5	161.6	156.1	172.0				*100.0*
Local HSMR LRTI	124.4	134.6	111.5	127.2	167.4	155.9	163.0	157.5	173.5				*100.0*
Local HSMR Pneumonia	127.7	128.3	134.8	145.0	144.5	142.5	135.9	132.7	135.8				*100.0*
Local HSMR Septicemia	92.2	86.9	93.5	94.3	88.4	93.8	92.5	89.9	87.4				*100.0*
Local HSMR Stroke	135.7	141.9	145.1	139.0	139.1	135.4	136.6	127.3	122.6				*100.0*
Local HSMR UTI	124.5	113.1	114.2	108.3	131.2	131.6	127.5	126.7	127.5				*100.0*
Local HSMR Acute Renal Failure	90.8	85.3	90.2	106.4	124.2	121.5	109.0	107.9	107.4				*100.0*
Mortality Screens - %	118.52%	94.12%	104.13%	91.01%	102.83%	106.76%	88.24%	90.77%	92.21%	72.73%	58.90%	53.45%	*100.00%*
SJRs											33	21	*0*
2nd Review											0	2	*0*
SIs											0	0	*0*
In Hospital Deaths	54	85	121	89	106	74	85	65	77	66	72	59	*77*

In Hospital Deaths Crude Rate	21.4	35.5	48.8	39.3	41.4	30.4	29.0	22.2	26.6	21.1	22.2	17.4	*31.0*
LD Deaths	0	1	0	0	1	0	1	1	0	1	0	0	*1*

Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

The latest month's data for the nationally reported indicators are for July 2018. The rolling 12 months HSMR (Jun 17 – Jul18) is showing a marginal decrease from the previous period, this is also the 4th consecutive month that this has dropped so is showing a positive declining trend.

The in-month HSMR increased in July to 117.7 from 95.1 in June. By utilizing the triangulation tool (see appendix 1) there is evidence that the Trust saw pressures across the urgent care pathway in July with poor A&E performance and extended waiting times. Evidence also shows that harm free care and safe staffing levels were particularly challenged in this month.

From the local HSMR disease specific indicators only septicaemia was below the 100 target, although Stroke and Renal Failure both showed a reduction on the previous month. Unfortunately all other local measures showed an increase on their previous performance, Bronchitis and LRTI in particular.

The new mortality screening process began in September and is still being embedded across the Trust but we expect to see a month on month improvement going forward. The difference in SJR reviews between sections 2 and 3 reflects the fact that this has been reported at different periods.

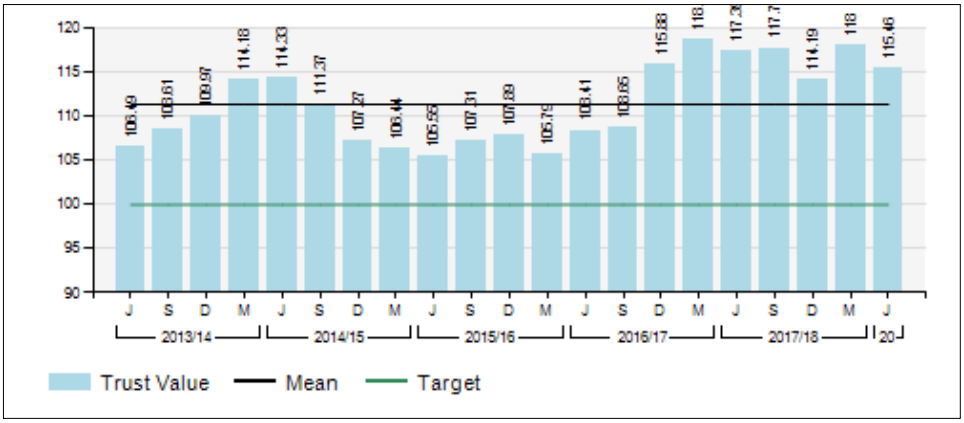
In hospital deaths were low in October which is very positive and is a great reduction from the peak of 121 seen in January this year which was at the height of winter pressures. This low rate is also shown by the crude death rate which demonstrates that the mortality rate is low without us seeing s reduction in demand across the Trust.

3.1 SHMI & HSMR

3.1.1 Summary Hospital-level Mortality Indicator (SHMI)

The SHMI ratio for Quarter One is 115.5. This represents a reduction on the previous quarter and a reduction on the same quarter in the previous year. Changes in performance will be reflected in SHMI gradually due to its method of construction.

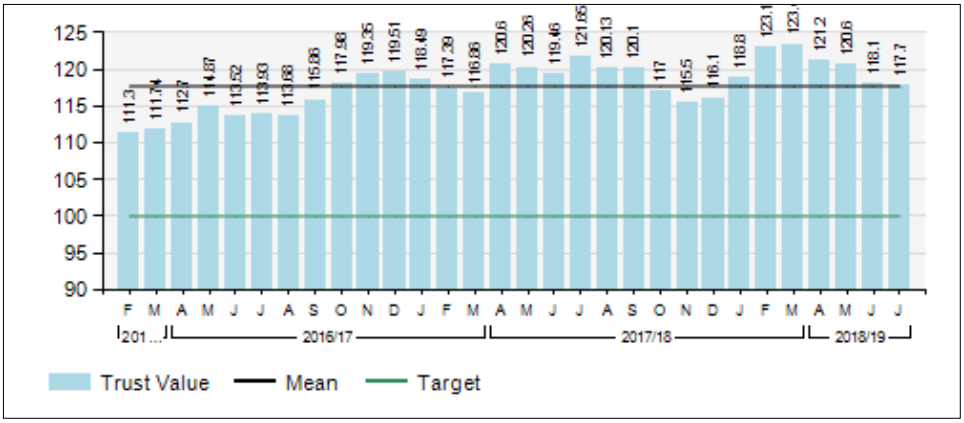
SHMI - Summary Hospital Level Mortality Indicator



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 July was 117.7 while the in-month HSMR was 117.7. The link between flow and mortality is repeated demonstrated and is one factor in this monthly performance.

HSMR - Hospital Standardised Mortality Ratio (*Rolling 12 month*)



3.2 Disease-Specific Mortality – June 2018

3.2.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

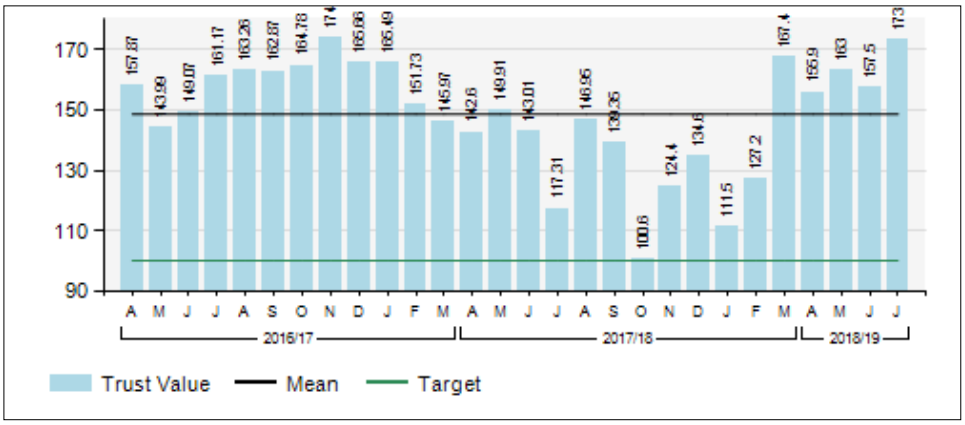
The rolling 12 month local Standardised Mortality Rate (SMR) for:

- Lower Respiratory Tract Infection (LRTI) 173.5 (from 157.5)
- Acute Bronchitis 172 (from 158)
- Pneumonia 135.8 (from 132.7)

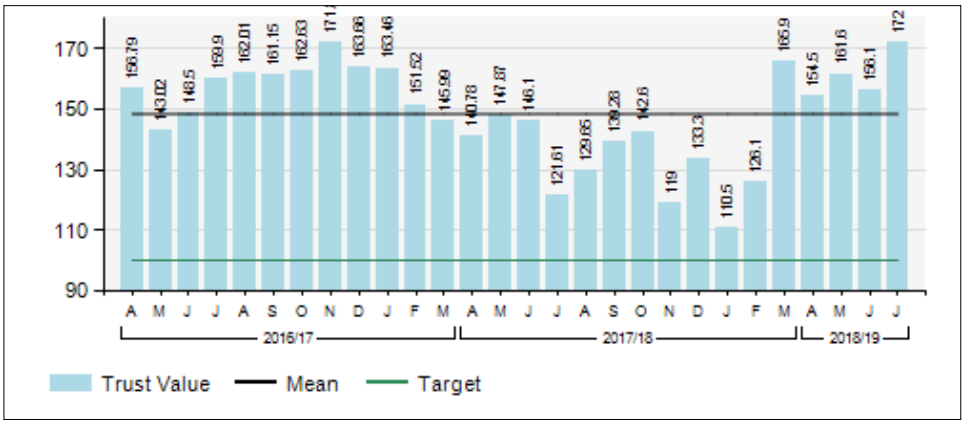
The elevated SMRs for respiratory infection reflect the fact that the trust serves a population particularly prone this particular cause of death, and that these diagnoses are frequently made at the end of life when there is little clinical evidence of a particular cause. Respiratory infection is frequently implicated as a decompensating factor in chronic co-morbid disease. This frequently made diagnosis is also managed by a heterogenous clinical team of physicians, surgeons and other doctors with a varying skill set for diagnosis and risk assessment of these patients.

Work in this area is to produce a clear risk assessment and plan of investigation (the completed pneumonia pathway) access to diagnostic imaging and reporting to aid diagnosis, and improving access to clinicians skilled in managing complex elderly care to improve the complex interplay of acute decompensation of chronic disease

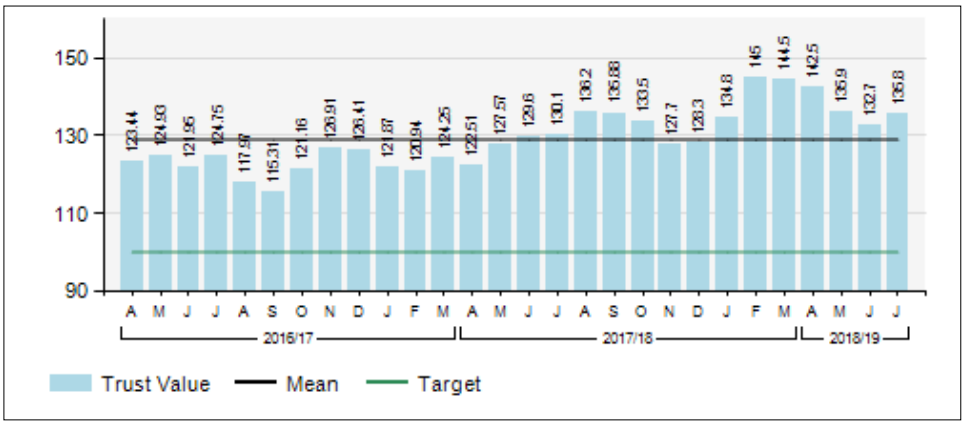
Local HSMR Lower Respiratory Tract Infection



Local HSMR Bronchitis

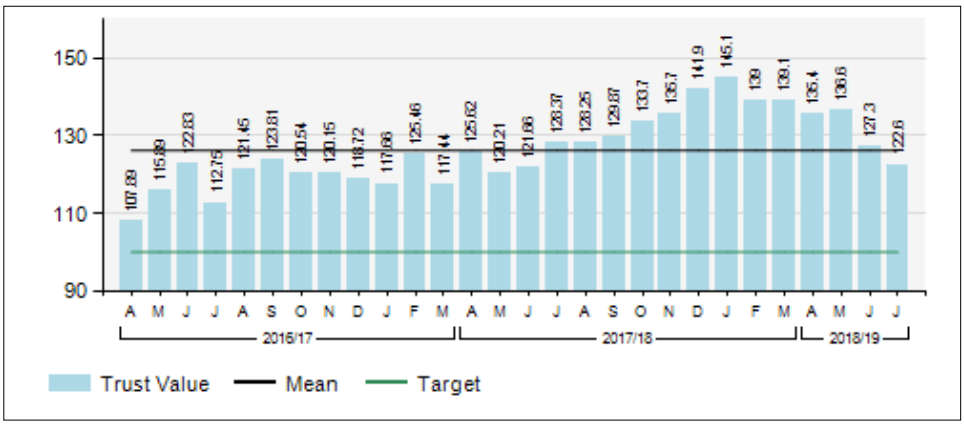


Local HSMR Pneumonia



3.2.2 Stroke

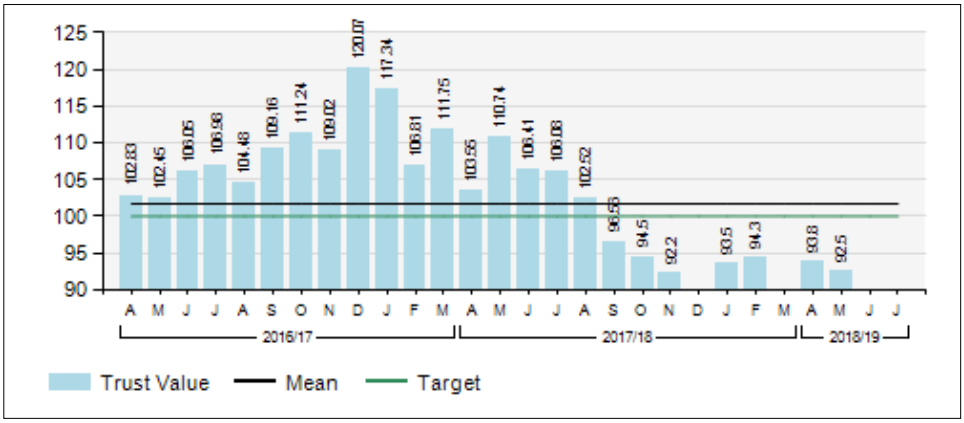
The rolling 12 month SMR for Stroke for July was 122.6 showing an improving trend. This area has seen investment in acute stroke beds, upgraded clinical monitoring, a dedicated nursing team with access to rapid diagnostics and a dedicated unit with specialist MDT input.



3.2.3 Septicemia (Except in Labour)

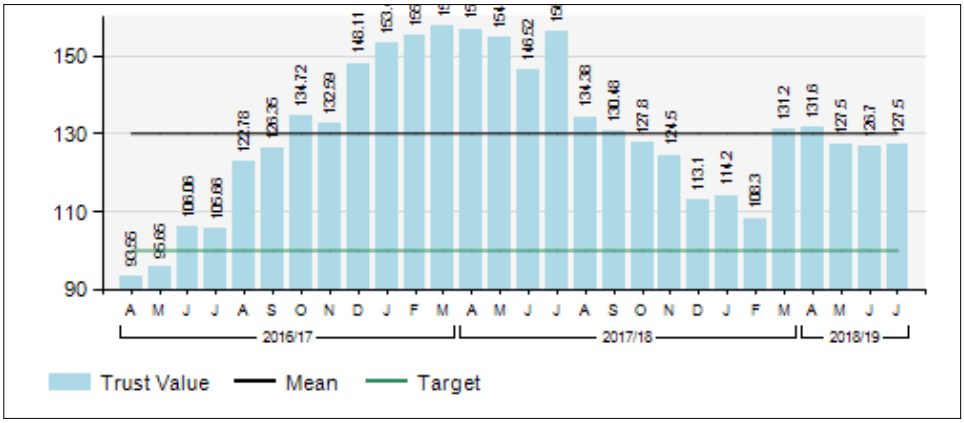
The rolling 12 month SMR for septicemia for July 2018 was 87.4

Sepsis has been a focus area for the trust for some time. The SMR and the trust performance against the Advancing Quality (AQ) measures remains good. This is at variance with the higher SMRs for pneumonia and UTI raising the possibility that sepsis is going undiagnosed. Vigilance and awareness are therefore to be maintained and this remains an important area of work



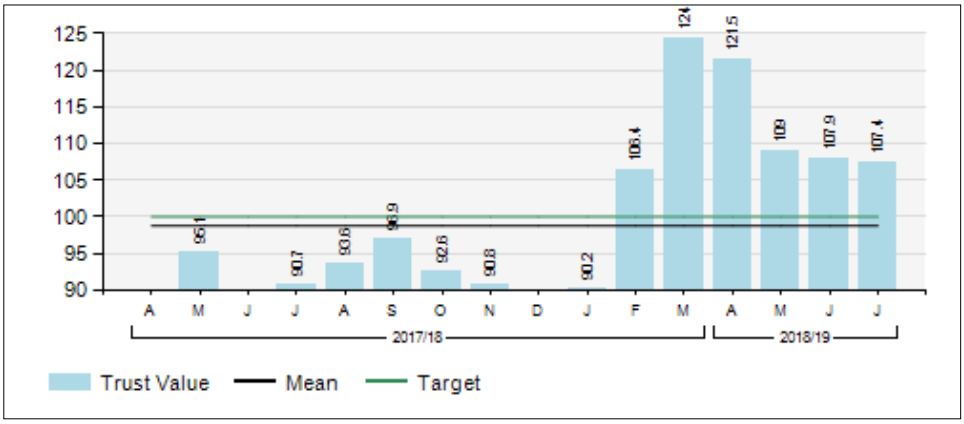
3.2.4 Urinary Tract Infection

The rolling 12 month SMR for Urinary Tract Infection for June 2018 was 127.5. There was a sudden spike in this in February 2018 which has been sustained. This needs further evaluation to understand. Urinary tract infection and gram –ve bacteraemia are important areas for improvement and are being looked at jointly with AKI, falls and nutrition/hydration.



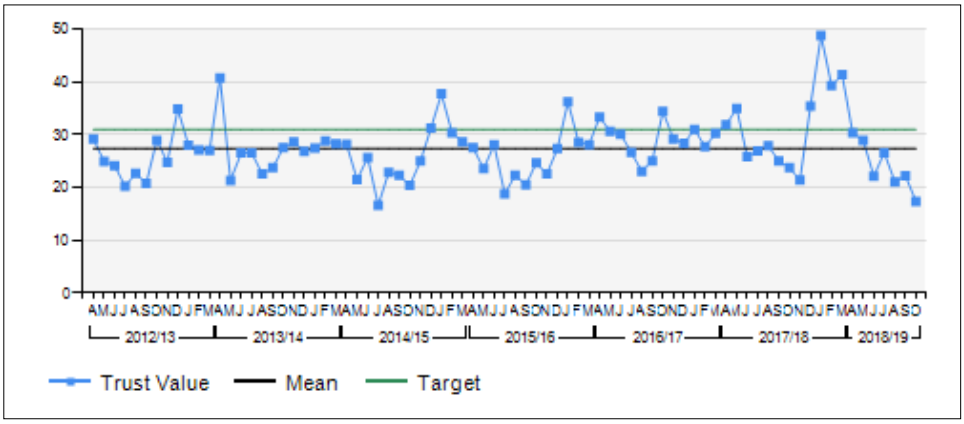
3.2.5 Acute Kidney Injury

The 12 month rolling SMR in July 2018 for AKI was 107.4. This probably reflects greater awareness of this as a significant clinical entity and greater availability of guidance on the immediate management. Further work to alert clinical teams to the development of an AKI electronically is ongoing.



3.3 Crude Mortality:

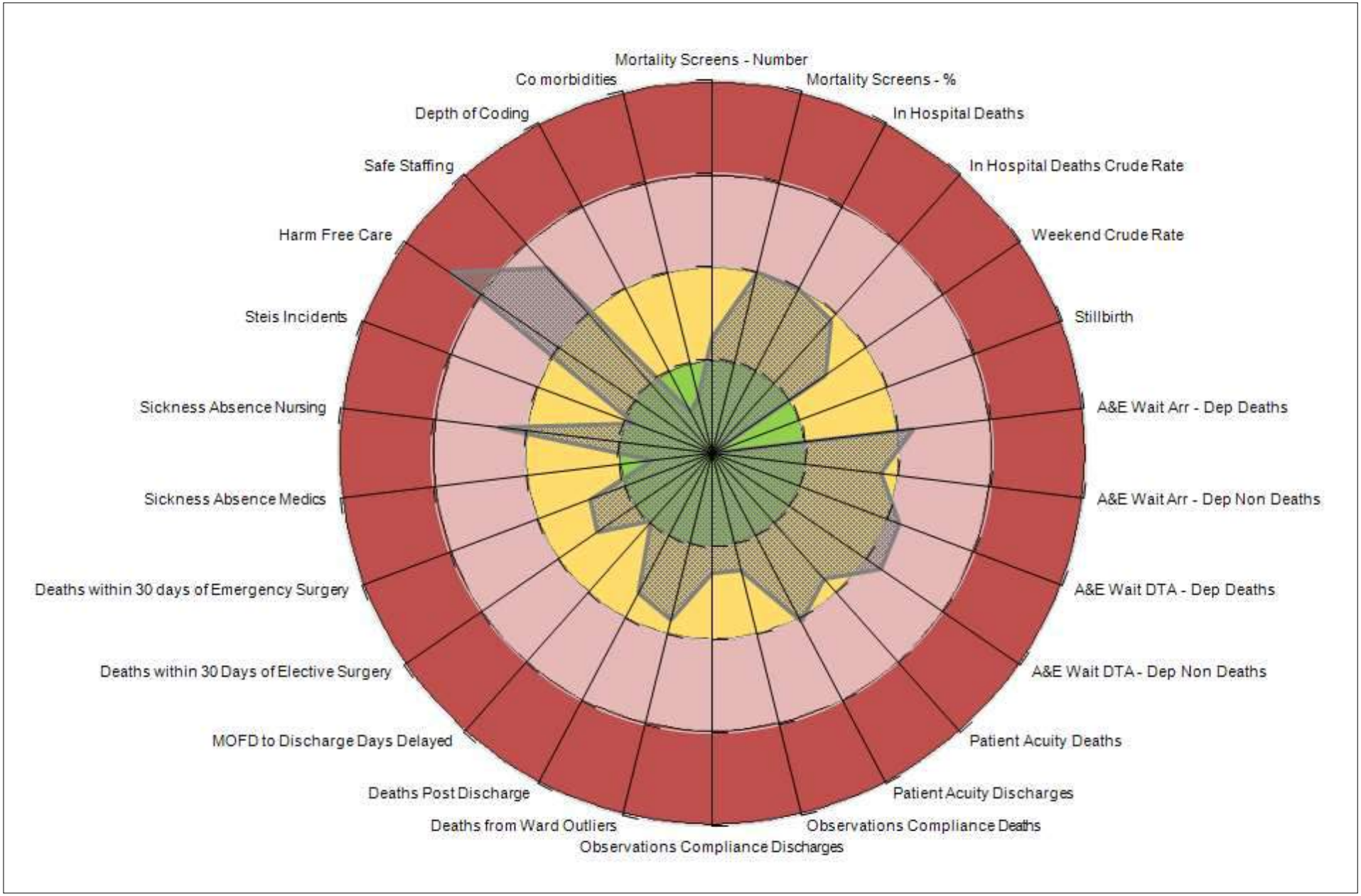
The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for October was 14.4 which was attributable to a total of 59 deaths. This is our lowest crude rate in October for some time.



3.4 Performance Distribution – July 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 July are once again 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. The mechanism for determining and monitoring harm free care also requires evaluation to ensure clinical feedback and relevance. 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 Other mortality areas of work

4.1 Design process with system partners to clinically evaluate deaths within 30 days of discharge.

4.2 Work with system partners to include the learning from LeDeR reviews of learning disability deaths.

4.3 NEWS2 Implementation group. NEWS2 to go live March 2019.

4.4 Revise Terms of Reference of Mortality Operational Group to include NELA, NHFD, SSNAP and ICNARC mortality data.

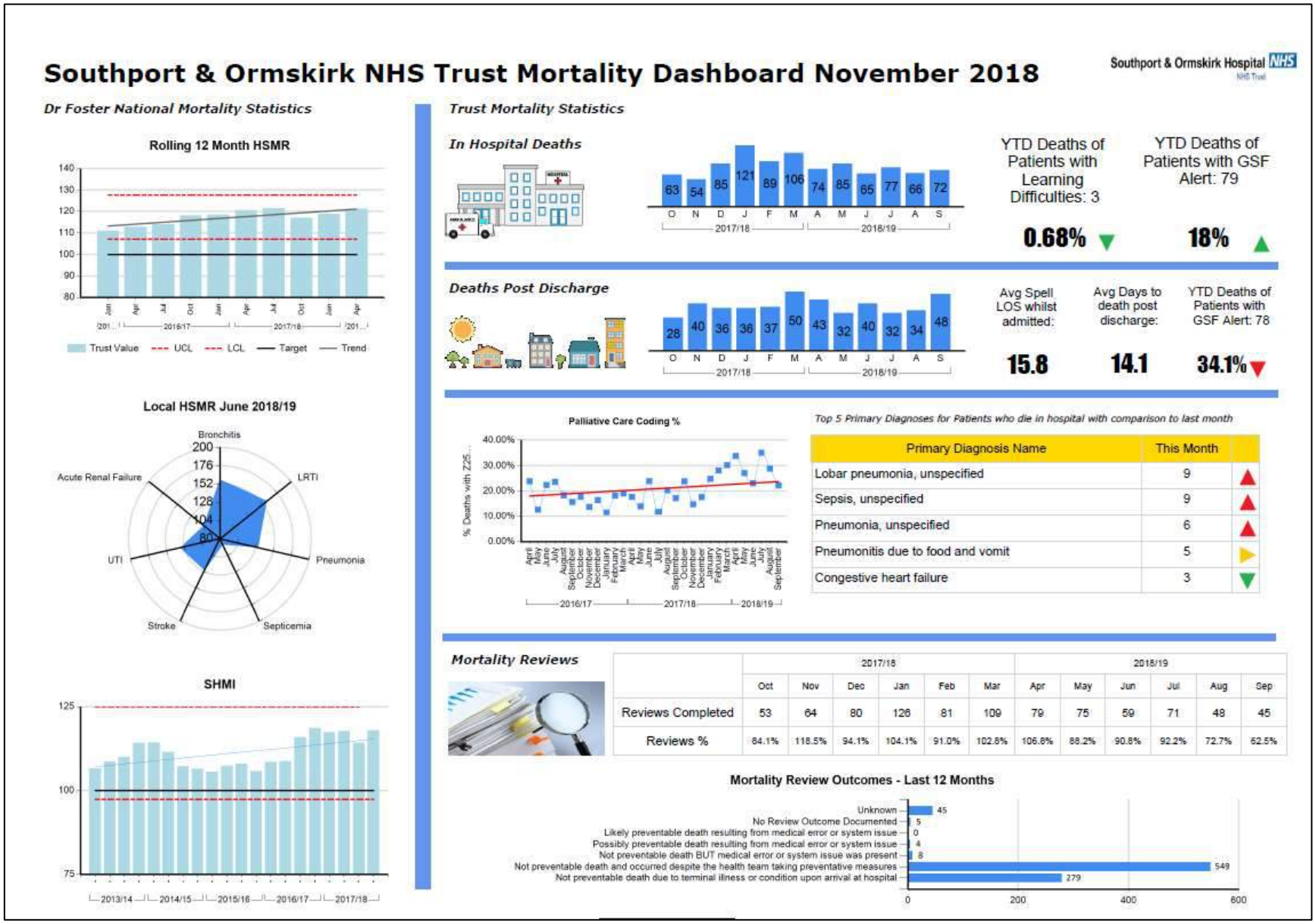
4.5 Complete review of deaths within 24 hours of admission.

4.6 Inform and support reviews of nutrition and hydration and falls.

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.

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



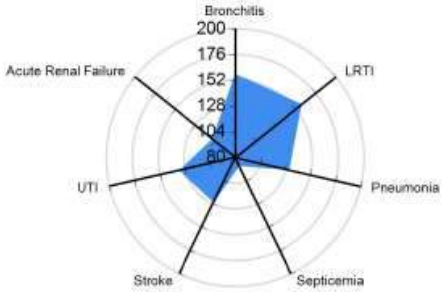
Southport & Ormskirk NHS Trust Mortality Dashboard November 2018

Southport & Ormskirk Hospital NHS

Dr Foster National Mortality Statistics

Rolling 12 Month HSMR

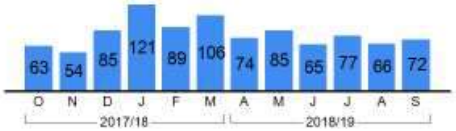
Local HSMR June 2018/19



SHMI

Trust Mortality Statistics

In Hospital Deaths



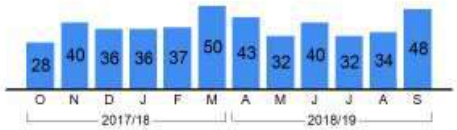
YTD Deaths of Patients with Learning Difficulties: 3

0.68% ▼

YTD Deaths of Patients with GSF Alert: 79

18% ▲

Deaths Post Discharge

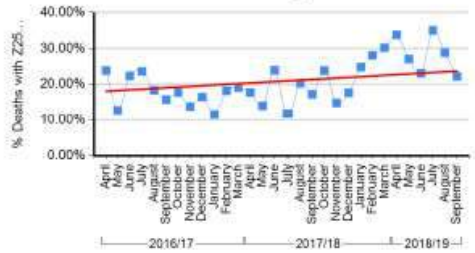


Avg Spell LOS whilst admitted: **15.8**

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

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

Palliative Care Coding %



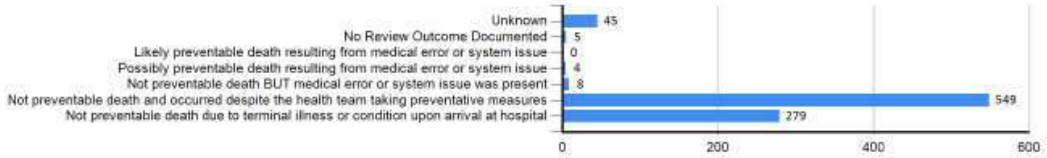
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

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



Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB009/19	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 - Workforce 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 November 2018.

For the month of November 2018 the Trust reports safe staffing against the national average (90%) at 95.76%.

Within the report there is an extensive gap analysis of the Trust compliance with National Institute Care Excellence 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – safe sustainable and productive staffing (NICE, 2016)'. This has been undertaken prior to reviewing compliance against 'Developing workforce safeguards' (NHS I 2018). There are a high proportion of non-compliant actions which will be reported upon through the Workforce Committee.

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).

Recommendation:
The Trust Board is asked to **receive** the report as 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*
✓	**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:

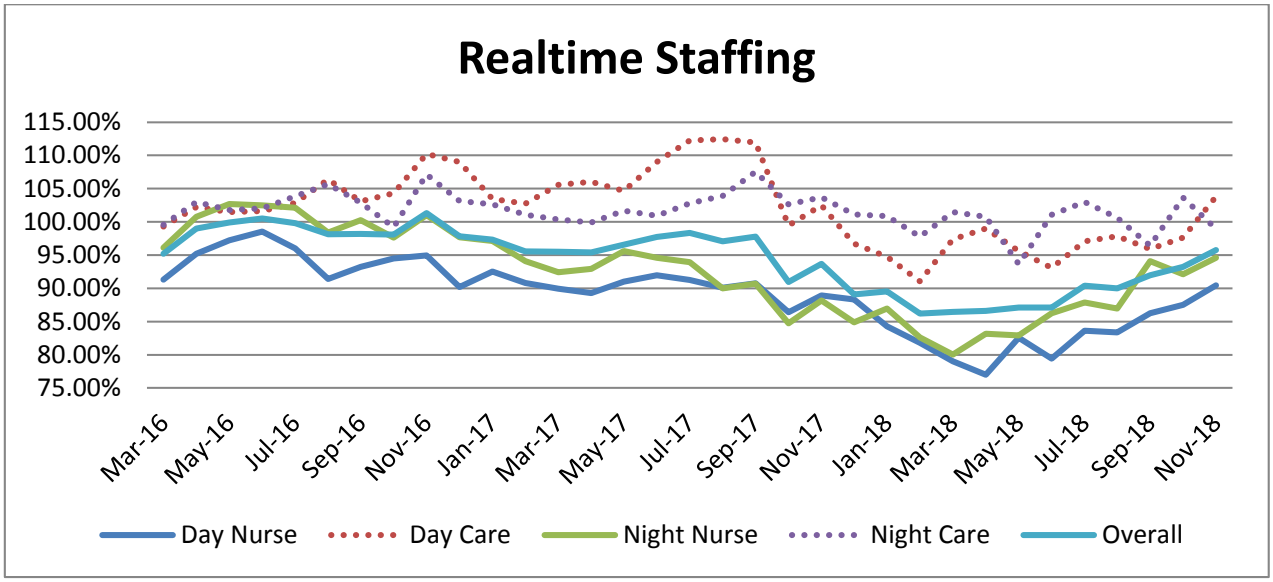
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee Workforce Committee

1. Introduction

This report provides an overview of the staffing levels in November 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 November 2018 was 95.76% compared to October 2018 that was 93.25%, compared to 91.99% in September (appendix 1).

- 90.45% Registered Nurses on days
- 94.58% Registered Nurses on nights
- 103.81% Care staff on days
- 98.95% Care staff on nights



As advised in last month's Trust Board report the Care Hours Per Patient Per Day (CHpPD) has now been divided up by clinical specialty to allow more understanding and scrutiny of the data (appendix 3). The percentage compliance, against national guidance, has also been added (80% above green, 79.9% below – red).

Although the overall CHPpD for the Trust is 8.3hr and slightly above the national average, there are a number of wards that have a low CHpPD, for example Frail & Elderly are showing 5 CHpPD. This means that in a 24hour period a patient would receive 5hrs of care, which could be registered nurse or HCA, against the national average of 7 CHpPD. At the same time 'H' ward requires further review as part of the overall Nurse staffing review as the CHPpD for the ward is 13 CHPpD.

2. November Safe Staffing

Trust whole time equivalent (wte) funded establishment versus contracted for November 2018:

	Funded WTE	Contracted WTE	Nov Total Vacancy
Registered	865.63	775	90.63
Non-registered	377.98	351.30	26.68
Total	1243.61	1126.30	117.31

Registered nurse vacancy has reduced / improved in month by 4 wte.
Non – registered vacancy has reduced / improved in month by 7.61 wte

The Trust remains engaged with the NHSI Recruitment and Retention pilot focusing its key deliverables over the next 3, 6, 9, 12 months. The Trust final action plan is to be shared with NHSI in December 2018.

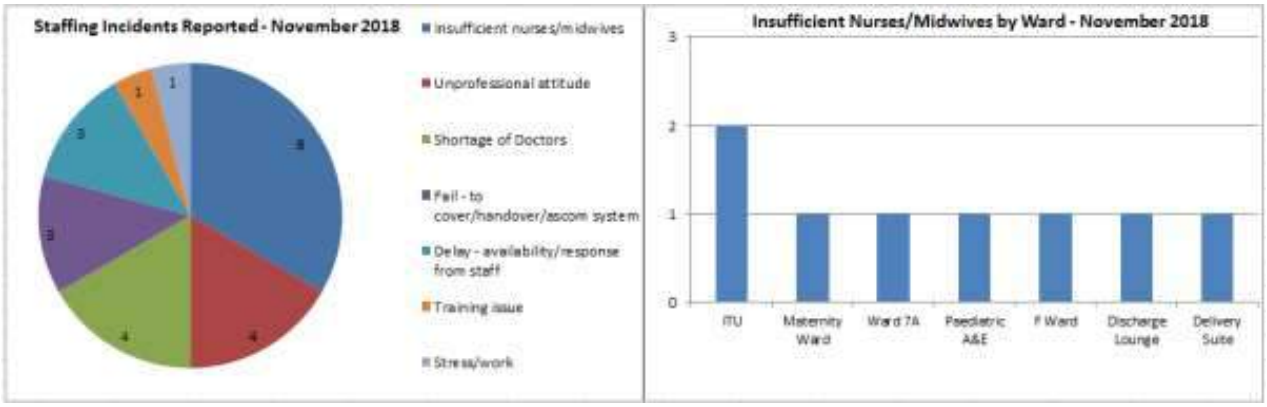
Further to this the Trust remains engaged with local recruitment opportunities hosting a successful recruitment event in the Clinical Education Centre SDGH site on Saturday 24th November 2018. 53 people attended the event with 39 healthcare assistants, 10 student nurses and 4 Registered nurses securing conditional offers of employment following interviews on the day.

In collaboration with the Clinical Business Units (CBU's) the Assistant Director of Nursing-Workforce has reviewed the outcomes of the daily Safe Staffing Huddles and further key performance indicators, including updated terms of reference, have been introduced to assure leadership, outcomes and efficiencies. Actions to capture medium and long term plans in the delivery of efficient utilisation of Trust staffing tools and ultimately inform future workforce planning remain in place.

The Assistant Director of Nursing-Workforce is chairing weekly staffing meetings to facilitate intense scrutiny of nurse workforce rosters during the festive period to assure clarity on flexible staffing requirements, timely release of these shifts to bank and to advise agency requirements inclusive of high cost agency requirements. The Trust has had a considerable number of registered nurse (RN) vacancies and Healthcare (HCA) vacancies over the last year. Against this backdrop patient case mix has continued to increase in both acuity and dependency of clinical need therefore requiring not just HCA bank but also RN bank and agency fill. Projected NHS Provider (NHSP) fill rate has formed part of the senior nurse weekly staffing reviews. There have been times when the Trust has had to use a non-framework nurse agency to maintain patient safety. Work is on-going to minimise the use of the non-framework agency and actions to support this are presented in a briefing paper in appendix 2.

Further scrutiny of roster performance is currently being facilitated by the Trusts work with Price Waterhouse Cooper (PWC). Following initial diagnostics PWC have actioned on a 'deep dive' approach to key wards and departments to facilitate further support and challenge going forward. The next steps going into January 2019 will include weekly support and challenge meetings at each senior nurse level across all CBU's.

3. Staffing Related Reported Incidents November



24 staffing incidents were reported in November, 18 less than the previous month. 8 of these incidents highlight insufficient nurses/midwives. Out of the 8 incidents reported there were no identified patient harms. The highest reported numbers were on ITU with incidents

highlighting failures to fill shifts through NHSp and a failure of an agency nurse to arrive for a shift.

4. Inpatients experiencing moderate harm or above in November 2018
In November there were 9 moderate (non-staffing related) or above incidents were reported, with 1 related to delay in medical staffing escalated as appropriate within trust processes.

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 and is progressing against planned timeframes. The implementation of the 'Red Flag' events has been shared with Matrons and Ward Managers and commenced in December 2018. The number of 'Red Flag Events' will be 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.

Developing workforce safeguards – supporting providers to deliver high quality care through safe and effective staffing (NHS Improvements, October 2018)
NHS Improvement published the above documentation with 14 recommendations which builds on earlier National Quality Board guidance (2013, 2016). 'Developing workforce safeguards' is relevant to our entire workforce. Our compliance, as a Trust, will be measured and monitored through the Single Oversight Framework and there will be a specific workforce statement that we will need to incorporate as part of our annual governance statement.

The first recommendation of 'Developing workforce safeguards' is:

- Trusts must formally ensure that National Quality Board (2016) guidance is embedded in the safe staffing governance.

To understand the Trust current compliance against NQB 2016 guidance ('Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – safe sustainable and productive staffing) a gap analysis has been undertaken, from a nursing/midwifery' perspective prior to reviewing the more recent trust-wide 'Developing workforce safeguards' 2018 guidance.

Within 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (NQB 2016) there are 38 recommendations (appendix 3). Following the gap analysis the Trust is compliant with 15 of the recommendations. Some of the remaining 23 recommendations have already been identified and form part of our current on-going improvement plan. However, from a Nursing & Midwifery perspective there are a number of actions that will require considerable time, resources and on-going work to implement across the Trust.

Key areas are:

- Model Hospital compliance
- Role & responsibilities of Ward Co-ordinator training
- Clinical skills training for B5 & HCA
- Review Ward Clerks as part of the Establishment Review
- Consider the implementation of Productive Wards

The areas of non-compliance will be added to the improvement plan and will be reported upon through Workforce Committee.

6. Recommendations

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

Appendix 1: Care Hours per Patient Day (CHPPD – November 2018

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		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										
Ward 7A-SDGH	300 - GENERAL MEDICINE	1,316.25	1,243.50	887.25	1,621.75	1,066.00	1,004.00	700.50	604.50	819	94.5%	182.8%	94.2%	86.3%	2.7	2.7	5.5		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	746.00	699.50	359.00	430.25	702.50	630.50	350.00	338.00	250	93.8%	119.8%	89.8%	96.6%	5.3	3.1	8.4		
E A U	300 - GENERAL MEDICINE	1,546.75	1,485.75	1,043.67	1,097.92	1,045.50	1,055.25	713.50	689.50	528	96.1%	105.2%	100.9%	96.6%	4.8	3.4	8.2		
FESS Ward	300 - GENERAL MEDICINE	1,474.08	1,066.50	1,310.50	1,090.00	1,071.50	985.50	714.00	702.00	775	72.4%	83.2%	92.0%	98.3%	2.6	2.3	5.0		Wd Manager & Matron reviewed acuity & dependency across the ward on a daily basis
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,315.50	1,075.50	1,071.25	1,456.42	1,077.50	744.50	708.50	1,019.00	774	81.8%	136.0%	69.1%	143.8%	2.4	3.2	5.5		Wd Manager & Matron reviewed acuity & dependency across the ward on a daily basis
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,532.43	1,402.50	1,306.50	1,592.75	1,062.75	1,062.25	715.50	691.00	873	91.5%	121.9%	100.0%	96.6%	2.8	2.6	5.4		
Short Stay Unit	300 - GENERAL MEDICINE	1,414.75	1,141.25	1,019.25	1,674.75	699.00	974.50	711.00	886.25	824	80.7%	164.3%	139.4%	124.6%	2.6	3.1	5.7		
Ward 15a General Med	300 - GENERAL MEDICINE	1,099.75	1,156.88	819.50	1,572.75	1,051.00	1,057.00	709.50	1,151.00	694	105.2%	191.9%	100.6%	162.2%	3.2	3.9	7.1		
Stroke Ward	300 - GENERAL MEDICINE	1,335.50	1,283.67	945.75	1,228.50	1,062.58	1,015.08	704.17	680.17	549	96.1%	129.9%	95.5%	96.6%	4.2	3.5	7.7		
Rehab & Discharge Lounge	314 - REHABILITATION	1,135.50	1,160.48	933.50	1,512.50	711.00	734.00	709.00	730.50	657	102.2%	162.0%	103.2%	103.0%	2.9	3.4	6.3		
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,213.48	1,327.49	1,546.25	1,589.23	716.00	1,013.50	693.00	997.50	871	109.4%	102.8%	141.6%	143.9%	2.7	3.0	5.7		
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,626.00	1,244.00	1,671.00	1,111.25	708.50	721.00	334.50	381.50	476	76.5%	66.5%	101.8%	114.1%	4.1	3.1	7.3		Wd Manager & Matron reviewed acuity & dependency across the ward on a daily basis
Ward H	110 - TRAUMA & ORTHOPAEDICS	720.00	580.00	718.50	362.50	711.00	579.00	357.00	69.00	118	80.6%	50.5%	81.4%	19.3%	9.8	3.7	13.5		Flexible activity has facilitated reduced staffing levels to maintain safety
Surgical Ward	100 - GENERAL SURGERY	1,281.75	1,082.00	1,082.50	992.50	719.50	735.24	720.00	360.00	507	84.4%	91.7%	102.2%	50.0%	3.6	2.7	6.3		
Spinal Injuries Unit	400 - NEUROLOGY	3,934.48	3,253.90	3,539.25	3,143.75	2,770.50	2,576.25	1,448.50	1,307.00	1,230	82.7%	88.8%	93.0%	90.2%	4.7	3.6	8.4		
Ward G	101 - UROLOGY	1,506.75	844.83	926.00	473.00	932.50	704.50	569.00	293.00	251	56.1%	51.1%	75.5%	51.5%	6.2	3.1	9.2		Flexible activity has facilitated reduced staffing levels to maintain safety
TOTAL		**23,198.98**	**20,047.75**	**19,179.67**	**20,949.82**	**16,107.33**	**15,592.07**	**10,857.67**	**10,899.92**	**10196**	**90.45%**	**103.81%**	**94.58%**	**98.95%**	**3.50**	**3.12**	**6.62**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		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										
A&E Nursing		3,947.67	3,272.17	1,879.25	1,433.75	3,257.50	3,168.00	719.50	719.50	N/A	82.89%	76.29%	97.25%	100.00%	N/A	N/A	N/A		
Ambulatory Care Unit		264.00	321.25	587.50	341.50	165.00	93.50	168.75	116.25	49	121.69%	58.13%	56.67%	68.89%	N/A	N/A	N/A		Matron reviewed acuity & dependency across the unit on a daily basis based on activity
TOTAL		4,211.67	3,593.42	2,466.75	1,775.25	3,422.50	3,261.50	888.25	835.75	49	85.32%	68.65%	71.97%	94.09%	N/A	N/A	N/A		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		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										
ITU/CCU	192 - CRITICAL CARE MEDICINE	4,518.17	4,674.67	1,036.50	913.00	3,946.75	3,203.50	1,079.00	923.00	353	103.5%	88.1%	81.2%	85.5%	22.3	5.2	27.5		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		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										
Delivery Suite	501 - OBSTETRICS	1,515.08	1,824.58	403.00	380.00	1,435.50	1,405.50	359.50	312.50	69	120.4%	94.3%	97.9%	86.9%	46.8	10.0	56.8		
Maternity Ward	501 - OBSTETRICS	1,031.08	1,066.50	700.00	584.00	718.50	767.25	359.50	622.00	301	103.4%	83.4%	106.8%	173.0%	6.1	4.0	10.1		
MAU	501 - OBSTETRICS	1,170.50	1,281.50	336.00	440.50	714.50	679.00	354.50	330.50	57	109.5%	131.1%	95.0%	93.2%	34.4	13.5	47.9		
TOTAL		**3,716.67**	**4,172.58**	**1,439.00**	**1,404.50**	**2,868.50**	**2,851.75**	**1,073.50**	**1,265.00**	**427.00**	**112.27%**	**97.60%**	**99.42%**	**117.84%**	**16.45**	**6.25**	**22.70**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		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										
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,068.00	1,059.75	336.00	300.00	1,079.50	1,055.50	144.00	36.00	224	99.23%	89.29%	97.78%	25.00%	9.4	1.5	10.9		
Paediatric Unit	420 - PAEDIATRICS	4,336.25	3,583.25	1,072.75	1,161.75	2,156.00	2,014.00	713.50	641.50	437	82.63%	108.30%	93.41%	89.91%	12.8	4.1	16.9		
TOTAL		**5,404.25**	**4,643.00**	**1,408.75**	**1,461.75**	**3,235.50**	**3,069.50**	**857.50**	**677.50**	**661.00**	**85.91%**	**103.76%**	**94.87%**	**79.01%**	**11.67**	**3.24**	**14.90**		

TRUST TOTALS		**41,049.73**	**37,131.43**	**25,530.67**	**26,504.32**	**29,580.58**	**27,978.32**	**14,755.92**	**14,601.17**	**11,686.00**	**90.45%**	**103.81%**	**94.58%**	**98.95%**	**5.0**	**3.3**	**8.3**		

Green- 80% and above
Red- Under 80%

Appendix 2

Briefing Paper
Thornbury Nurse Agency

Introduction:
The use of Thornbury Nurse Agency, which is a non-framework agency, commenced within the Trust in August 2018. This was due to a severe shortage of registered nurses to provide care of the patients with our services at that time. This briefing paper provides an overview of the current work to reduce and end the use of this agency.

Background:
The Trust has had a considerable number of registered nurse (RN) and Health Care Assistant (HCA) vacancies over the last year. Since April 2017 there have been approx. 140 – 150 vacancies, most of these at registered nurse position. Through this time recruitment initiatives have only sustained the level of vacancy not reduced the level of vacancy.

Against this backdrop patient case mix has continued to increase in both acuity & dependency of clinical need therefore requiring not just HCA bank but also RN bank and agency fill.

Current position:
On a daily basis there is a Safe Staffing Huddle attended by the clinical Matrons, chaired by a senior nurse (Head of Nursing/Midwifery, Assistant Director of Nursing -workforce or Deputy Director of Nursing). Through this meeting each wards acuity, dependency of patients and staffing is reviewed to consider if the ward is safe. Although many of the wards are on a minimum level of staffing, sometimes below 1 nurse to 8 patients, the Matrons continue to review the wards throughout the day to ensure that safety is maintained. If, following our internal escalation process, there is no alternative to maintain a safe environment then Thornbury agency is booked.

The use of Thornbury nurse agency is only used if no other option is available to maintain minimum levels of staffing.
The top 'users' of Thornbury over the past 3 months have been:

- 14 a – Trauma & Orthopaedics
- ITU

Following meetings with the Head of Nursing each area now has a plan to reduce the usage of Thornbury and increase / recruit staff to their specialist areas. For ITU the use of Thornbury has been directly attributed to Trust increase in activity. This increased usage at times is associated to 'wardable' patients being placed in the ITU environment due to bed capacity.

Recent actions:
Unfortunately during September & October there was no reduction in the number of Thornbury shifts used, in fact in late October the number of shifts increased considerably, which coincided with half term across the county. Therefore the following measures have since been taken:

- The authorisation process has been revisited and now a shift can only be booked within 6-8 hours of the shift commencement and has to go through Safe Staffing Huddle Chair or 1st on Call (flowchart in place).
- The shifts will be booked and recorded through NHSP to allow for closer monitored of our usage.

- There have been a number of discussions with other nurse agencies to review the possibility of utilising other providers that will be less expensive than Thornbury.
- Detailed discussions with NHSP to review compliance again contract and options to increase the fill rate.

Next steps:
The main focus will continue to be on proactively managing the reduction of Thornbury usage and wide-ranging recruitment/retention opportunities across the Trust.

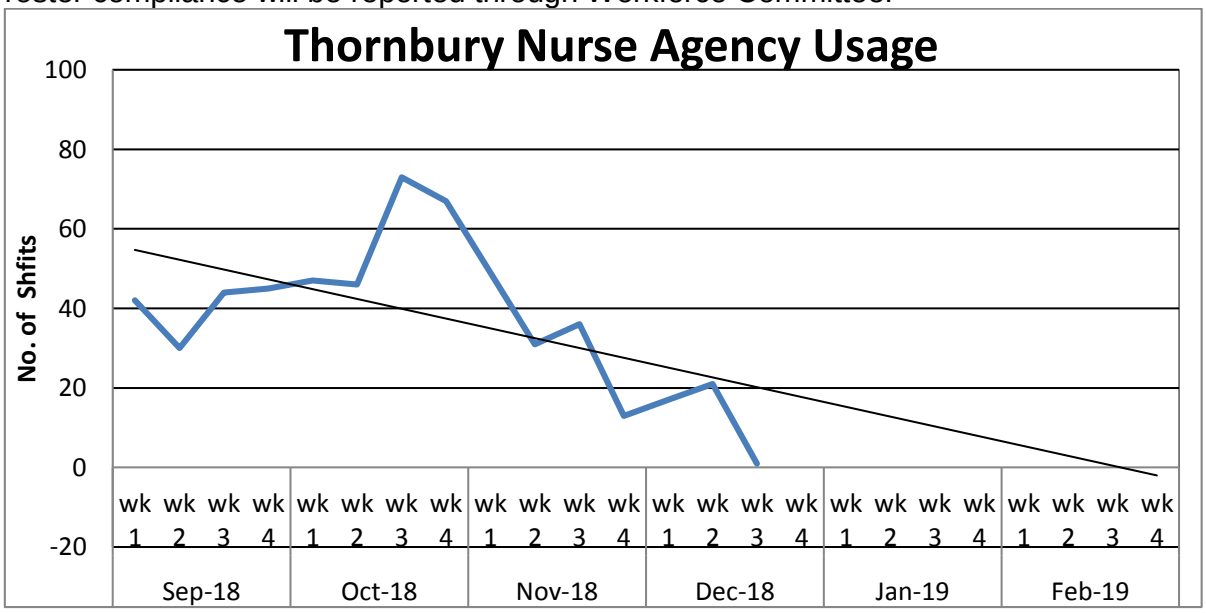
However, there is also an extensive review of the Health roster system, supported by Price Waterhouse Cooper (PWC), which will enable the Trust to scrutinise and manage our rosters more effectively and efficiently.

Meetings with three ward managers, their matrons, Assistant Director of Nursing -Workforce and PWC have occurred and through the development of a Health roster 'dashboard' an overview of a four week period of 'off-duty' can be seen and analysed. Through the first two meetings the ward managers have already recognised the limited efficiency of their rosters and started to address the 'hours owing'.
Further wider scrutiny of the hours owed has identified increased variances in 7 areas which will now form part of the focused efficiency reviews week commenced 17th December 2018.

The development of the 'dashboard' will enable further inspection and 'ownership' of the rosters although support from the Health roster team is fundamental to the on-going training and recognition of 'good practice'.

Through the Corporate Team the Assistant Director of Nursing- Workforce has set up weekly staffing meetings to initially review the Trust 'Festive Period' off-duty to maintain safety across the Trust. These meetings have now been planned into the New Year and will form the basis of a Roster Performance Review with the Head of Nursing/Midwifery and Matron. Prior to these meetings the Matrons will need to meet with their Ward Managers to ensure that the data is correct and any noncompliance can be understood and justified.

Further updates on the management of Thornbury usage and the improvement in the health roster compliance will be reported through Workforce Committee.



C Fowler, Assistant Director for Nursing & Midwifery Workforce - December 2018

Appendix 3

Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing, NQB 2016

Recommendations and gap analysis:

Recommendations	S&O Compliance	Further actions	Lead	Time frame
Expectation 1 – Right Staff				
1.1 Evidence-based workforce planning • Use evidence based guidance, ie. NICE	Trust is using Safer Nursing Care Tool (SNCT) in accordance with NHS Improvement			
• No modifications to maintain reliability & validity	No modifications to the licensed product			
• Workforce plans contain sufficient 'uplift' to cover AL, sickness, training & supervision	Trust uplift is 22.5%	National variation between 22% - 27% with RCN recommending 25%. Will form part of the Establishment Review	DDoN	Feb. 2019
1.2 Professional judgement • Clinical, managerial professional judgement and scrutiny as part of any review. Taking into account local context and patient needs.	Ward Manager (Wd M.) trained and leading the SNCT collection, Wd M. & Matron have completed the professional judgement tool and will be involved in the Confirm and Challenge meetings with Heads of Nursing/Midwifery			
• Professional judgement and knowledge used to inform skill mix of staff	As above			
1.3 Compare staffing with peers • Organisation compares local staffing with peers taking into account local differences	Trust currently benchmarking with Model Hospital	Data on Model Hospital needs on-going scrutiny	DDoN/ADF	May 2019

Recommendations	S&O Compliance	Further actions	Lead	Time frame
• Organisation reviews comparative data on actual staffing alongside data that provides context – i.e. case mix, pt. movements, ward designs	Part of the Confirm & Challenge meeting with Wd M. & Matron			
• Organisations have an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics e.g. model hospital data (CHPpD) and metrics.	Current dashboard includes – staffing, incidents, harms, complaints, FFT & sickness.			
Expectation 2 – Right Skills				
2.1 Mandatory training, development and education • Frontline staff clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing	Workshop with Wd M. with NHSI regarding SNCT.	To consider a workshop for ward co-ordinators to enhance the understanding of staffing escalation process	DDoN	April 2019
• Staffing establishments take account of the need to allow clinical staff time to undertake mandatory training and continues professional development, revalidation requirements, teaching, mentoring and supervisor roles, including pre& under graduate students	Mandatory training is part of the 22.5 % 'uplift' however this does not include teaching, mentoring and supervisory roles.	This will be considered as part of the Establishment Review	DDoN	Feb 2019
• Those with line management responsibilities ensure that staff are managed effectively with clear objectives, constructive appraisals and support to revalidate	New appraisal documentation cross the Trust implemented			
• The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff as part of the trust T & D strategy.	Currently part of the OD strategy	Further training has been identified to support the skill set for HCA & B5 staff.	Clinical T&D	July 2019
• The organisation develops its staff skills, underpinned by knowledge and understanding of public health and health, wellbeing &		To be part of future training opportunities for HCA & registered staff	Clinical T&D	July 2019

Recommendations	S&O Compliance	Further actions	Lead	Time frame
prevention				
• The workforce has the right competencies to support new models of care. Staff receive education and training to enable them to work more effectively in different care settings and in different ways		Competencies for Bands 2-8a to be developed.	Clinical T&D ADN WF	June 2019
• The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and sisters/charge nurses to discharge their supervisory responsibilities.	There is no agreed allocation to 'supervisory' time for Wd M.	As part of the Establishment Review there will be a recommendation to have Wd M supervisory	DDoN	Feb 2019
2.2 Working as a multi-professional team • The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing & midwifery staff to spend more time using their specialist training	New roles currently being developed are Nursing Associates, Assistant Practitioners, Advanced Care Practitioners	Further new roles for the future will consider: Ward Hostess & Pharmacy technicians,	DDoN	July 2019
• The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce, recognising the multi-professional approach to care delivery	Although this is acknowledged it requires dedicated workforce development.	Opportunities for multi-professional working will be part of the 'Older Peoples' Services	DDoN & Older Persons' Lead	July 2019
• The organisation works collaboratively with other in the local health and care system, including the development in future care delivery systems and models of care	This will form a significant part of Vision 2020			
2.3 Recruitment & Retention • The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves.	On-going recruitment initiatives supported by retention action plan.			
• The organisation has effective strategies to	The Trust has a retention	To enable the Trust to focus		

Recommendations	S&O Compliance	Further actions	Lead	Time frame
recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff	plan, supported by NHS Improvement	both on recruitment & retention the T&F group will become a trust-wide R&R Group in the New Year reporting to the Workforce Committee.	ADN WF	Jan 2019
• In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations through flexible approaches to recruitment and retention.		The R&R group will consider, as part of the action plan, the flexible needs of our workforce	ADN WF	On-going
Expectation 3 – Right place and time				
3.1 Productive working and eliminating waste • The organisation uses 'lean' working principles, such as the Productive Ward, as a way of eliminating waste		Productive Ward methodology is currently not sustained within the Trust	To be confirmed	
• The organisation designs pathways to optimise patient flow and improve outcomes and efficiency , e.g. by reducing queueing	This work will develop as part of our Vision 2020			
• Systems are in place to managing and deploying staff across a arrange of care settings ensuring flexible working to meet patient needs and making best use of available resources	Re-deployment of staff to manage the clinical risk across the Trust is proactive managed across the general wards	Further work is required to support cross –site working	DDoN	April 2019
• The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff		As part of the Establishment Review there is likely to be an increase in the number of staff within the general ward areas to improve patient care and the CHpPD	DDoN	Feb 2019

Recommendations	S&O Compliance	Further actions	Lead	Time frame
• The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority		As above The Establishment Review will also review the Ward Clerk availability within the clinical area.	DDoN	Feb 2019
• Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrates how staffing risks are identified and managed	Implementation of the Red Flag events through Datix commenced in December 2018.			
3.2 Efficient deployment and flexibility • Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation.	Wd M. /Co-coordinators are involved in re-allocation of staff on a short term basis.	To be considered as part of a ward co-ordinator role development workshop.	DDoN	April 2019
• Clinical capacity and skill mix and aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow		To be considered as part of the Establishment Review	DDoN	Feb 2019
• Throughout the day, clinical and managerial leaders compare the actual staff available with planned as required staffing levels, and take appropriate action to ensure staff are available to meet patient's needs.	Part of the Ward Co-ordinator/Ward manager role through SafeCare			
• Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care and staff are aware of the steps to take where capacity problems cannot be resolved.		SOP to be developed to clarify escalation process	DDoN	March 2019

Recommendations	S&O Compliance	Further actions	Lead	Time frame
• Meaningful application of effective e-rostering policies is evident and the organisation uses available best practice form NHS Employment and Carter Review Rostering Good Practice Guidance 2016.		E roster policy currently in draft	ADN WF	January 2019
3.3 Efficient employment, minimising agency use • The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option.		Annual Establishment Review currently on-going. Process for authorisation of non-framework nurse agency in place. On-going review of contract compliance of NHSp & alternative companies in process	ADN WF	On-going
• The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement nurse agency rules, supplementary guidance and timescales		On-going work to reduce non framework nurse agency and consider other alternative companies	ADN WF	On-going
• The organisation's workforce plan is based on the local Sustainability and Transformation Plan.	As part of Vision 2020			
• The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop s part of the STP	Lead by HR / T&D services and part of the Clinical Workforce Strategy			
• The organisation supports HEE by ensuring that high quality clinical placements are available within the organisation and across the patient pathway, and actively seeks and acts on feedback form trainees/students involving them wherever possible in developing safe, sustainable and productive services.	Close working relationships with both Edge Hill & UCLAN Universities.			

Key:
DoN – Director of Nursing, Midwifery, Therapies & Governance
DDoN – Deputy Director of Nursing – Workforce & Professional Standards
ADN WF – Assistant Director of Nursing & Midwifery– Workforce
ADF - Associate Director of Finance

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB010/19	Report Title	Guardian of Safe Working Report to Board for Period: 1 August 2018-31 October 2018.
Executive Lead	Jugnu Mahajan, Interim Medical Director		
Lead Officer	Dr Ruth Chapman, Guardian of Safe Working		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This is the delayed report from November 2018.

- Executive Team agreed employment of 8 Clinical Fellows to support trainee ward work in Medicine
- Executive Medical Director and Clinical Directors decided against implementing a combined on call rota for Surgery and Trauma and Orthopaedics
- Southport Doctor's Mess enlargement and refurbishment is underway
- GOSW resigned on 30th October 2019

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)*

A new GOSW to be recruited to carry on the work done by the incumbent

Previously Presented at:

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

NHS
Southport and Ormskirk Hospital
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THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT 1st August – 31st October 2018

Introduction

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

1. EXCEPTION REPORT OVERVIEW (WITH COMPARISON FOR SAME PERIOD IN 2017) (1st August – 31st October 2018)

AREAS	PERIOD: 01/08-31/10/18	PERIOD:26/07-9/10/17
Exception Reports ERs	13	19
Completed ERs	11/13	17/19
Trainees	7	9
Episodes	18	27
Review Interview Held	11/13	19/19
A&E	0	0
Medicine	8	15
Surgery	0	2
T & O	5	2
Anaesthetics	0	0
Ophthalmology	0	0
Paediatrics	0	0
Obs & Gynae	0	0
GP	0	0

See **Appendix A** for Exception Report for detailed Breakdown of figures

It has been possible for Time-Off-In-Lieu (TOIL) rather than payment to be given for most Exception Reports.

There is a significant improvement in completion rate and efficiency in Review Meetings.

An Exception Report Standard Operating Procedure (SOP) was ratified by the Workforce Committee on 24th October 2018.

2. MEDICINE

The Executive Team has agreed to the employment of 8 Clinical Fellows who will provide greater support of trainees, quicker patient review by more experienced staff, on call coverage and also allow trainees more time to attend education opportunities. Two of the 5 SAS doctors are in post with the others awaiting visas. There is a concern that they may not be in place before the expected increase in winter activity.

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

3. PAYMENT AND FINES

Payment for TOIL generated from Exception Reports from 1st August 2018 to 31st October 2018 was £26.03.

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

4. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

All Trust Rotas are 2106 compliant.

Work schedule reviews have occurred in Surgery and Ophthalmology

One trainee swap request resulted in non-compliance. This was forwarded to the GOSW and EMD. After checking the trainee's shifts, this was agreed as a safe swap for this one occasion.

A SOP Covering Unfilled Trainee Doctor Shifts has been written and was ratified by the Workforce Committee on the 24th October.

5. DOCTORS NOT ON THE NEW CONTRACT

Medical Staffing identified the 20 doctors not on 2016 contract in the last quarter. No concerns about safe working from non-trainee doctors have been escalated to the GOSW.
Medical HR will identify any trainee not on 2016 contract quarterly and GOSW will continue to monitor these trainees.

6. DOUBLE/TRIPLE BLEEP CARRYING

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

There have been 5 episodes of Double Bleep carrying. The Trauma and Orthopaedic trainee had to carry both Trauma & Orthopaedic and Surgery bleeps because the Surgery F2/CT Locum did not turn up for 3 weekend shifts. The Trauma & Orthopaedic F2 had to carry the F1 and F2/CT bleeps because it was not possible to recruit an F1 doctor for 2 week end locum shifts.

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

7. VACANCIES (as of 1st November 2018) See **Appendix 2**

I am pleased to say SOHT are actively recruiting and therefore vacancy rates are changing almost daily, so I cannot guarantee complete accuracy.

8. MIAA REPORT

The Mersey Internal Audit Agency Report on Junior Doctors Contracts was positively rated as Significant Assurance. A SOP for the Exception Reports dealing with safety issues, processing overtime payments resulting from exception reports and training has been written. This was ratified by the Workforce Committee on 24th October 2018. Terms of Reference for the Trainee Doctors' Forum have been written and sent to the Medical Education Committee for approval.

9. TRAINEE CONCERNS

The Trainee Doctor Forum continues to meet monthly. Unfortunately, the September Meeting had to be cancelled. Trainee attendance remains low, but trainees continue to email their concerns to the GOSW and representatives raise concerns forwarded to them. From August a change of day has being trialled to see if this would improve attendance. Unfortunately, no increase in numbers has occurred. A Skype link to Ormskirk was organised in August, but technical difficulties prevented this in October. There is now a dedicated Ipad for trainee use in the Education department at Ormskirk so that trainees from both sites can link into Trainee Doctors Forum.

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

9.1 Medicine

Once the additional 5 SAS doctors and 8 Clinical Fellows are in post, the effect on trainee workload and training can be assessed.

Clinical Supervisors and trainees have been specifically asked about opportunities for trainees to attend clinics for training.

ACTION*: Monitor employment of more staff and effect on excessive workloads*
ACTION: *Medical Education Department to monitor training clinic attendance*

9.2 Surgery

The Trust has employed 4 additional F2/CT doctors in Trauma and Orthopaedics. Once these doctors are in post the Trauma and Orthopaedic on call rota will then be fully staffed. The Surgery rota will have 3 gaps in an 8 doctor rota at F2/CT level from 5th December. The EMD and CDs have decided not to move to a combined rota. This is the trainees preferred option. The GOSW is concerned that only 2 of the doctors have a start date prior to December and the remainder have proposed start dates of February and March 2019. The Surgery rota still has 3 unfilled posts in an 8 person rota which will be filled by locum/bank doctors. The EMD has given assurance this should not result in Double Bleep carrying if the shifts remain unfilled, the Registrars and Consultants will act down.

ACTION: *GOSW and EMD will continue to monitor Surgery and T & O closely.*
ACTION: *EMD will ensure acting down occurs*

9.3 Facilities

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

enlarge the mess. Work commenced on the 5th November with a proposed finish date of 14th December.

Ormskirk Mess facilities do not have a working microwave and the room is left unlocked. Steve Treadgold is aware of this and has agreed to purchase a microwave and investigate use of the coded lock.

ACTION *GOSW to monitor Southport mess extension and refurbishment*
ACTION: *GOSW to monitor initial improvements in Ormskirk Mess*

10. ADDITIONAL GOSW CONCERNS

Medical HR encouraged trainees to apply for holidays in advance of starting to try and spread leave allocation more evenly, however decision on leave requests were not being actioned promptly in August Investigation revealed this was mainly due to unfilled management posts and has now been rectified.

ACTION: ***GOSW will continue to monitor timely response to leave requests***

11. SMART CARDS

GOSW has identified that trainees at F1/F2 and CT level do not need Smart cards. This should provide both financial and time savings.

12. GOSW's ROLE

Core GOSW work load has improved. Excellent administration support of 4 hours/week is now in place. This has reduced the GOSW additional hours on a monthly basis. Additional work supporting implementation the combined rota in Surgery and T & O was been agreed by the CEO and EMD.

On the 18th October 2018 GOSW and Ruth Adams, Healthmedics Lead, spoke at the National Allocate Conference. The presentation suggested improvements which could be made to the GOSW Dashboard. Developments addressing some of these areas are in progress. The presentation also showcased the innovative changes SOHT Healthmedics team have developed to capture data about Additional hours worked by trainees and TOIL taken. SOHT Healthmedics Team have implemented a streamlined payment system utilising the MOL roster system. Allocate plan to implement this payment procedure nationally.

I tendered my resignation as GOSW on 30th November and I wish this to be with immediate effect.

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

Dr Ruth Chapman
Guardian of Safe Working
15th November 2018

Appendix 1

EXCEPTION REPORT OVERVIEW (1st August – 31st October 2018)

Exception Reports **13 by 7 trainees**
8 Medicine
5 Trauma & Orthopaedics
11/13 Completed on system
18 Episodes

Exception Episodes

Medicine *13 Episodes*

8 Extra Hours Episodes
4 Service Support
1 Training Episodes

Extra Hours
7/8 Episodes Completed
7/8 Episode interviews have taken place
6/8 Episode Interviews within 14 days*
1/7 Awaiting trainee sign off
9.00 Extra hours worked
6.00 hours TOIL agreed
3.00 hours Overtime pay agreed
0 Episodes overdue
0 days overdue

*1 trainee was initially allocated a Clinical Supervisor who had retired, once new Clinical Supervisor allocated review meeting took place within 14 days.

Service Support
4/4 Episodes Completed
4/4 Episode interviews have taken place
4/4 Episode Interviews within 14 days
4/4 Awaiting trainee sign off
0 Episodes overdue

Training
0/1 Episodes Completed
0/1 Episode interviews have taken place
0/1 Episode Interviews within 14 days **
0/1 Awaiting trainee sign off
0 Episodes overdue

**not yet overdue

Trauma & Orthopaedics
5 Episodes
0 Extra Hours Episodes
5 Service Support
0 Training

Service Support
5/5 Episodes Completed
5/5 Episode interviews have taken place
5/5 Episode Interviews within 14 days
5/5 Awaiting trainee sign off
0 Episodes overdue

Appendix 2
VACANCIES AS OF 1st NOVEMBER 2018

AED

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

Anaesthetics

Consultant	4 vacancies in 20 posts (1 locum in post)
SAS	2 vacancy in 16 posts
ST3	0 vacancies in 3 posts
FY2 – ST2	1 vacancy in 8 posts (X2 CT not on on-call rota)

Dermatology

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

GP Practice

FY2 – ST2	1 vacancy in 9 posts

Medicine

Consultant	4 vacancies in 20 posts (4 locums in post) 0 vacancies in 11 person rota (2 SAS acting up)
SAS	1 vacancy in 7 posts (1 locum in post)
ST3 and above	2.4 vacancy in 10 posts (1 on Parental leave) (1 locum in post)
FY2 – ST2	2.6 vacancies in 16 posts (1 on Parental leave) (2 locums)
FY1	0 vacancies in 16 posts

Obstetrics and Gynaecology

Consultant	0.5 vacancies in 13 posts (1 locums in post)
>ST3	1 vacancy in 8 posts (2 locums in post)
FY2 – ST2	0 vacancies in 8 posts

Ophthalmology

Consultant	2.4 vacancies in 3 posts (1 locum in post)
SAS	0 vacancies in 5.7 posts
ST1-7	0 vacancies in 1 posts

Orthopaedics

Consultant	0 vacancies in 9 posts
SAS	1 vacancy in 7 posts (1 locum in post)
ST3	0 vacancy in 1 posts
FY2 – ST2	3 vacancies in 8 (3 locums in post)
FY1	0 vacancies in 3 posts

Paediatrics A&E

Consultant	0 vacancies in 2 posts
SAS	0 vacancies in 11 posts
ST3	0.4 vacancies in 4 posts
FY2 – ST2	0 vacancies in 2 posts

Paediatrics

Consultant	0 vacancies in 7 posts
SAS	0 vacancies in 4 posts
ST3	0.4 vacancies in 4 posts
FY2 – ST2	0 vacancies in 8 posts
FY1	0 vacancies in 1 post

Psychiatry

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

Spinal Injuries

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

General Surgery

Consultant	0 vacancies in 7 posts
SAS	1 vacancies in 6 posts
ST3	2 vacancies in 5 posts (2 Locum in post)
FY2 – ST2	3 vacancies in 8 posts (2 Locum in post)
FY1*	0 vacancies in 5 posts

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

Urology

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

NHS Southport and Ormskirk Hospital NHS Trust

GOSW Jan 19 Trust Board Report Action Log

Matters Arising Action Log

Aug-18

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Owner	Original Deadline	Forecast Completion	Status Outcomes	Status
GOSW Nov T	Nov-17	Exception Report training	GOSW to ensure more user-friendly e-Exception reporting training as part of Induction August 2018. Education department have arranged more user friendly Exception Report training as part of induction and an extended time slot for GOSW	GOSW	Aug-18	Aug-18	Feedback from February and August Induction was positive Extended Exception Reporting Presentation was given as part of F1 teaching programme in September	BLUE
GOSW Nov Trust Board Report	Nov-17	Exception Report Completion	Changes to ER process to ensure TOIL and payment only occur if trainee signs off report.	GOSW	Feb-18	ongoing	Over the last 12 months 188/204 Exception Epiode Review meeting occurred, however only 115/204 have been signed off as completed. New payment system using MOL put in place - first payment being processed	GREEN
GOSW Nov Trust Board Report	Nov-17	Payment System for Exception Reports and Fines	GOSW, HR and Finance to organise a suitable system. GOSW to present Exception and Fine costs at the May Board	Fianance, GOSW	Dec-18	Aug-18	All payment requests submitted before 5th July paid to trainees in July pay. 1 trainee submitted request in early August paid in September.	BLUE
GOSW Nov Trust Board Report	Nov-17	Rota Compliance and In-house Locum Arrangements policy	GOSW, Interim EMD and HR to agree in-house locum arrangements and write a policy. EMD to formalise a SOP	GOSW/EMD	Dec-18	Jun-18	Agreement has been reached for when payment of breaks is appropriate. SOP for Internal Locums written. Agreed at May TDF and ratified by Workforce committee in October.	BLUE
GOSW Nov Trust Board Report	Nov-17	Double/Triple Bleep Carrying	GOSW has and will continue to forward all instances of double bleep carrying to EMD.	EMD/GOSW	Nov-18	ongoing	Any episodes of Double Bleep carrying reported to GOSW escalated to EMD - 5 in Surgery and T & O in the last quarter. EMD to ensure acting down occurs	RED
GOSW Nov Trust Board Report	Nov-17	Doctors in Difficulties	Monitoring and support have been given. GOSW, EMD and DME to monitor situation.	GOSW/EMD/ DME	NOv-17	Jan-18	Both trainees completed their year and have left SOHT	BLUE
GOSW Nov Trust Board Report	Nov-17	ID Badges	Task and finish group to ensure ID badges will be available and working. GOSW to check whether there were any issues for new starters in February	EMD/HR	Jan-18	Ongoing	No issues with new trainees start in Feb 18. ID badges available for August trainees. Smart cards not required for trainees below ST2	BLUE
GOSW Nov Trust Board Report	Nov-17	GOSW extra hours reviewed by interim EMDs and payment made	Extra hours reviewed by interim EMDs and actioned for payment. EMD to review extra hours on a monthly basis.	EMD/Finance	Feb-18	Aug-18	GOSW supporting service development in Surgery and Medicine. Extra hours sanctionned by CEO	GREEN
GOSW Nov Trust Board Report	Feb-18	Exeception Report Overview	GOSW has advised TOIL as default from 1st August.	GOSW/EMD	Aug-18	ongoing	Continued monitoring - only 1 Exception report given as Payment	GREEN
GOSW Nov Trust Board Report	Feb-18	Southport Doctors' Mess	Extension of Southport Mess Area agreed and refurbishment	GOSW/HR	Feb-18	Oct-18	Work delayed, started 5th November with provisional completion date of 14th December 2018	AMBER
GOSW Nov Trust Board Report	Feb-18	Medicine Workload	EMD and AMD for medicine to determine safe medical staffing levels for each ward following the principles of safe nurse staffing.	EMD/AMD Medicine/G OSW	Aug-18	Aug-18	5 SAS doctors employed - awaiting visas and start dates. Business Case for 12 Clinical Fellows, Executive	AMBER
GOSW Feb Trust Board Report	May-18	Surgery unfilled shifts - 2 Psychiatry F1s removed from on call rota at short notice.	F1 Surgery rota reduced from 1 in 11 to 1 in 9	EMD/GOSW	Aug-18	Aug-18	New F1 rota started 20th August.	BLUE
GOSW May Trust Board Report	May-18	Surgery and T & O unfilled shifts Gaps in F2/CT rota have led to further issues with unfilled shifts in surgery.	Combined F2/CT rota for Surgery and T & O agreed by AMD and CDs	EMD/GOSW/ AMD Surgery	Aug-18	Dec-18	EMD and CDs decided against a combined rota. T & O have recuited 4 F2/CT level doctors, 2 starting in November, 2 in February/ March 2109. EMD to ensure acting down to cover unfilled shifts occurs.	AMBER
GOSW May Trust Board Report	May-18	MIAA identified SOP for Exception report required	GOSW to write a SOP for the exception reporting dealing with exception reporting for safety issues and processing overtime payments resulting from exception reports	GOSW	Jun-18	Jun-18	SOP written and ratified by Workforce Committee in October	BLUE
GOSW May Trust Board Report	May-18	MIAA identified Terms of Reference for TDF required	GOSW to write Terms of Reference for Trainee Doctors Forum by June 2018	GOSW	Jun-18	Jun-18	ToR written and awaiting agreement by Medical Education Committee	GREEN
GOSW May Trust Board Report	May-18	Inadequate Bank holiday staffing levels identified	Week end staffing levels put in place and GOSW and EM	GOSW/EMD	Jun-18	Sep-18	Week end staffing in place for both May Bank holidays. Monitor August Bank holiday	BLUE
GOSW May Trust Board Report	May-18	Accomodation Concerns	ACTION GOSW to monitor accommodation concerns	GOSW	Aug-18	Aug-18	All trainees emailed about new accomodation arrangements after 6 weeks - no concerns raised	BLUE
GOSW Sept Trust Board Report	Sep-18	Ormskirk Mess Improvement	Purchase of a microwave and enable trainees to lock doors	GOSW	Dec-18	Dec-18	Assessed by Steve Treadgold and agreement by facilities to action improvements	AMBER
GOSW Sept Trust Board Report	Sep-18	Timely action of Leave requests	GOSW to contact OSMs re timely action on leave requests	GOSW	Aug-18	Aug-18	GOSW spoke to OSMs. Trainees have not raised any issues with leave requests being actionned	BLUE
GOSW Trust Board Sept	Sep-18	GP Trainees working outside schedule	GOSW contacted GP practice and they apologised and agreed to amend the trainee hours	GOSW	Aug-18	Aug-18	Hours have been amended and 2 trainees at practice from August working to schedule	BLUE

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB011/19	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 contains the following components:

- Performance Dashboard
- Executive Assurances
- KPI Graphs and Narrative

Recommendation

The Board is asked to **receive** 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 January 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - November 2018

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	2	8	2			
Never Events	0	0	2	0			
VTE Prophylaxis Assessments	95%	96.1%		185			
Harm Free (Safety Thermometer)	94.99%	97.8%	97%	8			
Falls - Moderate/Severe/Death	1	0	0	0			
Patient Safety Incidents - Low, Near Miss or No Harm		594	4521	594			
Safe Staffing	90%	95.8%		N/A			
Fractured Neck of Femur	90%	63.2%	72%	12			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
SHMI (Summary Hospital-level Mortality Indicator)	100.1	115.5		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	117.7	117.7	N/A			
WHO Checklist	99.9%	100%		1			
Stroke - 90% Stay on Stroke Ward	80%	72.7%	78.1%	6			
Sepsis - Timely Identification		100%	96.3%	N/A			
Sepsis - Timely Treatment		100%	81.8%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	5	73	5			
Written Complaints	44	35	185	35			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	96.2%		16			

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%	89.5%	91%	1079			
Accident & Emergency - 12+ Hour trolley waits	1	5	16	5			
Ambulance Handovers <=15 Mins	99%	55%	42.8%	671			
Diagnostic waits	1.01%	1.4%		39			
14 day GP referral to Outpatients	93%	94.6%	94.5%	46			
31 day treatment	96%	100%	98.3%	0			
31 day treatment (Surgery)	94%	100%	96.2%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	86.1%	77.5%	5			
62 day GP referral to treatment	85%	90.3%	80.2%	3.5			
Referral to treatment: on-going	92%	96.2%	96.2%	381			
Bed Occupancy - SDGH	93%	95.6%		N/A			
Bed Occupancy - ODGH		35.1%		N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	100%	79.4%	0			
Duty of Candour - Evidence of Letter	100%	85.7%	58.7%	1			
I&E surplus or deficit/total revenue	-1%	-17.6%	-19%	N/A			
Liquidity	-23	-41	-41	N/A			
Distance from Control Total	0%	0.4%	-7.9%	N/A			
Capital Service Capacity	-2.423	-2.52	-3.559	N/A			
% Agency Staff (cost)	5.6%	6.7%		N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	29.9%	-5.6%	N/A			
Staff Turnover	0.76%	0.6%	6.8%	N/A			
Vacancy Rate - Medical		7.6%	7.6%	N/A			
Vacancy Rate - Nursing		9.7%	9.7%	N/A			
Sickness Rate	3.9%	5.9%	5.7%	N/A			
Personal Development Review	85%	70.5%	70.5%	N/A			
Mandatory Training	85%	84.4%	84.4%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.3		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		12		12.13			
DTOC - Number of Beds lost per month		4		4			
Length Of Stay		7.3		N/A			
New:Follow Up	2.64	2.5	2.4	N/A			
DNA (Did Not Attend) rate	8%	7.2%	7.3%	1647			
Cancelled Ops	0.61%	0.1%	0.2%	3			
Theatre Utilisation - SDGH	90%	65.1%	66.3%	N/A			
Theatre Utilisation - ODGH	90%	82.1%	81.2%	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 Programme was approved 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 for the last financial year and will be undertaken again at the end of the 2018/19 year..

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.
As part of the Board Development Programme AQuA has been commissioned to undertake an external Well Led Review of the Trust. This commenced in December and will continue until the end of March 2019
Further, we are having discussions with HealthSkills to agree and roll out a programme focusing on High Performing Teams

Board Governance

A quarterly review of the Board Assurance Framework takes place. This now has the KPIs from the IPR mapped thus creating synergy between the two key documents.
Corporate Risk Registers are reviewed monthly at the board and assurance committees

Governance Framework

The following forums have been established with Terms of Reference and work plan/annual business cycle:
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 Performance 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 continues to improve. A new process has been introduced to ensure early confirmation of harm as well as early escalation.
Safe staffing levels have remained above 90%, including registered nurse levels which are now above 90%

Not Assured/Most Deteriorated

Nine pressure ulcers have been reported in November; however all were classified as grade two.

Delivering single sex accommodation breaches are improving, this was due to improving occupancy rates within the Southport site, and however this is likely to come under further pressure during the winter period.

Patient falls still remains a concern and an increase within Planned Care has been seen. 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: Medical Director	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. Workstreams under the 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

A&E 4 Hour Performance

- The Trusts reported 4 hour A&E performance in November was 89.4%, November 2017 it was 80.7%.
- This is mainly due to performance at Southport which has improved in the year from 53.5% to 76.7%, despite an increase in attendances of more than 100 patients in the month.
- This is the fourth consecutive month that performance has been better than last year and December is so far continuing this trend despite further increases in demand as we enter the winter period.
- November was also the first time since June that the Trust has beat the trajectory target agreed with NHSI.

Ambulance Handover Times

- The Trust had 30 ambulance handovers greater than 1 hour in November 2018. In November 2017 this was 278 – an improvement of 89%.
- Since July the Trust had made steady improvements of ambulance handovers over 1 hour – but whereas last year performance deteriorated into the winter this year it is improving.

18 Week RTT Performance

- November 18-week performance was 96.24% which is the highest performance the Trust has had since April 2017.
- This was an improvement again from October when it was 96.02% and a bigger improvement from last November when it was 95.1%
- The ongoing waiting list has increased in this time though and currently is 10127 – this has grown over the year from 8514 last November.
- There are no patients waiting over 40 weeks and only 32 waiting over 30 weeks
- Despite this performance level there are still challenges in Community Paediatrics, Vascular Surgery, Optometry and Oral Surgery which are not meeting the target at present.

Assured/Most Improved

Length of Stay

- Length of stay for regular emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 8.94 days in November. This is 1 whole day less than the average length of stay for the same cohort of patients in November 2017.
- Improved length of stay is also evident in the improvement made in the Stranded patients metric which shows that November has 11% fewer stranded patients and 25% fewer super stranded patients than last year

Overdue Follow Ups Backlog

- Since the peak in September 2017 when the backlog of overdue follow ups reached 5,000 the Trust has managed to decrease this number down to its lowest level on record at approximately 1,800 this month.
- Between January 2018 and September 2018 numbers were fairly static, deviating around 3,000. However, in the past 2 months this has been reduced by around 40% to current levels.
- The most notable contribution to this is from Ophthalmology which has seen a 71% reduction in waiters in this time.

Diagnostics

- Performance for November against the 2% 6-week-wait target was 1.45%. This is the first time since February 2018 the Trust has achieved this target when it was 1.95%.
- Since a peak of 6% in May 2018 performance has been on an improving trajectory, with 4 out of the last 7 months showing improvement on the last.
- November was the biggest of these improvements – with the % change in performance 65% (4.18% to 1.45%)

Not Assured/Most Deteriorated

Cancer 62 Day

- Performance for October was above the 85% target at 90.3%, however, this was the first month for 4 months that the target has been met and only the second time in the last year so there is no indication of an improvement in trend.
- September performance was 70.1% with October 2017 at 87.2% so this is an improvement on both of these.

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

Overview

Vision 2020

- Ensure delivery of 2018/19 plan and support development of more sustainable position in 2019/20 so that the deficit reduces below £25 million by 2020.
- Ensure that the Trust governance supports delivery of quality service to patients in agreed financial envelope.
- Reduce usage of agency staff and locum medics to improve quality of service and to deliver more sustainable financial position.
- Ensure delivery CQUINs in 2018/19 to improve quality of service provided to patient and to receive the associated financial benefits.
- Ensure focus on operational excellence and efficiency is embedded in culture and becomes part of business as usual.
- Build financial rigor, grip and control into everyday use of Trust resources to ensure that the Trust meets is 18/19 plan and reduces deficit in future years.

Month 8

Month 8 financial performance was on plan so the YTD adverse variance remains the same at £0.3M. Both income and expenditure levels were consistent with month 7. There are a number of risks that will impact on whether the Trust will deliver the planned deficit of £28.8M as follows:

- 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 £2.4 million minimum. The CDU element at risk could be as high as £1.8 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 eight month's performance is £1.5 million with a forecast of £2.1 million at the year end.
- Commissioners have challenged the average unit price charged for non-elective activity.
- Pressures from vacancies, high sickness levels, rota gaps and the implication of "safe staffing" in nursing continues to put pressure on budgets.
- CQUIN underperformance could result in reduced income of up to £500,000 for the full year although recent focus could reduce this to £320,000.
- Delivery of £7.5million CIP remains at risk although additional schemes are continually being identified.

Assured/Most Improved

- October and November's monthly deficit averaged £1.95 million which, if replicated across the whole financial year, would achieve the Vision 2020 objective of reducing the deficit below £25 million.
- The clinical income rise seen in October has continued into November resulting in being ahead of plan in month and year to date (YTD). All points of delivery (POD) have exceeded plan in November with the exception of electives where the level of underperformance continues (7.2%).
- The cost of agency staff as a proportion of the total cost of the workforce has reduced which reflects the lower nurse agency spend in month although agency spend needs to reduce much further to give assurance that this metric is under control.
- Discretionary spend and petty cash policies continue to have a positive impact on spend. Further work is required regarding the rollout of full purchase order compliance to provide full assurance.
- Reduction in nurse agency spend in November as the number of shifts filled by agency staff has been reduced. Further improvements in nursing agency spend are anticipated to be achieved in next 3 months as work continues on improvements to nurse e-rostering and on recovery of hours owed by nursing workforce.
- The forecast medical staff run rate reductions in November were achieved in line with the plan.
- CIP check and challenge work continues, a number of CIPs have been progressed reducing the overall CIP gap. However, there is still a risk around the Trust not being able to deliver its CIP target of £7.5 million.
- People and Activity Group (PAG) is operating successfully with compliance with documentation and communication of intentions significantly improved. Focus in on cross-cutting schemes which will deliver operational efficiencies such as outpatients and length of stay, these will have positive impact both on patient experience and run rate.

- Work around delivery of CQUINs continues, with key risks linked to CQUIN delivery being identified and recovery plans formed.

Not Assured/Most Deteriorated

- Income levels at month 8 YTD and year end forecast are subject to CCG challenge.
- Elective activity is under plan in month and, despite recent improvements, continues to deteriorate.
- PAG compliance and effectiveness remains an issue. The causes of non-compliance are being reviewed and corrective actions will be proposed by the Director of HR in early January.
- As stated above, CIP gap remains an issue as whilst gap continues to reduce, it is likely that the Trust will have a small shortfall at the year end.
- Out of 137 cost improvement projects identified to date, 57 projects have not yet been subjected to QIA. The HMB held on 20th December agreed that all QIAs will be completed by 31st January 2019. Progress is being monitored by Executive Directors on weekly basis.

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 70.48% in November which is disappointing as this bucks the continuous improvement trend of the last 6 months as it is a slight decrease on last month. There continues to be 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. Specialist Services is the only CBUY over 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. Additionally further training on the policy will be provided by the HR team in the new year.

Mandatory Training
Mandatory training rates continue to steadily increase and improve each month. In November the overall Trust rate was 84.43%. 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 was a success with 80% of staff having obtained the vaccinations.

Not Assured/Most Deteriorated

Sickness Absence

Sickness absence has decreased in November 18 to 5.94%, from 6.26% in October 18. 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.

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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
Pre Consultation Business Case project team to be set up to oversee the outputs and ensure resources, timescales and scope are defined and delivered
Silas Nicholls and Clare Powell arranging a series of meetings with system leaders to engage them in the PCBC roadmap and agree outputs
ESTATES SOLUTIONS
Hot Site - A visit to learn from the Cramlington model is booked in January.
Cold Site - The Regional Elective Care Centre model is in design phase with a visit to Glasgow's Golden Jubilee Hospital booked for February.
Estates strategy – a system wide strategic workshop is taking place on the 13th December reporting on a comprehensive baseline of existing and proposed assets and infrastructure and a critical analysis of gaps and issues, informed by the emerging clinical and service strategies that are being developed across the partners in the Sefton Transformation Programme
Acute estates planning – work has commenced to provide a site control plan for both Southport and Ormskirk sites
FINANCE SOLUTIONS
Work has commenced to explore system Financial models
OPERATING MODEL
Target operating models to emerge from the clinical scenarios

KEY ACHIEVEMENTS/PROGRESS IN MONTH
Women and Children's workshop held in November initiating the clinical models development, follow on paediatric workshop early December. Constructive meeting with paediatric and obstetric Clinical Director, consultant midwife and neo natal ward manager held in December.

Not Assured/Most Deteriorated

Maturity of Out of Hospital solutions to inform acute demand modelling continues to be a concern. Need to develop a MoU with each neighbourhood and advance the integrated Delivery Framework in West Lancs
Capital bid for new hospital not successful in wave 4. Additional diverse funding sources to be investigated, focus on Ormksirk development in 2019/20

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KPI Graphs and Update

Board Report - November 2018

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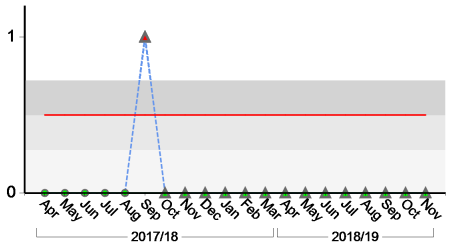
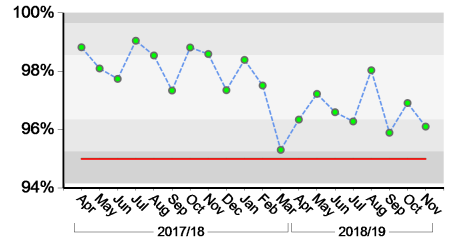
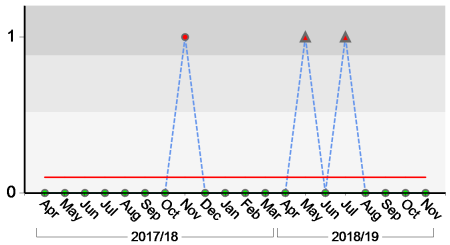
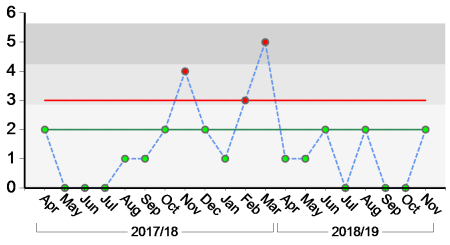
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	It is now 14 Months since the last MRSA bacteraemia - the last incidence was in September 2017 - There is continued provision of training/education on the importance of cannula maintenance and 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 November - 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 2 never events in the last 12 months, both were in the current YTD, in May and July. - There were 0 Never Events reported for November. 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 were 2 cases of C diff infection in November which is 6 cases in total for the YTD - There was 1 case on EAU and 1 case on ward 7B. The Trust continues to be under trajectory by 15 cases on the NHSI target and by 5 cases in relation to the Trust internal stretch target. 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 in both scenarios.	

Board Report - November 2018

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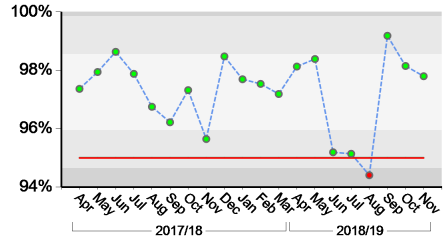
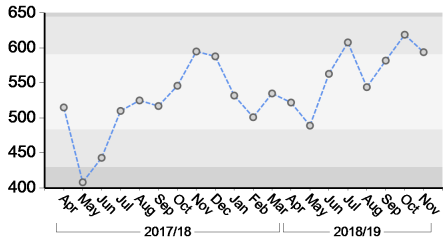
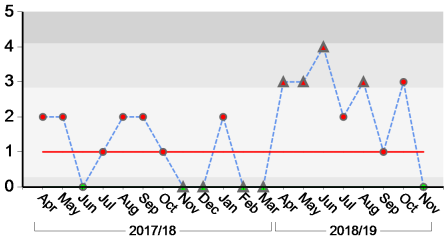
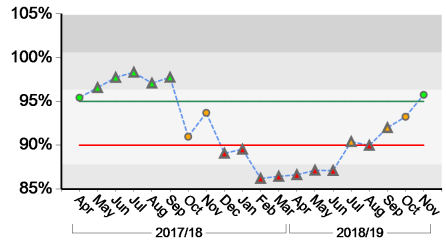
Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance compliance continues to exceed the national benchmark - National benchmark of 95% reached for month of November. During the census period of data collection (n=363 the Trust reported 8 new patient harms which were made up of: 2 new HAPU (Grade 2 or above) – Ward 14A (1 x new Grade 2) and Ward 7a (1 x G2) 2 x falls – 2 x low harm on wards14b and 9a 1 x CAUTI – Ward 7b 3 x VTE – 2 x PE on wards 11b and 7a and 1 x DVT on ward 14b	
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.	There were 595 No Harm/Near Miss/Low Harms in November - There has been a decrease in the reporting of lower level incidents during November for the Trust - 595 reported compared to 619 last month. For November there were 33 near miss incidents , 395 no harm and 167 low harm incidents. The categories with the top 3 highest reported incidents relate to Clinical Care, Accidents and Safeguarding (non-pressure ulcer). 48 of these are DoL's applications which are reported for information. There is a theme around 40 incidents relating to blood tags.	
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	There were no reported falls categorised as moderate/major/death in November - The Falls Group continue to review multifactorial assessment and to ensure robust actions are undertaken. Monthly falls report now being produced to break down falls per 100 bed days and per CBU to be circulated through Q&S Committee 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%.	The trajectory shows further increased performance against safe staffing. This is supported by the Trust's continued robust actions - Based on the current establishments performance for the month of Nov reports above the threshold of 95%, a positive achievement that has not been reported in the last 14 months. The supportive actions delivered through the daily safe staffing huddles and the daily confirm and challenge seen through these meetings continues. Roster requirements over the festive season have been reviewed stringently through roster performance meetings to assure safe staffing compliance is maintained.	

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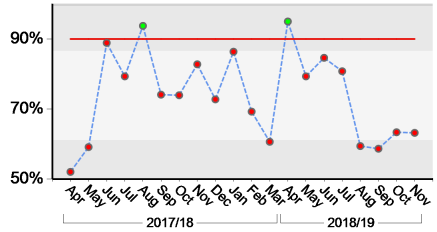
NHS
Southport and Ormskirk Hospital
NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance Improving due since the commencement of the preparation for 'Consultant Of The Week' - To commence in January. Patients will be optimised for surgery the day before, where possible, which should lead to fewer delays in meeting the 36 hours to theatre target.	

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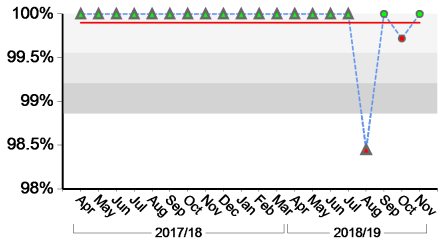
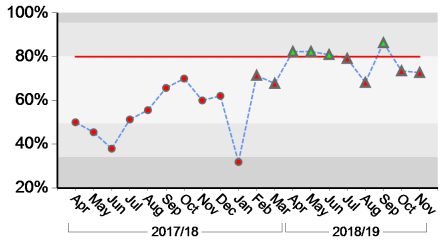
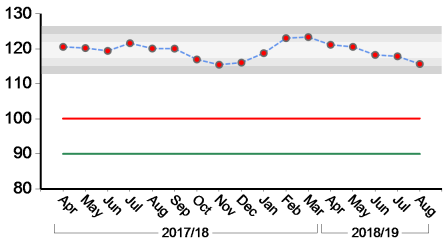
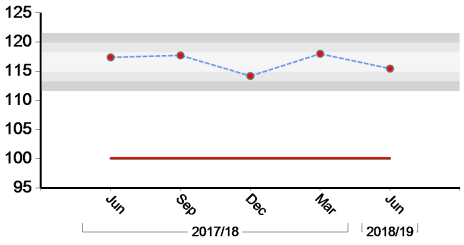
NHS
Southport and Ormskirk Hospital
NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
WHO Checklist	WHO Checklist.	WHO Checklist was 100% compliant in November - 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.	Stroke performance remans under target at 72.73% but is within normal variation. YTD is only slightly under the 80% target at 78.7% - November data could be subject to correction. - Stroke data has now been validated for the current YTD and Ward 7B included as a Stroke Ward.	
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 July 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 1 2018/19 - SHMI decreased in the Quarter up to the end of June 2018 to 118 - When compared to the same period last year the SHMI has reduced, despite an increase in patient acuity and increase in total patients treated. Please see HSMR comments for extended narrative. The actions for both scales (while measured differently) are identical.	

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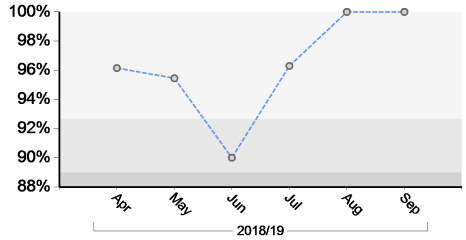
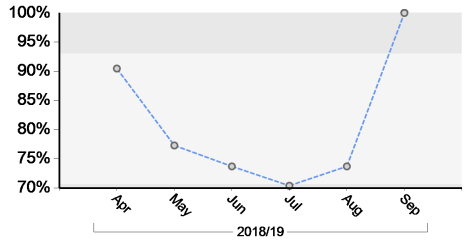
Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
Sepsis - Timely Identification	Sepsis Timely identification of sepsis in emergency departments and acute inpatient settings - National early warning score (NEWs) recorded within 1 hour of hospital arrival.	The Trust is 100% compliant. There were 26 patients diagnosed with Sepsis in September within one hour of arrival - September is the latest data available.	
Sepsis - Timely Treatment	Sepsis Timely treatment for sepsis in emergency departments and acute inpatient settings- the rate of rapid administration of antibiotics within one hour of diagnosis of sepsis.	The Trust is 100% compliant. Out of the 26 patients diagnosed with Sepsis within one hour of arrival, following review, 22 patients were confirmed as having Sepsis, all of whome were treated with antibiotics within one hour of the diagnosis. - September is the latest data available	

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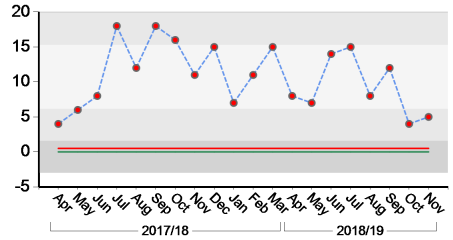
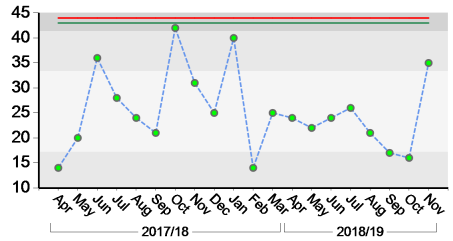
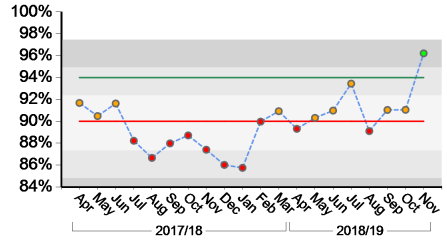
NHS
Southport and Ormskirk Hospital
NHS Trust

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.	There were 5 breaches of DSSA In November. Whilst this is an increased number compared to October (4), this is still significanlty lower than previous months, and is the second lowest number since April 2017 - There is ongoing monitoring to maintain. There is a review of patients within critical care identified at each bed meeting; improvements in flow will reduce delayed transfers from critical care; introduction of #longstaytuesday is having a positive impact on LoS	
Written Complaints	The total number of complaints received. A lower number is good.	There were 35 reported complaints in November. This is the highest number in the last 10 months, although comparable to November 2017 which had 31 reported complaints - The three main themes are: communication, clinical treatment and staff attitude. There is a weekly complaints review group, and a complaints improvement group which looks at improving the processes. Performance Review Boards have a focus on complaints resolution and work continues on developing behaviours and skills around complaints resolution	
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.	Performance has improved since October and has achieved above the target of 95%. However, the response rate has reduced from 7.6% in October to 4.22% and is below the average response rate of 6.58% - Works continues to support the patient experience strategy and outcomes of national surveys.	

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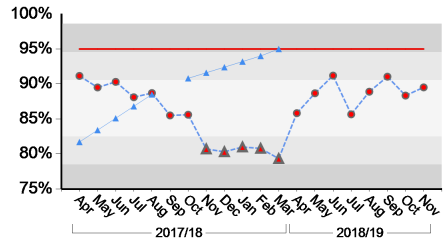
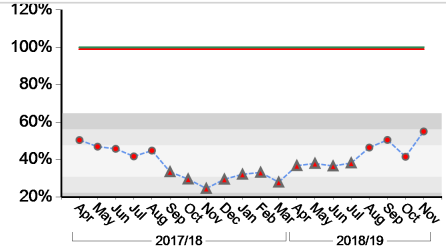
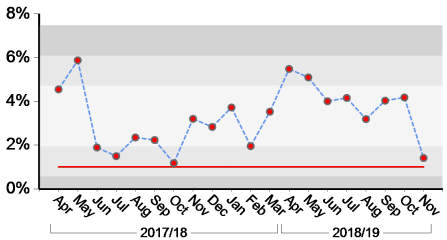
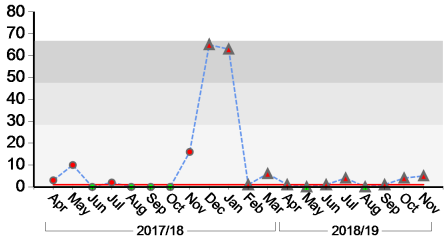
NHS
Southport and Ormskirk Hospital
NHS Trust

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.	- Although the Trust did not achieve the 95% target, there was over a 20% improvement in performance on the 4-hour reported position for the Southport site for November 2018 compared to November 2017 (76.7% compared to 53.5%). This is testament to the continued improvement programmes focusing on front door, streaming, clinical estate works and the targeted work across the wards improving inpatient flow. November saw a 2.3% increase in overall attendances and a 5.8% increase in majors category. The conversion rate from attendance to admission was marginally higher than the previous year but less than 1%. The 1st phase of the ED redesign opened at the start of November creating additional triage space, and dedicated ambulance cubicles. The 2nd phase is due for completion by 21 December, which will release a further 3 clinical rooms and increased waiting area.	
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.	Improvement in ambulance handover times - During the month of November, over half of the patients who arrived by ambulance were handed over within 15 minutes of arrival. This is the first time that this has been achieved and the Trust's performance has been one of the strongest in the region at times across the month. The new ambulance area opened at the beginning of November, which has greatly aided timely handover of patients. There has been a significant reduction in ambulance delays in excess of 1 hour, and the use of the corridor continues to decrease. There are still difficulties in achieving this target during periods of surges and exit blocks from ED, however ED, NWAS and the flow teams continue to work together to keep avoidable delays to a minimum	
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.	Performance has significantly improved in the last month, from 4.18% In October, to 1.45% in November - Audiology - 1 patient - 0.6% - unusually high no. of referrals Cardiology - Echo - 1 - 0.3% - patient choice and nursing home unable to meet appt Colonoscopy - 7 - 5.7% - patient choice Cystoscopy - 3 - 2.7% - patient choice/capacity Cystoscopy (Gynaecology) - 9 - 8.2% - capacity Flexi Sigmoidoscopy - 3 - 4.1% - patient choice Gastroscopy - 1 - 0.7% - patient choice Non-obs Ultrasound - 8 - 0.8% - capacity/unable to contact patient Urodynamics - 6 - 13.3% - capacity/patient choice Out of 2763 patients in total, 39 breached beyond the 6 week wait. We have started a programme of work supported by the PMO to review productivity and utilisation of endoscopy sessions. Process Mapping dates have been agreed for January 2019. We are also working with the Cheshire and Merseyside Cancer Alliance to adopt their scheduling/utilisation tool which would provide benchmarking data and highlight areas of improvement. Some of the Treatment Centre management team attend a CMAC event to listen and learn about good practice.	
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.	- There were x6 12 hour breaches reported during the month of November. x4 of these were patients awaiting mental health beds. x2 were Southport & Formby, x1 was West Lancs, and x1 had recently relocated from Prescot and was admitted to a Merseycare bed. ECIST has carried out a deep dive into Mental Health and a local stakeholder group has now been formed to work through recommendation made in the report;.the first meeting is due to take place on 7 December. The demands on mental health beds across the region remain a challenge. however, patients receive support from ED and Mental health teams whilst they are in ED, and 1:1 support is provided where possible whilst in our care. The remaining 2 patients breached whilst awaiting acute beds - both patients breached during the same day at a weekend when bed occupancy was over 100%, discharges had been lower than expected across the previous week, additional escalation areas had been opened in response to shortfall in bed availability, and diverts had been sought to attempt to alleviate pressures in ED. 1st, 2nd oncall and COO were all on site in response to the pressures, and additional senior nursing support had been called in to ensure patient safety was paramount. The increased drive to embed Red to Green across the wards, the continuation of #longstaytuesday, and the commitment to transfer patients to available beds in the community continue in efforts to improve inpatient patient flow.	

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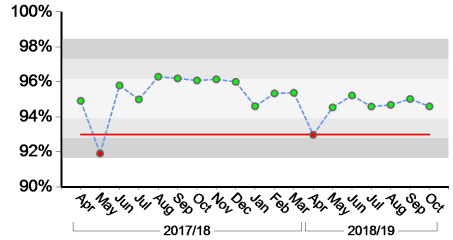
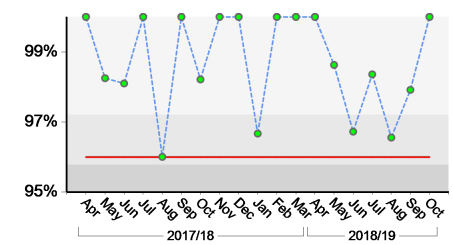
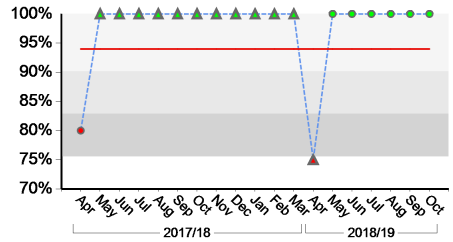
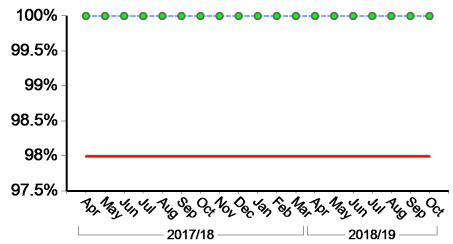
Southport and Ormskirk Hospital NHS Trust

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.	Standard remains compliant in spite of issues caused by ERS - Breaches against this standard continue to be primarily due to patient choice and teething issues with the introduction of ERS. However the standard remains compliant.	
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.	Compliance against standard maintained - This standard applies to all cancer patients treated by the Trust and as such, is a good indicator of our activity. The compliance level in September was due to one breach, who was a patient who went on holiday and so deferred the start of their treatment.	
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').	Compliance maintained at 100% - The Trust continues to maintain compliance for this standard.	
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').	100% compliance against standard - Numbers of patients reported against this target remain low. The Trust continues to maintain compliance against this standard.	

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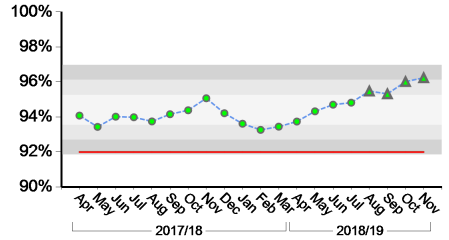
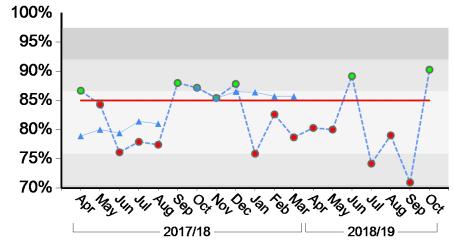
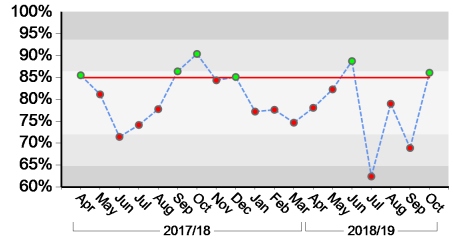
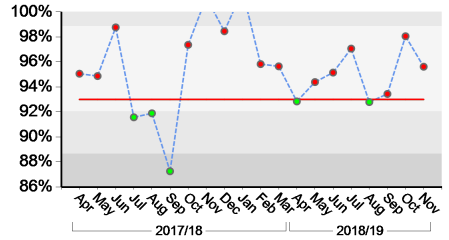
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher.	The Trust is still compliant at 96.24% with a slight increase on last month's position. - This overall Trust figure does not reflect the challenges faced in some of the smaller sub-speciality areas i.e. Pain 88.7% and Vascular 87.8%. 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.	Trust continues to struggle to meet 62 day standard - Issues remain around diagnostic capacity but an extensive, many streamed, improvement plan is underway.	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Post reallocation performance continues to be difficult to achieve - Full, rather than half breaches are allocated to us for patients that we send late to tertiary centres. Breaches in September included, 3.5 in Urology, 1 upper GI, 1 unknown, 1 skin, 0.5 lung, 1 haem, 1 gynae, and 3 in colorectal.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	slight reduction in bed occupancy at SDGH to 95.6% - Red2green re-launch on 6 wards to promote quality, pj paralysis, last 1000 days; red2green lead now in post; part of ECIST peer groups for red2green; improvements in data and LoS reviews with system partners	

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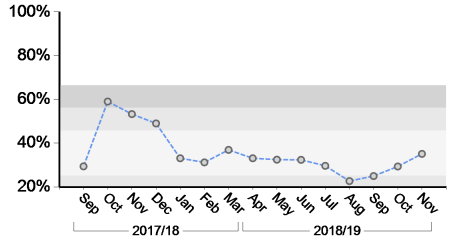
Southport and Ormskirk Hospital NHS Trust

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%.	Performance continues to improve for the 4th consecutive month. - Review is currently underway of utilisation of staffed beds.	

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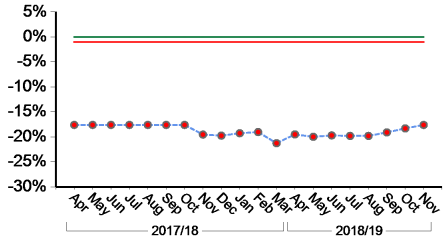
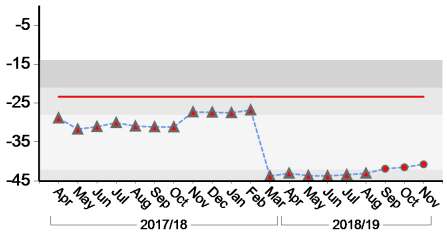
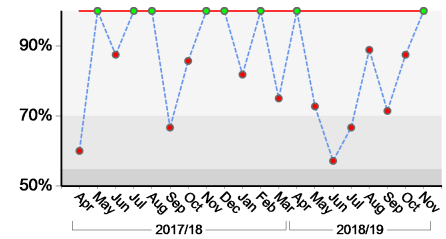
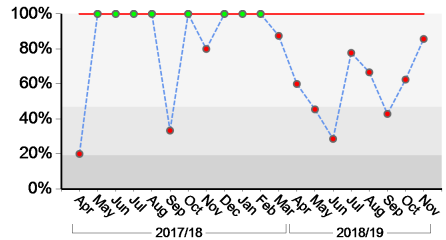
NHS Trust

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 Director of Finance Report for detail -	
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Metric has slowly been improving since June and there is further improvement in November - 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.	Duty of Candour - Evidence of Inital Disussion - This month the Trust reached 100% compliance; this improvement is due to the daily monitoring and escalation process which is having a positive impact.	
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.	Duty of Candour letter - The Trust is showing improvement with this statutory requirement since the introduction of daily monitoring and the escalation process. The one patient who did not receive a letter within the timeframe has now been sent their letter.	

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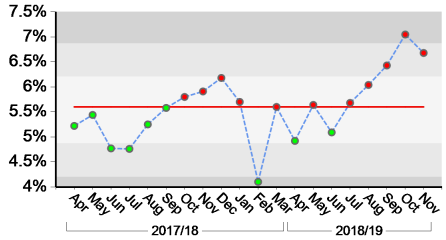
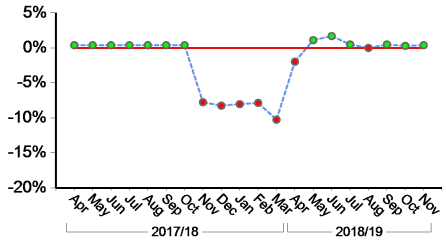
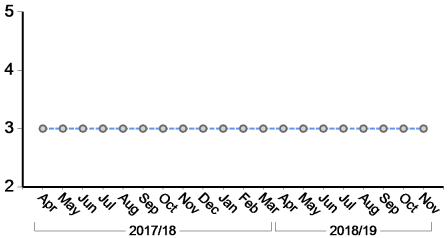
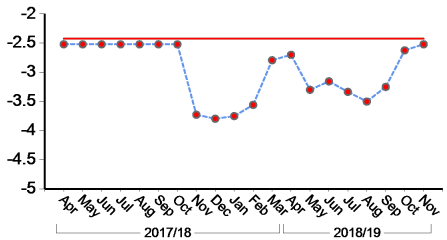
NHS Trust

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.	Marginal improvement in November. - Agency spend has reduced with the highest reduction in Nursing due to lower use of premium cost agencies, a lower number of vacancies and a higher bank fill rate. However, safe staffing levels are now being met and, until all vacancies are recruited to, agency spend will continue. Recruitment to medical posts has been successful recently although agency spend continues until medical staff in post.	
Distance from Control Total	Distance from Control Total.	0.4% ahead of plan. - The Trust has delivered a higher I&E margin (-17.6%) than plan (-18%). Although the actual deficit is £261,000 worse than plan this is over a higher turnover (plan £111.8m; actual £108.3m)	
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 3.2 which is worse than last month's unrounded rating of 3. The adverse movement is caused by the agency metric which has risen above a 25% variance. 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 3).	
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.	Slowly improving position since August and in fact matches to plan. - A minor improvement in the metric since last month.	

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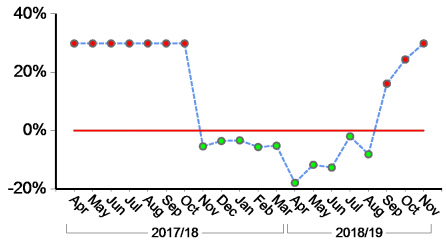
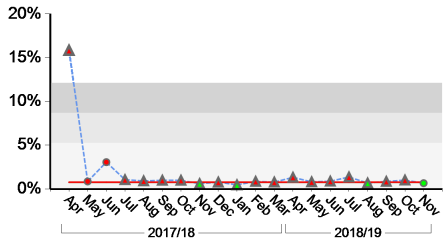
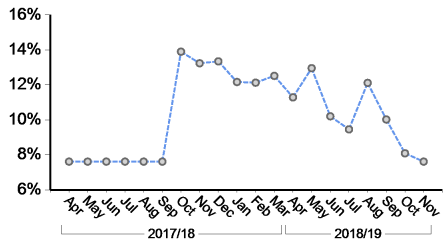
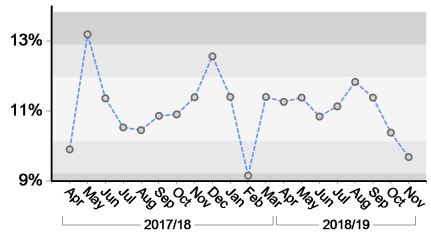
Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Please refer to the Director of finance report for the detail. The cap cannot be achieved in 2018/19. -	
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 and remains on target - 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 is being created 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. November 2018 recruitment event reflected 39 HCA conditional offers, 10 student nurse conditional offers and 4 RN conditional offers.	

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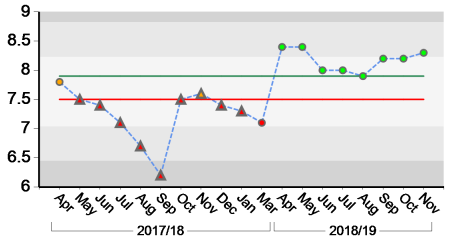
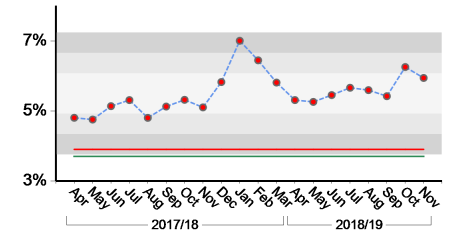
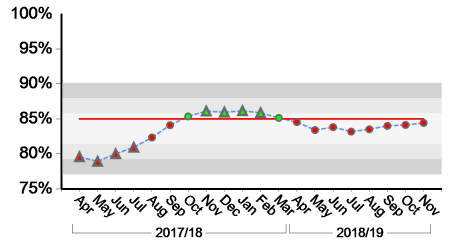
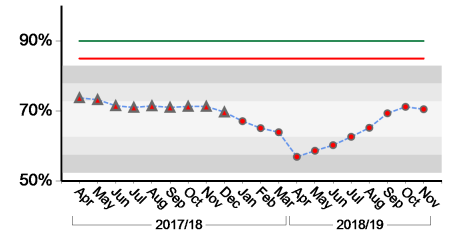
NHS
Southport and Ormskirk Hospital
NHS Trust

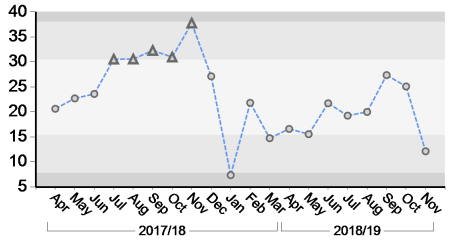
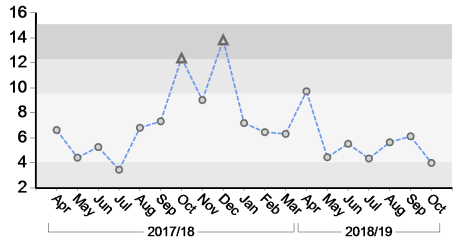
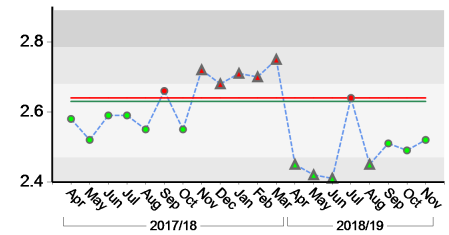
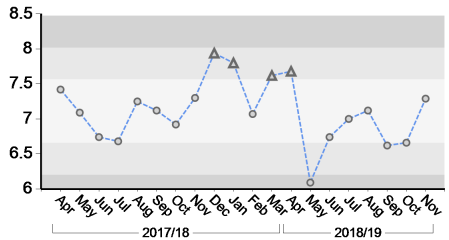
Well-Led

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.	Performance remains above trajectory - Data review on going to cleanse all reporting areas within all clinical business units.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence has significantly increased in month to 6.26% and remains high above target. - Sickness absence continues to be a concern for the Trust. There are a number of ongoing action plans that link into reducing sickness absence, there is the Health and Wellbeing Action Plan supported by NHSI; Nursing Retention Workforce Pilot with NHSI; Trust and CBU staff survey action plans. All action plans performance will be monitored at Workforce Committee to ensure progress.	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Slight increase in month of 0.29% - Core mandatory training continues to rise steadily towards achieving the Trust's 85% target although in November 2018 there was a rise in DNA's with 269 no shows. Subject matter experts have either delivered bespoke training to 'red' areas or increased their communications to remind staff of their responsibilities. Core mandatory training will be a standing agenda item at the Risk & Compliance Committee once it is active and will be closely monitored on a month/quarterly basis.	
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 now at 71.17% which is a 6th month consecutive improvement. All CBU's PDR improvement plans report to meet 85% improvement target by November, to meet this trajectory there would need to be a 13.83% overall improvement this month. Consequently all CBU's have been asked to review and if applicable revise their improvement trajectories to ensure that they have a realistic plan to deliver the improvement.	

Board Report - November 2018

NHS
Southport and Ormskirk Hospital
NHS Trust

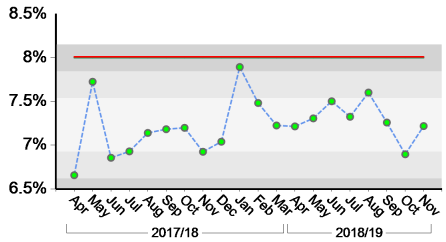
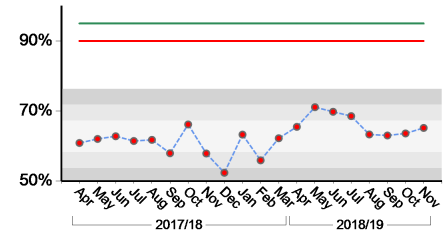
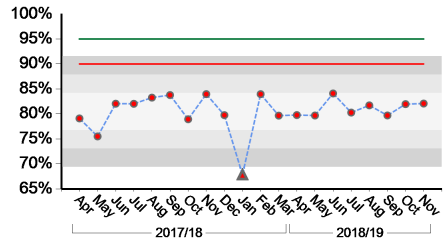
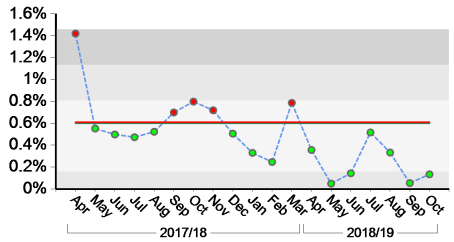
Efficiency

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.	Performance shows a significant improvment in November where 12.13 beds were lost in month, compared to 25.1 in October - improvements in d2a beds and data accuracy - 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).	Continued improvements with DTOC, increased use of community beds - introduction of community discharge to assess beds has improved our delays; continued weekly PDSA to support process; now reviewing fast track process to support improvements in delays for this group of patients;	
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 November 2018 with performance recorded as 2.52. - This is a slight increase on last month but still remains within threshold.	
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 length of stay slightly increased in November from 6.66 to 7.29, although this is within the normal variation and slightly lower than the annual average of 7.77 - - #longstaytuesday is being implemented - 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. 5 day mini MADE with ECIST support and system partners completed to look at patient journeys	

Board Report - November 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 increased in November to 7.22% but still remains within threshold. - The OPD Project Board has commenced and an action from this is to start phoning all New Patients to reduce the number of DNA's and increase income.	
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%. - 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 remains stable at 82.08% - Utilisation data is currently under review . 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 eighth month in succession - November performance was 0.13%	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9 January 2018

Agenda Item	TB012/19	Report Title	Director of Finance Report - November 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 8 year to date (YTD) the Trust's financial performance is a deficit of £19.772 million which is £281,000 worse than plan. Income and activity continues to be above plan for A&E attendances and non- elective admissions. This includes income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. Elective activity underperformance against plan has continued in November.

Expenditure run rate is consistent with October but there are signs of increasing cost pressures. The cumulative pay budget overspend increased significantly from £779,000 (month 7 YTD) to £1.129 million (month 8 YTD). CIP underperformance on expenditure schemes contributes significantly to this as does the use of agency. In month we did see a slight reduction in agency spend reversing the trend of previous months.

There are a number of risks to delivering the year end deficit of £28.8 million the others being:

- Contract sanctions; Trust has made no provision to date as discussions have been taking place with Regulators and Commissioners; at month 8 total value to date is £1.5 million.
- Contract challenges on non-elective activity and CDU tariffs.
- Ability to mitigate additional business case costs and any other expenditure pressures using reserves.
- CIP; the programme is forecast to be £0.6 million less than the £7.5 million plan although additional schemes are expected to mitigate.
- Agency spend; YTD spend is £5.2 million which means the Trust is in breach of its NHSI agency cap set at £5.6 million.

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.

Recommendation:

The Board is asked to **receive** the Month 8 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 Committee	☐ Workforce Committee

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 8 (the financial period ending 30th November 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. The Trust was £11,000 short of the plan for the month of November as commissioning income exceeded plan by £586,000.

2.3. Year to date the Trust's financial performance is a deficit of £19.772 million which is £281,000 worse than plan.

2.4. This includes income accrued for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity.

2.5. As reported in previous months, year to date A&E attendances and non-elective activity continues to over perform while Elective activity is under plan.

2.6. A&E activity is up by 5.57%; resulting in additional income of £392,000.

2.7. Non elective activity is up by 24.74%; resulting in additional income of £2.641 million when the recommendation of the MIAA report has been applied.

2.8. Elective activity is down by 10.85%; resulting in reduction in income of £896,000.

2.9. Outpatient activity is down by 1.48%; but a favourable case mix has resulted in £254,000 of additional income.

2.10. A provision of £326,000 has been made for non-achievement of CQUIN at month 8 (same as month 6 and 7 as this figure is now the likely case at year end).

2.11. The CIP programme is forecast to be £0.6 million lower than the £7.5 million plan although the Trust continues to work on additional schemes to mitigate this risk.

2.12. Expenditure run rate is consistent with October but there are signs of increasing cost pressures. The cumulative pay budget overspend increased significantly from £779,000 (month 7 YTD) to £1.129 million (month 8 YTD).

2.13. Non-pay expenditure in November is marginally higher than October with the cumulative budget overspend increasing significantly from £570,000 to £908,000.

2.14. CIP underperformance on expenditure schemes contributes significantly to this as does the use of agency but overspends in nursing and non consultant medical staff are also contributing to the total expenditure exceeding plan at month 8.

2.15. Agency spend has reduced this month (£736,000 in month; YTD £5.2 million) reversing the trend of previous months; the NHSI cap of £5.6M cannot be achieved.

2.16. The table below is the I&E statement for November:

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	99,673	101,453	1,780	12,733	13,319	586
PP, Overseas & RTA	1,383	921	730	(191)	116	79	(37)
Other Income	14,411	9,548	9,821	273	1,223	1,352	129
Total Income	**164,716**	**110,142**	**112,004**	**1,862**	**14,072**	**14,750**	**678**
Operating Expenditure							
Pay	(129,215)	(86,605)	(87,734)	(1,129)	(10,658)	(11,008)	(350)
Non-Pay	(53,134)	(35,541)	(36,449)	(908)	(4,387)	(4,725)	(338)
Total Expenditure	**(182,349)**	**(122,146)**	**(124,183)**	**(2,037)**	**(15,045)**	**(15,733)**	**(688)**
EBITDA	**(17,633)**	**(12,004)**	**(12,179)**	**(175)**	**(973)**	**(983)**	**(10)**
Non-Operating Expenditure	(11,217)	(7,478)	(7,484)	(6)	(935)	(934)	0
Retained Surplus/(Deficit)	**(28,850)**	**(19,482)**	**(19,663)**	**(181)**	**(1,908)**	**(1,918)**	**(10)**
Technical Adjustments	63	41	(59)	(100)	6	5	(1)
Break Even Surplus/(Deficit)	**(28,787)**	**(19,441)**	**(19,722)**	**(281)**	**(1,902)**	**(1,913)**	**(11)**

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

2.18. The Trust continues to require cash support and continues to provide monthly, rolling 13 week cash forecast to NHSI to support the monthly application for revenue support loans.

2.19. There remain a number of risks in delivering the year end deficit of £28.8 million.

2.19.1. Contract sanctions; Trust has made no provision to date as discussions have been taking place with Regulators and Commissioners; at month 8 total value to date is £1.5 million (£2.1 million forecast for full year) and commissioners have indicated they will apply in full and not reinvest in the Trust.

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

2.19.3. Ability to mitigate additional business case costs and any other expenditure pressures using reserves.

2.19.4. CIP; the programme is forecast to be £0.6 million less than the £7.5 million plan although additional schemes are expected to mitigate.

2.19.5. Agency spend; YTD spend is £5.2 million which means the Trust is in breach of its NHSI agency cap set at £5.6 million.

2.20. 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.

3. Income Performance

3.1. Elective activity continues to underperform (£896,000 YTD) despite slight improvement in recent months. The Trust's original forecast outturn assumed that the elective shortfall is brought back to plan although this is looking increasingly challenging.

3.2. Outpatient activity performance has improved but remains below plan. However, the case mix continues to generate a £254,000 YTD favourable variance.

3.3. A & E attendances exceeded plan once again this month and now contribute a favourable variance of £392,000 YTD.

Non Elective

3.4. Non elective activity continues to over perform against plan. As this is above the agreed baseline, the Marginal Rate Emergency Tariff (MRET) has been applied resulting in a reduction in income of £1.107 million

3.5. CCG's have accepted ACU tariffs but are still challenging the tariff for CDU on the basis that this is a coding and counting change and hasn't been notified appropriately. The Trust contests their view as it was the implementation of a pathway change to deliver best practice that does not need prior notification in line with the coding and counting requirements.

3.6. ACU/CDU income is included in the month 8 YTD position and, based on activity now going through the assessment units, it is likely that the full year value could be in the region of £2.4 million.

3.7. Overall non elective activity (including ACU and CDU activity) is generating a favourable variance against plan of £2,641,000 YTD after the marginal rate deduction.

Commissioning for Quality and Innovation payments (CQUINS)

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

3.9. In September, the Trust recognised the likely non-achievement of antibiotic review and advice & guidance for Quarters 1 and 2 and reduced CCG income by £326,000.

3.10. No further provisions have been made as it is now expected that additional resource has been targeted at ensuring CQUIN targets are delivered and the latest forecast is that the underperformance will be no greater than £326,000 for the full year.

Sanctions

3.11. The Trust may be subject to sanctions in 2018/19 for non-compliance with performance standards.

3.12. Based on performance in the first eight months sanctions of £1.5 million (£2.1 million forecast for full year) could be levied by commissioners. The YTD income position does not include any reduction for sanctions.

3.13. It is anticipated that commissioners will apply sanctions in full in order to negate the impact of any over performance against their contract values.

4. Expenditure

4.1. Underlying expenditure levels for pay have reduced in November due to a reduction in nurse agency spend, Thornbury agency has reduced in month; non-pay is constant in comparison to October.

4.2. 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.

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

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

5. Non pay spend has remained comparable to October with the YTD overspend 2.6% (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. The Trust has spent £736,000 on agency staff in November (7.8% of the substantive payroll) and is across all staff groups, medical, nursing and other staff such as key senior manager and A&C posts.

6.2. The monthly profile of the plan reduced from July, however spend is above plan and it is no longer possible to achieve the NHSI agency cap of £5.6 million as YTD the Trust has spent £5.2 million**.**

6.3. Nurse agency spend is £294,000 in November which is still high but has reduced from £367,000 spend in October.

6.4. As reported last month high agency levels continue in A&E, general medicine, general surgery and theatres and Thornbury nurse agency spend has been increasing month on month, June £24,000; July £45,000; August £122,000; September £132,000; October £146,000 but reduced in November to £72,000.

6.5. Nurse vacancy levels have reduced in month to 9.4% (10.3% October) along with an increase in bank fill rate by NHSP.

6.6. Bank fill has increased in month contributing to the reduction in agency; the focus continues to be recruiting to substantive posts.

6.7. The cost of providing cover for nurse sickness in November was £142,000 (bank £117,000; agency £25,000) based on the information provided by NHSP.

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

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

6.10. 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)

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

6.12. There was no cost of providing cover for medical sickness in November based on the information provided by TempRE.

7. Cost Improvement Plan (CIP)

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

7.2. This figure rises to £7.5 million to take account of the balance to FYE of 2017/18 schemes. These schemes have already been delivered in 2017/18 but are included to be consistent with monthly reporting to NHSI.

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

	Annual Plan £000	YTD Plan £000	YTD Actual £000	YTD Var £000	In Month Plan £000	In Month Actual £000	In Month Var £000
18/19 Plan	7,006	4,064	2,691	(1,373)	718	772	54
17/18/ balance to FYE	535	359	359	0	45	45	0
Total	7,541	4,423	3,050	(1,373)	763	817	54

7.4. Once again the CIP has underachieved and is contributing materially to the adverse expenditure budget performance in month.

7.5. The CIP shortfall is now forecast to be in the region of £0.6 million at year end as additional schemes come to fruition.

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 (November's cash flow was sent on 10th October).

8.3. The Trust borrowed £5.196 million in November. Of this, £3.2 million was used to settle prior year CCG invoices.

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 November was as follows:

Description	Target £000	Actual £000	Comments
Opening balance	1,000	1,227	Brought forward balance.
Cash inflows	19,449	21,093	Improvement in aged position (£0.5m), SAU capital monies (£280k), contractual income increase (£0.3m), two Sefton council payments (£0.2m), NHS Property Services catch up payment (£0.35m).
Cash outflows	-19,449	-21,101	Additional cash entirely used on NHS and non-NHS payment runs.
Closing balance	**1,000**	**1,219**	

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

8.7. December's approved loan request is £2.09 million and January's loan request is £2.437 million.

8.8. 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 (such as from ACU) rather than CIP savings.

8.9. Discussions with the CCGs 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 of this activity.

9. Capital

9.1. In month capital spend was £449,000 with the largest element (£175,000) relating to replacement radiology equipment as part of the managed service contract.

9.2. Year to date spend now stands at £3.162 million.

9.3. Commitments now stand at £1.924 million with the largest areas including £619,000 of IT approved orders (not yet received), £172,000 of medical equipment, £391,000 on A&E phase 3, £143,000 on the Ormskirk Theatre UPS and £193,000 for the new sexual health accommodation.

9.4. Additional funding of £280,000 was received in November for the Surgical Assessment Unit and the capital plan has been increased by this amount.

9.5. The table below illustrates the impact on the Trusts' opening capital plan excluding donations and IFRIC 12 adjustments:

	£ 000
Opening Capital Plan	4,184
Wifi	127
Surgical Assessment Unit	280
Revised Capital Plan	**4,591**

9.6. The Trust has drawn down £455,000 in December in respect of the Strata patient flow system so the table above will be updated in next month's report.

9.7. Capital Investment Group is fully sighted on being able to spend the full capital allocation including the additional monies highlighted in 9.4 and 9.6.

10. Risks

10.1. Contract sanctions have not been deducted from the income position; at month 8 total YTD is £1.5 million (£2.1 million forecast for full year) and commissioners have recently indicated they will apply in full and not reinvest in the Trust.

10.2. Contract challenge for non-elective activity. Current activity performance will lead to CCG payments exceeding their contract value. The risk is that contract challenges will reduce income levels that Trust needs to achieve in order to deliver its year end forecast.

10.3. The tariff for CDU has been challenged by commissioners.

10.4. Potential further business case costs or any other expenditure pressures (including winter) may not be fully mitigated by reserves.

10.5. CIP; the programme is forecast to be £0.6 million less than the £7.5 million plan although

additional schemes are expected to mitigate.

10.6. Agency expenditure; although agency spend decreased in month the YTD pay costs are exceeding budget. YTD spend is £5.2 million which means the Trust is in breach of its NHSI agency cap set at £5.6 million

11. Forecast Outturn 2018/19

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

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

12. Recommendations

12.1. The Board is asked to receive the month 8 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	99,673	101,453	1,780	12,733	13,319	586
PP, Overseas & RTA	1,383	921	730	(191)	116	79	(37)
Other Income	14,411	9,548	9,821	273	1,223	1,352	129
Total Income	**164,716**	**110,142**	**112,004**	**1,862**	**14,072**	**14,750**	**678**
Operating Expenditure							
Pay	(129,215)	(86,605)	(87,734)	(1,129)	(10,658)	(11,008)	(350)
Non-Pay	(53,134)	(35,541)	(36,449)	(908)	(4,387)	(4,725)	(338)
Total Expenditure	**(182,349)**	**(122,146)**	**(124,183)**	**(2,037)**	**(15,045)**	**(15,733)**	**(688)**
EBITDA	**(17,633)**	**(12,004)**	**(12,179)**	**(175)**	**(973)**	**(983)**	**(10)**
Non-Operating Expenditure	(11,217)	(7,478)	(7,484)	(6)	(935)	(934)	0
Retained Surplus/(Deficit)	**(28,850)**	**(19,482)**	**(19,663)**	**(181)**	**(1,908)**	**(1,918)**	**(10)**
Technical Adjustments	63	41	(59)	(100)	6	5	(1)
Break Even Surplus/(Deficit)	**(28,787)**	**(19,441)**	**(19,722)**	**(281)**	**(1,902)**	**(1,913)**	**(11)**

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening Balance	Closing Balance	Movement	Mvt in month
	01/04/2018	30/11/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	125,703	(1,087)	(105)
Other assets	1,382	1,186	(196)	(60)
TOTAL NON CURRENT ASSETS	**128,172**	**126,889**	**(1,283)**	**(165)**
CURRENT ASSETS				
Inventories	2,454	2,391	(63)	(62)
Trade and other receivables	9,591	13,680	4,089	4,645
Cash and cash equivalents	1,079	1,219	140	(8)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**17,290**	**4,166**	**4,575**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(25,448)	(217)	(853)
Provisions	(131)	(162)	(31)	0
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)	(166)	305	7
TOTAL CURRENT LIABILITIES	**(32,199)**	**(32,142)**	**57**	**(846)**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(14,852)	4,223	**3,729**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**112,037**	**2,940**	**3,564**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(89,258)	(22,643)	(5,196)
PFI/Finance lease liabilities	(13,807)	(13,770)	37	(6)
DH Capital loan	(1,400)	(1,000)	400	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(104,294)**	**(22,194)**	(5,202)
TOTAL ASSETS EMPLOYED	**26,997**	**7,743**	**(19,254)**	**(1,638)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	97,648	407	280
Retained earnings	(83,484)	(103,145)	(19,661)	(1,918)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**7,743**	**(19,254)**	**(1,638)**

In month material movements are as follows:

Trade and other receivables increased by over £4.6m. This in the main is a presentational change in that previously amounts owed to the CCGs for the expert determination were shown on this line i.e. the value of receivables was reduced.

In totality £5.1m of prior-year income disputes was moved into current liabilities from receivables.

The Trust then utilised the additional cash received in November's DH loan to pay down £3.3m of these prior year invoices.

PDC of £280k was received for the Surgical Assessment Unit.

Movement in retained earnings matches the in month deficit.

Statement of Cash flows

NHS
Southport and Ormskirk Hospital
NHS Trust

	Actual Apr-18 £'000s	Actual May-18 £'000s	Actual Jun-18 £'000s	Actual Jul-18 £'000s	Actual Aug-18 £'000s	Actual Sep-18 £'000s	Actual Oct-18 £'000s	Actual Nov-18 £'000s	Plan Dec-18 £'000s	Plan Jan-19 £'000s	Plan Feb-19 £'000s	Plan Mar-19 £'000s	Total £'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,217)	(2,330)	(2,192)	(2,274)	(2,376)	(1,792)	(1,669)	(1,507)	(2,235)	(1,509)	(2,085)	(1,688)	(23,874)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)	(20)	0	(6)				(9)	(160)
Depreciation and Amortisation	523	524	523	524	523	524	518	522	517	507	507	507	6,219
Impairments and Reversals	0	0	0	0	0	0	0	0					0
(Increase) in Inventories	(50)	59	(83)	0	(39)	19	95	62				(63)	0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818	(805)	(540)	(4,585)	973	973	973	974	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	(144)	492	472	(313)	(1,013)	288	174	(1,392)
Increase in Provisions	(3)	(3)	(61)	82	0	(3)	7	0		(30)		(29)	(40)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(1,465)	(2,221)	(1,097)	(5,042)	(1,058)	(1,072)	(317)	(134)	(19,247)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	5	4	4	2	3	2	3	35
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(8)	0	(2)	(167)	(88)	(284)	(243)	(1,001)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(214)	(114)	(114)	(984)	(1,006)	(1,022)	(716)	(5,889)
Receipts from disposal of fixed assets	0	0	1	2	0	0	37	31					71
Receipt of cash donations to purchase capital assets	5	52	30	18	20	20	0	6				9	160
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(197)	(73)	(75)	(1,149)	(1,091)	(1,304)	(947)	(6,624)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	127	0	280	456				863
Public dividend capital repaid	0	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	2,090	2,437	2,329	2,501	32,000
Loans repaid to DH	(200)	0	0	0	0	0	(200)	0					(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(554)	(122)	(8)	(8)	(243)	(8)	(991)
Capital element of PFI, LIFT	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(16)	(162)	(14)	(14)	(162)	(760)
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)	(75)	(194)	(80)	(80)	(194)	(1,415)
PDC dividend (paid)/refunded	0	0	0	0	0	(77)	0	0				(32)	(109)
Net Cash Inflow/(Outflow) from Financing Activities	2,338	1,973	1,966	2,512	2,335	1,342	1,364	5,108	1,989	2,163	1,621	1,081	25,792
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**(1,076)**	**194**	**(9)**	**(218)**	**0**	**0**	**0**	**(79)**
Cash - Beginning of the Period	1,079	2,531	1,380	1,018	1,446	2,109	1,033	1,227	1,218	1,000	1,000	1,000	1,079
Cash - End of the Period	**2,531**	**1,380**	**1,018**	**1,446**	**2,109**	**1,033**	**1,227**	**1,218**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

Statement of Capital Expenditure and Commitments

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	Forecast outturn £'000		Remaining budget £'000
			Original Plan	Plan	Actual	Variance	Actual	Actual	Plan (Rev)	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0072	870	535	324	211	75	97	735	496	239
	Beds / Trolleys	G0060	50	50	51	(1)	0		50	51	(1)
	Sub total MEDICAL DEVICES		**920**	**585**	**375**	**210**	**75**	**97**	**785**	**547**	**238**
IM&T	Electronic Patient Record	F6409	190	145	64	81	6		190	70	120
	Patient Service Signposting	G0081	0						0	0	0
	Vitalpac	G0007	30	21	3	18	2		30	5	25
	eDMS	F6447	160	107	0	107	15		160	15	145
	Wireless network upgrade	G0073	150	302	179	123	146		302	325	(23)
	Server warehouse infrastructure incl. storage	G0078	75	75	25	50	235		75	260	(185)
	Telephony system replacement	G0059	120	95	9	86	0		95	9	86
	Cyber security	G0071	50	34	0	34	18		50	18	32
	Fixed network infrastructure	F6498	100	66	22	44	12		100	34	66
	Datacentre	G0075	50	50	5	45	185		50	190	(140)
	Virtual desktop infrastructure	G0076	25	18	2	16	0		25	2	23
	Equipment refresh	G0077	50	34	5	29	0		50	5	45
	Sub total IM&T		**1,000**	**947**	**315**	**632**	**619**	**0**	**1,127**	**934**	**193**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	400	(50)	115	(165)	77		200	192	8
	Southport A&E Redesign	G0068	350	753	468	285	56	335	753	859	(106)
	Ward reconfigurations	G0064	140	140	134	6	0		140	134	6
	Medical gasses	G0067	30	30	34	(4)	11		30	45	(15)
	UPS Theatre	G0053	50	140	0	140	3	143	140	146	(6)
	Waste management storage facilities	G0080	100	100	2	98	0		100	2	98
	Theatre airplant controls		45	45	0	45	0		45	0	45
	Generator connectors		65	65	0	65	0		65	0	65
	Fire compartmentation	G0052	165	12	12	(0)	0		12	12	(0)
	Fire Precautions - Fire Doors	G0019	45	7	7	0	0		7	7	0
	Discharge lounge	G0074	70	134	134	0	3		134	137	(3)
	Spinal isolation works		200	200	0	200	0		200	0	200
	Additional Car Parking		0	50	0	50	0		50	0	50
	Sexual Health Accomodation	G0079	0	260	2	258	0	193	260	195	65
	Doctor's Mess Facilities	G0082	0	0	0	0	0		0	0	0
	Capital team	F6305	155	62	123	(61)	0	69	155	192	(37)
	Aseptic isolator		30	75	0	75	0		30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**1,845**	**2,023**	**1,031**	**992**	**151**	**740**	**2,321**	**1,922**	**399**
FACILITIES	Catering equipment	G0026	100	100	24	76	0		100	24	76
	Sub total FACILITIES		**100**	**100**	**24**	**76**	**0**	**0**	**100**	**24**	**76**
	CONTINGENCY	**F6301**	**319**	**159**	**93**	**66**	**6**		**258**	**99**	**159**
	Capital plan excluding donations and IFRIC 12		**4,184**	**3,814**	**1,838**	**1,976**	**852**	**837**	**4,591**	**3,527**	**1,064**
OTHER	Donated assets	000000	120	60	151	(91)			120	151	(31)
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	2,168	1,392	1,173	219		235	1,488	1,408	80
	Sub total Donations and IFRIC 12		**2,288**	**1,452**	**1,324**	**128**	**0**	**235**	**1,608**	**1,559**	**49**
	TOTAL CAPITAL SPEND		**6,472**	**5,266**	**3,162**	**2,104**	**852**	**1,072**	**6,199**	**5,086**	**1,113**

Actual spend is £3,162k with a further £1,924k committed.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB013/19	Report Title	Board Assurance Framework and its Integration with Performance and Risk Management
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary Anita Davenport, Interim Performance Manager		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

This paper presents an update on the Board Assurance Framework (BAF) and the Trust's aim to integrate performance and risk management.

At the October Board in 2019, a workshop entitled *Effective Use of Integrated Performance Management and Reporting.* The workshop posited the assertion that for integrated performance management and reporting to achieve maximum effectiveness it needed to be aligned with risk management, namely the BAF reporting on strategic risks and the corporate risk register reporting on operational risks. The Board at the time agreed to see how this integration would work. This report on the BAF is the next step in trying to achieve synergy between the BAF and performance management.

Performance management is typically a retrospective view of *'what has been'* whilst *risk management* assesses *'what might be'*. The two disciplines are typically monitored through separate channels (performance via the CBUs, the Strategic Review Boards, and Finance, Performance & Investment Committee whilst the BAF, which is Board owned at the Board and Audit Committee) and as such the Board may miss valuable intelligence that may give a more rounded view of the big picture and whether the Trust is on track to deliver both operationally and strategically.

This version of the BAF has the KPIs, normally reported in the IPR, incorporated into it as Controls across the six risks as appropriate and the assurances and action plans have benefited as a result.

The current risks position for the quarter ending 31 December 2018 are shown below: along with the risk scoring matrix which is attached for reference:

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

Strategic Objective	Principal Risk	Last Score (Oct. 2018)	Current Score	BRAG
SO1 Agree with partners a long term acute services strategy	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards	**12 3x4 (LxC) High**	**10 2x5 (LxC) *Downgraded but remains High***	**AMBER**
SO2 Improve clinical outcomes and patient safety	Poor clinical outcomes and safety records	**15 3x5 (LxC) Extreme**	**15 Unchanged**	**RED**
SO3: Provide care within agreed financial limit	Failure to live within resources leading to increasingly difficult choices for commissioners	**16 4x4 (LxC) Extreme**	**16 Unchanged**	**RED**
SO4 Deliver high quality, well-performing services	Failure to meet key performance targets leading to loss of services	**16 4x4 (LxC) Extreme**	**16 Unchanged**	**RED**
SO5 Ensure staff feel valued in a culture of open and honest communication	Failure to attract and retain staff	**12 3x4 (LxC) High**	**12 Unchanged**	**AMBER**
SO6 Establish a stable, compassionate leadership team	Inability to provide direction and leadership	**12 3x4 (LxC) High**	**12 Unchanged**	**AMBER**

The key next steps are to embed the process of cross-referencing the BAF and the IPR through a joint approach of ensuring synergy between the two, and to upskill colleagues in providing timely and relevant updates through the IPR process. The Executive Team will be encouraged to consider the BAF when providing their executive assurance within the IPR for the Board. Wherever possible this information will be utilised in other appropriate forums to ensure the process is efficient and effective.

Recommendation

The Board is asked to **receive** the report and highlight any further assurances required.

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)*
The Executive Team and senior leaders will be encouraged to deal with risks in such a way to ensure synergy between the BAF and IPR.

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

Board Assurance Integrated with Performance and Risk Management

Background

At the October Board in 2019, a workshop entitled *Effective Use of Integrated Performance Management and Reporting.* The workshop posited the assertion that for integrated performance management and reporting to achieve maximum effectiveness it needed to be aligned with risk management, namely the BAF reporting on strategic risks and the corporate risk register reporting on operational risks. The Board at the time agreed to see how this integration would work. This report on the BAF is the next step in trying to achieve synergy between the BAF and performance management.

Performance management is typically a retrospective view of '*what has been'* whilst risk management assesses *'what might be'*. The two disciplines are typically monitored through separate channels and as such the Board may miss valuable intelligence that would give a more rounded view of the big picture and whether the Trust is on track to deliver both operationally and strategically.

Monitoring of performance and risk separately can create a disconnection between the two, which may impact negatively on comprehensive decision making. The Trust's integrated approach to performance and risk management enables the linking of both operational and strategic risks to performance and where performance compliance can demonstrate the effective management of risk. The report below provides details of the link.

Since the current format of the BAF was approved by the Board in September 2018, there have been a lot of positive developments in each of the risk areas. More controls and assurances have been evidenced although there remain some important gaps in each.

Because performance management tends to be positive in terms of reporting on improvement activities, it can fail to consider sometimes multiple risks that cumulatively could threaten the achievement of the Trust's strategic objectives as set out in the BAF. From a risk management perspective, key performance indicators can provide assurance that strategic (principal) risks are being successfully managed by reporting on the delivery against targets linked to the strategic objectives. By making links between the Integrated Performance Report (IPR), Board Assurance Framework (BAF) and the Trust's Risk Register, the Board can be assured that all angles are being considered when making decisions.

Performance and particularly risk management can become a '*compliance trap*' which reduces the process to a static monitoring role. The key to successful management of risks is that it should be seen as a dynamic process, rather than a *'tick-box exercise'*. This relies on the Trust adopting a management framework that encourages and enables active continuous improvement using risk and performance information.

Recent work on the development of the Trust's Integrated Governance Structure sets out clear lines of accountability and reporting from both an assurance and management perspective. The aim of this piece of work is to contribute to a '*whole system'* management approach that presents *one version of the truth* to enable streamlined operational and strategic decision making. This is facilitated through a simple and efficient process and supporting systems whereby colleagues are informed and assured that there is complete understanding of both facts and perceptions of threats and opportunities.

The Approach to Integration

The Trust has undertaken to develop an integrated approach to performance, assurance and risk management. The integration is comprehensive and includes not only reporting, but a way of working

that embeds the concept that performance and risk management are two sides of the same coin and therefore part of everyone's day job. Although management processes have traditionally used separate information flows originating from different organisational functions, there is recognition that in order to see and manage the *'big picture'* we must include elements of risk into the Trust's performance scorecard. This will enable the organisation to better manage performance through a better understanding of the threats and opportunities that could affect our future performance.

Colleagues in the Performance, Quality and Risk departments are working collectively to develop the processes, systems and reporting for an integrated approach. The work comprises 4 work streams:

- Mapping of KPIs against the relevant Strategic Objectives within the BAF;
- Developing BAF reporting to provide regular updates of how performance is or is not providing assurance. This utilises the current mechanism for providing updates against KPIs for the IPR so it includes training and coaching in developing high quality performance updates that consider risks;
- Mapping risks on the risk register to KPIs to enable the collation and reporting of risks against KPIs;
- Encouraging better use of Datix through educating colleagues on the benefits of logging risks and developing a clearer understanding of how to describe risks. Sometimes the situation creating a risk is described as the risk, rather than the possible outcome that could happen as a result of that situation.

The Integrated BAF

Below is an example of the proposed updated/refined BAF to include KPIs and assurance details. Elements of the BAF are updated on a two-monthly basis and reported to the Board's assurance committees as per their area of responsibility. The BAF in its entirety is updated on a quarterly basis and is reported to the Audit Committee and the Board. In order to remain succinct and avoid duplication, reference will be made to the IPR for factual evidence.

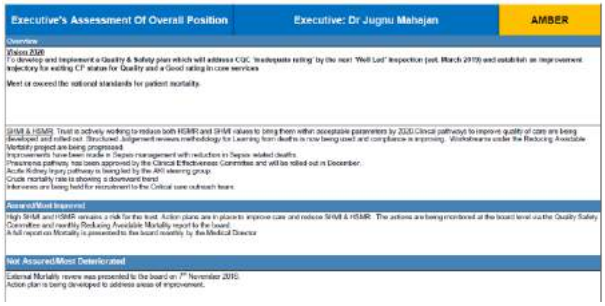
Strategic Objective		SO2 - Improve clinical outcomes and patient safety				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1822	Director of Nursing & Quality	Audley Charles	Principal Risk 2: Poor clinical outcomes and safety records			
Description	Potential Cause: • Failure of national performance target (cancer, RTT). • Failure to reduce delayed transfers of care in the changing NHS environment • Significant number of clinical staff vacancies Potential Effect: • High numbers of people waiting for transfer from inpatient care, particularly older people. • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience. • Failure of KPI's and self- certification • Reputational damage leading to difficulty in recruitment. Potential Impact: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation. • Failure to meet contractual requirements.						

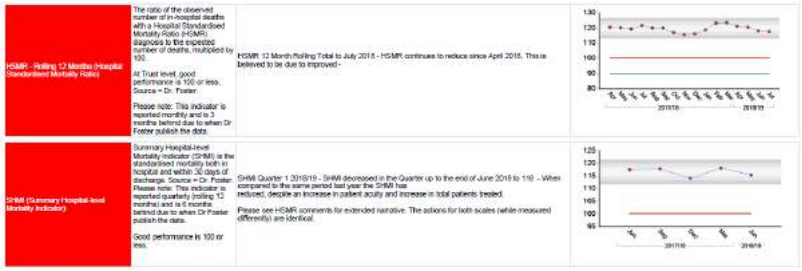
The blue arrows indicate where the narrative refers to performance reported in the IPR:

	The Experience of Care Strategy now in place.								
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	15	Extreme risk	15	12	High Risk	18/12/2018	18/03/2019
Assurance	Workforce Committee STEIS and Incident Reporting Governance Reports Integrated Performance Report demonstrates compliance against the following indicators in November 2018: MRSA, C.diff, VTE, Harm Free Care, Patient Falls, Incident reporting, safe staffing, sepsis screening and treatment, FFT, 14/31 day Cancer targets, RTT, cancelled ops. Also improving performance for 90% stay on stroke ward Emergency Planning Annual Report Patient Flow Improvement Board Quality & Safety Committee Trust Board Clinical Effectiveness Group Weekly Patient Flow Project Report to ETM Freedom to Speak Up Guardian in post External Mortality Review commissioned to look into death from pneumonia and stroke.						**Gaps in Assurance**	IPR data for the month of November 2018 demonstrates failure to achieve target thresholds for the following indicators: Never Events, FNOF repair within 36hrs, SHMI/HSMR, WHO Checklist, DSSA, A&E 4hr wait/trolley waits, Ambulance handovers, 62 day cancer pathways, bed occupancy, theatre utilisation. These are being addressed as part of the Quality Improvement Plan No Engagement Strategy Slow Improvement between CQC Inspection. Reducing Avoidable Mortality Action Plan. External Mortality Review Action Plan.	
Action Plan	Completion of all actions on the Quality Improvement Plan Freedom to Speak Up Champions to be appointed across the Trust Develop the Experience of Care Strategy (including FFT) Finalise Workforce & OD Strategy Implement Recommendations of Culture Review Robust medical job planning process to be in place Operational Plan 19/20 to be developed to include all specialities with plans for sustainable delivery in future. Develop, implement, embed and review Strategic Plan						**Action Plan Due Date**	30/06/2020 31/07/2018 29/06/2018 31/05/2018 31/01/2019 30/11/2018 04/04/2019 29/03/2019	**Action Plan Rating** Moderate Progress Made Completed Completed Completed Actions Almost Completed Moderate Progress Made Moderate Progress Made Moderate Progress Made

This can be cross-referenced with the IPR Dashboard, Executive Assurance and the more detailed update for further information:

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
SHMI (Summary Hospital-level Mortality Indicator)	100.1	115.5		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	117.7	117.7	N/A			
WHO Checklist	99.9%	100%		1			
Stroke - 90% Stay on Stroke Ward	80%	72.7%	78.1%	6			
Sepsis - Timely Identification		100%	96.3%	N/A			
Sepsis - Timely Treatment		100%	81.8%	N/A			





The process for collecting the performance narrative can be developed to prompt for an update relating to the BAF and can be captured within the narrative box. Performance and BAF updates are

then provided at the same time in the same place and reports can be designed to provide the appropriate type and level of information depending on the audience and reporting requirements.

The risk scores and any movements since the BAF was reported to the Board are shown in the Table below.

Strategic Objective	Principal Risk	Last Score (Oct. 2018)	Current Score	Mitigating Actions Required to address Gaps in Controls and Assurance	BRAG
SO1 Agree with partners a long term acute services strategy	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards	12 **3x4 (LxC) High**	10 **2x5 (LxC)** ***Downgra-ded but remains High***	• Develop, implement, embed and review Communication and Engagement Strategy • Develop Plans to deliver Transformational CIP Schemes • Consider the need for review of strategic planning • Produce reports on Operational Plan to the Board • Conduct an objective setting and strategic planning exercise with the Board. • Review of the strategic plan and associated risk management processes (BAF) • Review of relationship management processes may be required. • Periodic reports on externally facing activities	**AMBER**
SO2 Improve clinical outcomes and patient safety	Poor clinical outcomes and safety records	15 **3x5 (LxC) Extreme**	**Unchanged** 15	• Completion of all actions on the Quality Improvement Plan • Freedom to Speak Up Champions to be appointed across the Trust • Develop the Experience of Care Strategy (including FFT) • Finalise the Workforce & OD Strategy Implement Recommendations of Culture Review • Robust medical job planning process to be in place • Operational Plan 2019/20 to be developed to include all specialities with plans for sustainable delivery in future. • Develop, implement, embed and review a Strategic Plan for 2019/20 • Deliver the Reducing Avoidable Mortality • Action Plan • Deliver the External Mortality Review Action Plan.	**RED**
SO3: Provide care within agreed financial limit	Failure to live within resources leading to increasingly difficult choices for commissioners	16 **4x4 (LxC) Extreme**	**Unchanged** 16	• Roll out of improved financial governance arrangements to all departments within the Trust e.g. budget training/SFI's • Modelling of emerging clinical options in progress as part of the work of the strategy development. Ensure consistency of financial analysis, reporting and control across all areas within the Trust. • Roll out of financial training to all relevant staff and reinstate budget holder workshops. Re-launch HFMA e-learning modules. • Turnaround Director required as directed by NHS-I to support the delivery of 2018/19 financial plan of £28.8m deficit or less. • Develop Plans to deliver Transformational CIP Schemes	**RED**
SO4 Deliver high quality, well-performing services	Failure to meet key performance targets leading to loss of services	16 **4x4 (LxC) Extreme**	**Unchanged** 16	• Delivery against the Trust's internal improvement plans for each standard - 4 hour performance / LoS / 18 weeks / Cancer • HR to cascade and embed the Sickness Absence Policy. Negotiations on-going. IT Strategy to be developed, cascaded and embedded • Address issues with diagnostic waiting	**RED**

				times • Development of a clear and concise integrated performance framework and associated report.	
SO5 Ensure staff feel valued in a culture of open and honest communication	Failure to attract and retain staff	12 **3x4 (LxC) High**	**Unchanged** 12	• Return of the workforce team to Southport & Ormskirk Hospital Trust • New initiative with NHSI to improve retention of staff, focusing on nursing staff Succession Planning Strategy in Workforce & OD Plan to be cascaded and embedded • Workforce Strategy to be developed Communication & Engagement Strategy to be developed • As part of Annual business cycle refine Cycle of Board Development • Review Annual Staff Award - Pride Awards • Exit Interview Procedure to be reviewed and implemented • Working with AQuA to introduce QE methodology into the Trust.	**AMBER**
SO6 Establish a stable, compassionate leadership team	Inability to provide direction and leadership	12 **3x4 High**	12 **3x4 (LxC) Unchanged**	• Roll out the Board Development Programme • Set-up diversity training for staff • Develop Staff Engagement Strategy Cascade and embed the Organisational Development Plan • Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed • Cascade implement and embed the Leadership Model • Develop and Implement Recruitment & Retention Strategy • Develop a Joint Workforce & OD Strategy • Work with AQUA to introduce QE methodology into the Trust.	**AMBER**

The Risk Scoring Matrix is ashown below for reference

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

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

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

Board Assurance Framework report

NHS
Southport and Ormskirk Hospital
NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy				Link to BAF	
Business Unit		Executive Management		**Specialty**		**Location**	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**			
25/01/2018	1783	Director of Strategy	Audley Charles	Principal Risk 1: Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards			
Description	Potential Cause: Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels • Lack of robust plans across healthcare systems • Loss of Commissioner support • Inability to respond to requirements to flex capacity as there is a mismatch with their plans. Potential Effect: Loss of existing market share. • Stranded fixed costs due to poor demand management / QIPP. • Difficult to manage capacity plans. Potential Impact: Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance.						
Controls	Sefton Transformation Board and Sefton PMO established Vision 2020 complete monitoring of single improvement plan through Southport and Ormskirk Improvement Board Strategy developed with commissioners. Compliant Contracts in place for 2017/18. Commissioner alignment meetings in place. Contingency plans for withdrawal from services developed. Clinical models in development initial presentation to Trust Board 5 December Board to Board meetings with CCGs Site control plans for both sites being developed to support strategy Operational business process begun for 19/20 star chamber held on 13 December IT Strategy Tri-Board with CCG's Healthwatch liaison meetings to support clinical workstreams Developing Experience of Care Strategy A&E Delivery Group Commissioner Contract and Quality Meetings GIRFT being incorporated into specialty strategic plans Acute Sustainability Programme in progress			**Gaps in Controls**	Operational plan in development Communication and Engagement Strategy in draft to implement from January 19 PCBC timelines being revised due to capital constraints Delay in delivering Transformational CIP Schemes		

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Unlikely (2)	Catastrophic (5)	10	High Risk	15	10	High Risk	17/12/2018	17/03/2019

Assurance	CEO's reports to Board Director of Clinical Services reports re review of services reported to Board. Finance Reports include contractual and commissioning issues, where relevant reported to Board Progress of agreeing contracts reported via Finance to Board annually Business Cases involving commissioners reported, where these occur, reported to Board Minutes of Network/Alliance meetings Update reports from Community Partnership Network Minutes of Monthly Contract Review Meetings Monthly CEO Patch Meetings Quarterly review against plan (Titration system) Monthly meetings with CCG's CBU's Governance Meetings FP&I Reports Weekly Executive Team Meeting DOF's Monthly Report to Board Operational Plan reporting to Board now in place	**Gaps in Assurance**	Review of relationship management processes may be required. Periodic reports on externally facing activities		
Action Plan	Develop, implement, embed and review Communication and Engagement Strategy Develop Plans to deliver Transformational CIP Schemes Consider the need for review of strategic planning Produce reports on Operational Plan to the Board To conduct an objective setting and strategic planning exercise with the Board. Review of the strategic plan and associated risk management processes (BAF)	**Action Plan Due Date**	31/01/2019 31/03/2019 29/06/2018 30/04/2018 31/03/2019 31/03/2019	**Action Plan Rating**	Little or No Progress Made Moderate Progress Made Completed Completed Moderate Progress Made Little or No Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1822	Director of Nursing & Quality	Audley Charles	Principal Risk 2: Poor clinical outcomes and safety records			
Description	Potential Cause: • Failure of national performance target (cancer, RTT) • Failure to reduce delayed transfers of care in the changing NHS environment • Significant number of clinical staff vacancies Potential Effect: • High numbers of people waiting for transfer from inpatient care, particularly older people. • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience. • Failure of KPI's and self- certification • Reputational damage leading to difficulty in recruitment. Potential Impact: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation. • Failure to meet contractual requirements.						
Controls	Quality Visits by NEDs and EDs Duty of Candour Healthwatch Review Freedom to Speak Up Speak Up Champion (NED appointed by Board) Monthly CBU Quality and Safety Reports Incident Reporting Quality Account Quality Improvement Plan Partnership working across STPs Trust SCOPE Values "Safe at all times" Programmes established Weekly sustainability scrutiny meetings with plan monitoring/ QIA process Embedded Governance structure and processes National surveys for service users Patient forum and patient groups Lessons learned feedback Trust Vision and Values Strategic Objectives Board Assurance Framework Extreme Risk Register Operational Plan Apprenticeship Strategy HR Policies Staff Engagement Maternity services Strategy Results from 2017/18 Staff Survey show the Trust is performing better than national average for; staff working extra hours, staff suffering work related stress, staff experiencing discrimination at work, staff witnessing potentially harmful errors and staff attending work despite feeling unwell Organisational Development Strategy went to Trust Board June 2018			**Gaps in Controls**	Low response rate on Friends & Family Test with unfavourable results Systematic clinical leadership development to provide a culture of trust and candour Perceived inequity of treatment or rewards between and within staff groups No Stakeholder Engagement Strategy Communication and Engagement Strategy not in Place Staff survey for 2017/18 received, identified areas where Trust performing worse than national average: Support from immediate managers, effective team working, staff able to contribute towards improvements at work, quality of appraisals and fairness and effectiveness of procedures relating to reporting incidents. Clinical workforce plan not fully developed. Higher than expected HSMR and SHMI.	

	The Experience of Care Strategy now in place.								
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	15	Extreme risk	15	12	High Risk	18/12/2018	18/03/2019
Assurance	Workforce Committee STEIS and Incident Reporting Governance Reports Integrated Performance Report demonstrates compliance against the following indicators in November 2018: MRSA, C.diff, VTE, Harm Free Care, Patient Falls, Incident reporting, safe staffing, sepsis screening and treatment, FFT, 14/31 day Cancer targets, RTT, cancelled ops. Also improving performance for 90% stay on stroke ward Emergency Planning Annual Report Patient Flow Improvement Board Quality & Safety Committee Trust Board Clinical Effectiveness Group Weekly Patient Flow Project Report to ETM Freedom to Speak Up Guardian in post External Mortality Review commissioned to look into death from						**Gaps in Assurance**	IPR data for the month of November 2018 demonstrates failure to achieve target thresholds for the following indicators: Never Events, FNOF repair within 36hrs, SHMI/HSMR, WHO Checklist, DSSA, A&E 4hr wait/trolley waits, Ambulance handovers, 62 day cancer pathways, bed occupancy, theatre utilisation. These are being addressed as part of the Quality Improvement Plan No Engagement Strategy Slow Improvement between CQC Inspection. Reducing Avoidable Mortality Action Plan.incomplete External Mortality Review Action Plan not completed.	
Action Plan	Completion of all actions on the Quality Improvement Plan Freedom to Speak Up Champions to be appointed across the Trust Develop the Experience of Care Strategy (including FFT) Finalise Workforce & OD Strategy Implement Recommendations of Culture Review Robust medical job planning process to be in place Operational Plan 19/20 to be developed to include all specialities with plans for sustainable delivery in future. Develop, implement, embed and review Strategic Plan Deliver the Reducing Avoidable Mortality Action Plan. Deliver the External Mortality Review Action Plan.						**Action Plan Due Date**	30/06/2020 31/07/2018 29/06/2018 31/05/2018 31/01/2019 30/11/2018 04/04/2019 29/03/2019 31/08/19 30/09/19	**Action Plan Rating**	Moderate Progress Made Completed Completed Completed Actions Almost Completed Moderate Progress Made Moderate Progress Made Moderate Progress Made

Strategic Objective		SO3 - Provide care within agreed financial limit				Link to BAF	
Business Unit		Executive Management		**Specialty**		**Location**	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**			
04/04/2018	1823	Director of Finance	Audley Charles	Principal Risk 3: Failure to live within resources leading to increasingly difficult choices for commissioners			

Description	Potential Cause: • Failure to deliver the required levels of CIP. • Failure to effectively control pay and agency costs. • Failure to generate income from non-core healthcare activities • Failure to manage outstanding historic debt. • Services display poor cost-effectiveness • Failure to streamline corporate services. Potential Effect: • Additional CIPs may need to be identified and delivered. Potential Impact: • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention.
Controls	PMO Governance improved with roles and responsibilities CIP lead appointed Cash support through agreed loan arrangements Annual Financial Plan including target to reduce underlying deficit within Vision 2020 Financial governance arrangements in place at a number of levels: FP&I Committee/CBU's Monthly governance meeting and performance meetings with Execs Monthly Directorate Meetings (budget scrutiny at this level) Revised CIP planning processes and PMO co-ordination of planning and delivery. Weekly CIP review meetings Turnaround Director in post with Trust governance, grip and control measures implemented, including Discretionary Spend Policy, CQUIN Group, Business Development Group & Investment sub-Committee (BDISC), People & Activity Group (PAG) CIP plan for 2018/19 in place
Gaps in Controls	Future Clinical Model not finalised 5 Year long term financial model (LTFM) to be updated to reflect current financial performance and future financial plan 2018/19 CIP plan underachieving Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate Modelling of Acute Sustainability into 5 year LTFM to provide savings from any reconfiguration in line with Sefton Transformation Board Strategy

Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	Extreme risk	16	12	High Risk	20/12/2018	20/03/2019

Assurance	Hospital Management Board Trust Board Fortnightly Acute Sustainability Programme Board Finance, Performance & Investment Committee Southport & Ormskirk Improvement Board meets monthly BAF-Quarterly to Board and Audit Committee 13 week rolling cash flow forecast agreed by NHSE CIP Reviews through fortnightly Sustainability Scrutiny Meetings Internal and External audit reports and opinion at Audit Committee Monthly Performance Review Boards Executive Team Meeting Weekly Update	**Gaps in Assurance**	Agency costs exceed the NHSI cap Lack of robust Financial recovery Plan that delivers an acceptable I&E deficit positon
Action Plan	Roll out of improved governance arrangements to all departments within the Trust e.g. budget	**Action Plan Due Date**	31/03/2019
		Action Plan Rating	Little or No

	training/SFI's Modelling of emerging clinical options in progress as part of the work of the strategy development. The next step in clinical assurance of the models is the visit of the Yorkshire and Humber Clinical Senate now awaiting final report. Work on clinical models is in progress. Ensure consistency of financial analysis, reporting and control across all areas within the Trust. Roll out of financial training to all relevant staff and reinstate budget holder workshops. Re-launch HFMA e-learning modules. Turnaround Director required as directed by NHS-I to support delivery of 2018/19 financial plan of £28.8m deficit or less. Develop Plans to deliver Transformational CIP Schemes		28/02/2019 28/02/2019 29/03/2019 31/08/2018 31/03/2019		Progress Made Moderate Progress Made Actions Almost Completed Little or No Progress Made Completed Moderate Progress Made

Strategic Objective		SO4 - Deliver high quality, well-performing services					Link to BAF	
Business Unit		Executive Management		Specialty		Location		
Opened	ID	ADO/Exec Lead	Risk Lead	Title				
04/04/2018	1824	Chief Operating Officer	Audley Charles	Principal Risk 4: Failure to meet key performance targets leading to loss of services				

Description

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

Potential Effect:
• Poor patient outcome and standards of care.
• Inaccurate or inappropriate media coverage or reputational damage
Duplication of services with negative impact on CIP

Potential Impact:
• Potential loss of license to practice.
• Potential loss of reputation.
• Financial penalties may be applied.
• Poor NHSI Governance Risk Rating

Controls	Gaps in Controls
4 hour performance - Structural changes to the Emergency Department to improve internal flow 4 hour performance - Investment in Acute Medical staffing to improve resilience 4 hour performance - ED Medical staffing levels - To increase physical resource to support the increase in demand into the ED 4 hour performance - Dedicated discharge team and developing resilience of the patient flow tam 4 hour performance - Improve bed management policy and full to capacity protocol 4 hour performance - Dedicated discharge team and developing resilience of the patient flow team 4 hour performance - Systematic implementation of Red to Green improvement tool and application of the SAFER patient flow bundle 4 hour performance - Enhanced provision of AHP teams supporting patient flow 4 hour performance - Fully establish the AEC (ACU and SAU) facilities at the Trust to offer emergency care to patients in a non-bedded setting 4 hour performance - Introduction of a dedicated Discharge lounge Cancer pathway - Reduce the number of pathway steps Cancer pathway - Reduce overall size of PTL- Introduction of 28 day target tracker resulting in clearer and proactive tracking of cancer confirmed patients 18 week performance - The Trust undertakes weekly Access Meetings where each specialty is discussed and areas of concern highlighted 18 week performance - ongoing assessment of capacity / demand against waiting list to ensure timely allocation of appointments in line with RTT standards 18 week performance - Work streams supported by the Project Management Team have recently been set up to review utilisation and productivity for OPD, Theatre, Endoscopy and Workforce. The improvement plans have agreed improvement trajectories that are monitored through the Trusts governance arrangements	Workforce strategy - recruitment of key delivery posts Service Improvement methodology - no consistent approach to a S&O way to deliver continuous and sustainable improvement Whole system engagement - support from key health and social care partners to address increased demand on the non-elective pathway and helping reduce LoS for patients not requiring acute hospital care

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review

	Likely (4)	Major (4)	16	Extreme risk	16	12	High Risk	19/12/2018	19/03/2019	
Assurance	Winter Planning and Length of Stay discussed at weekly Performance Improvement Board (PFIB) Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board Weekly activity data reported to CBUs Turnaround Director in post Endoscopy Project in place to deliver endoscopy diagnostic targets Finance Performance and Investment Committee Southport & Ormskirk Improvement Board (SOIB) Monthly Mortality Operational Group Monthly Performance Review Board (PRB) for each CBU CBU Governance meetings QIA process to approve all CIPs Monthly contract meeting with Commissioners Engagement of EY to address patient flow Monthly Report to FP&I committee Monthly Report to Q&S Committee Report to Mortality Operational Group Monthly Trust-level and CBU-level dashboard for performance forum Monthly Reports presented to CBU governance meetings Performance against A&E 4 hour target report to Board monthly Hospital Management Board Improvement Board Performance Review Boards IPR indicators demonstrate compliance against 14 day cancer target, 31 day cancer treatment target and RTT						**Gaps in Assurance**	A&E 4 hour target/trolley waits/ambulance handovers longstanding issues in relation to poor patient flow and subsequent impact although improving Sickness absence amongst the worst rates of all acute Trusts. Poor performance a longstanding issue Mixed sex accommodation –due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready to be moved to a general ward. Diagnostic waiting times not met Communication and Engagement Strategy not in Place 62 day cancer performance-some improvements have been realised but underlying issues within certain tumour groups remain Mortality: above expected limits for some time		
Action Plan	Delivery against the Trust internal improvement plans for each standard - 4 hour performance / LoS / 18 weeks / Cancer Engagement of EY to address A&E performance and patient flow issues HR to take urgent steps to amend Sickness Absence Policy. Negotiations on-going. IT Strategy to be developed Address issues with diagnostic waiting times Development of a clear and concise integrated performance framework and associated report						**Action Plan Due Date**	31/03/2019 31/10/2018 31/01/2019 04/07/2018 31/10/2018 31/10/2018	**Action Plan Rating**	Moderate Progress Made Completed Actions Almost Completed Completed Completed Completed

Strategic Objective		SO5 - Ensure staff feel valued in a culture of open and honest communication				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1825	Director of HR	Audley Charles	Principal Risk 5: Failure to attract and retain staff			
Description	Potential Cause: • Difficulty recruiting and retaining high-quality staff in certain areas • Low levels of staff satisfaction, health & wellbeing and engagement • Insufficient provision of training, appraisals and development. Potential Effect: • Low levels of staff involvement and engagement in the trust's agenda. • High than average vacancy rates. • Failure to deliver required activity levels / poor staff productivity • Higher than average sickness rates Potential Impact: • Poor patient experience and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation embed new ways of working. • CEO/Senior Team Visits • CEO Focus Group • Reduced ability to deliver high quality service with low morale • Poor response to NHS Staff Survey						
Controls	Organisational Development Strategy Staff engagement and awareness programme in place Divisional Staff induction Corporate staff Induction Education and development processes in place Appraisal compliance and training attendance monitored Mandatory training PDR Robust employment checks (FPPT) Disclosure Barring Service (favour CRB) Quality Visits by NEDs and EDs Professional Bodies Checks and Balances for clinicians (NMC/GMC) Duty of Candour/Safe Care Staff Survey & Quarterly Staff FFT/Survey Sickness Absence Policy Staff Engagement Strategy Speak Up Champion & Guardian Recruitment Strategy Retention Strategy Annual staff Appraisal Executive blog Freedom to Speak Up Guardian appointed NHSi Nursing Retention Programme NHSi Health and Wellbeing Project Workforce and OD Strategy Partnership Working			Gaps in Controls	Delays in recruitment of staff through shared service highlighted Lack of local in year feedback in relation to staff views / staff surveys Recruitment & Retention of staff Strategy Lack of OD resource Lack of focused resource for staff engagement		

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Possible (3)	Major (4)	12	High Risk	12	9	High Risk	19/12/2018	19/03/2019

Assurance	Workforce Committee Staff survey and values update work reported specifically and through Quarterly workforce reports to Board Annual NHS Staff Survey NHSI's Single Oversight Framework-Workforce metrics Appraisal and PDRs Staff Induction Workforce & OD Committee Weekly Executive Team Meeting Monthly Corporate Induction Monthly JNC meeting Bi-Monthly JMSNC meeting Monthly E&D meeting CEO Walkabout Joint Quality Visits by NEDS and Executive Directors Working with NHSI on Recruitment and Retention Board Development Plan and Board Development Workshops in place Board to Floor Initiative Thanks a Bunch Initiative Grapevine Magazine AQUA QI Initiative across the Organisation	**Gaps in Assurance**	No Communication & Staff Engagement Strategy Survey Action Plans recurring themes Inability to finance key projects relating to staff development Staff Survey update report to the Board IPR indicators demonstrate failure to achieve target thresholds for staff turnover, medical vacancy rate, sickness rate, PDRs and mandatory training. Action plans are in place to address this		
Action Plan	Return of the workforce team to Southport & Ormskirk Hospital Trust New initiative with NHSI to improve retention of staff, focusing on nursing staff Succession Planning Strategy in Workforce & OD Plan Workforce Strategy to be developed Communication & Engagement Strategy to be developed As part of Annual business cycle develop Cycle of Board Development Review Annual Staff Award - Pride Awards Exit Interview Procedure to be reviewed and implemented The Trust is working with AQUA to introduce QE methodology into the Trust.	**Action Plan Due Date**	01/04/2019 31/01/2019 31/05/2018 31/05/2018 31/01/2019 30/04/2018 31/07/2018 30/09/2018 30/06/2019	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made Completed Completed Little or No Progress Made Completed Completed Completed Moderate Progress Made

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

	Workforce and OD Strategy Recruitment of substantive Board posts Vision 2020								
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Major (4)	12	High Risk	12	9	High Risk	19/12/2018	19/03/2019
Assurance	Staff Survey Staff Side Meeting with Management Trust's Vision and Values Internal Audit Reports Fit and Proper Persons' Test (FPPT) Directors' Code of Conduct Declaration of Interest for Board and Senior Managers Gifts and Hospitality & Commercial Interest Policy Standard of Business Conduct and Conflict of Interest Policy PDRs Board of Directors Annual FPPT and Code of Conduct () LA reports to Audit Committee External Auditors Reports Counter Fraud Report to Audit Committee Declaration of Interests at every Board and Committees Health and Wellbeing Action Plan Education & Monitoring Report Monthly Workforce & Organisational Committee Monthly Remuneration Committee Monthly Leadership Executive Group Weekly Executive Team Meeting Monthly Hospital Management Board IPR to Board Monthly Annual Health & Safety Report HR & Workforce Report Ad hoc reports to Board (Staff Survey, Board Development, Board Induction) Corporate Induction Bi-Annual Staffing Report NEDs' Induction Pack in place Staff Friends and Family Test						**Gaps in Assurance**	Staff Engagement Strategy New Conflict of Interest Guidance not yet formalised in an approved policy Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation Communication and Engagement Strategy requires ratification Lack of robust Executive Director's Induction Pack Lack of NEDs Development Programme		
Action Plan	Establish Board Development Programme Set-up diversity training for staff Develop Staff engagement strategy Develop Organisational Development Plan Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed Develop and Implement Leadership Model Develop and Implement Recruitment & Retention Strategy Joint Workforce & OD Strategy The Trust is working with AQUA to introduce QE methodology into the Trust.						**Action Plan Due Date**	30/04/2018 31/07/2018 29/03/2019 31/05/2018 31/01/2019 07/11/2018 30/11/2018 31/05/2018 30/06/2019	**Action Plan Rating**	Completed Completed Moderate Progress Made Completed Actions Almost Completed Completed Little or No Progress Made Completed Moderate Progress Made

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB013/19	Report Title	The Corporate 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.

One risk has been removed from the risk register:

- **1901** - Cancellation of elective activity in theatres. This risk has been downgraded to high due to dedicated HR support to support sickness management, block booking of agency staff and DDON supporting theatres.

There are currently 7 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
- **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

The following risks will be closed in January 2019.

- **1367** - Failure to have a motivated and engaged workforce (culture). This risk is not reflective of the current position and does not reflect the ongoing work. A replacement risk has been drafted and will be approved onto this risk register in January 2019.
- **1329** - Returning to financial balance by 2021. A new risk has been drafted which reflects the Vision 2020 objective of reducing deficit to below £25M by 2020. This will be signed off by the Execs and reviewed by FP&I in January.

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

DECEMBER 2018 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 20/12/2018

Risk ID	Principle Objective(s)	Risk	Executive Lead	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
1367	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	Failure to have a motivated and engaged workforce (culture)	Director of HR	=16	=16	=16	=16	=16	=16
1329	SO3 - Provide care within agreed financial limit	Returning to financial balance by 2021	Director of Finance	=16	=16	=16	=16	=16	=16
1549	SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication	Postgraduate Medical Education 'enhanced monitoring' GMC/HENW	Executive Medical Director	=15	=15	↓12	=12	=12	=12
1132	SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services	AED Staffing	Executive Medical Director	=16	=16	=16	↓12	=12	=12
1688	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	Inadequate Staffing Levels in Anaesthetic Department	Chief Operating Officer	=10	=10	=10	↑15	=15	=15
1902	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	Failure to comply & improve governance of services in relation to the areas of non compliance identified by CQC	Director of Nursing & Quality				!16	=16	=16
1917	SO2 - Improve clinical outcomes and patient safety	Quality of Older Peoples Care	Director of Nursing & Quality				!16	=16	=16
1901	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	Cancellation of elective activity in theatres	Chief Operating Officer			!15	=15	=15	↓9
1314	SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services	Management of mental health pathways	Chief Operating Officer	=12	=12	=12	↑16	=16	=16
1862	SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services	Maintaining safe quality nursing care with current level of nursing & HCA vacancies	Director of Nursing & Quality				!16	=16	=16

TRUST RISK PROFILE AS AT 20/12/2018

	CONSEQUENCE (impact/severity)				
LIKELIHOOD (frequency)	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)					
Likely (4)				**1314 - Management of mental health pathways** **1329 - Returning to Financial balance by 2021** **1367 - Failure to have a motivated and engaged workforce (culture)** **1917 - Quality of Older People's Care** **1862 - Maintaining safe quality nursing care with current level of nursing & HCA vacancies** **1902 - Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC**	
Possible (3)					**1688 - Inadequate Staffing Levels in Anaesthetic Department**
Unlikely (2)					
Rare (1)					

NHS Southport and Ormskirk Hospital NHS Trust

Board/Sub-Board Committee: Trust Board Risk Register

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. Business case produced for review at next BDISC meeting. Restructure and appoint new cohort of staff required to deliver the service and sustain long term. Short term proposal also put forward for approval to ensure safe staffing levels now.									
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 Agency locums being sought to support gaps						**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	19/12/2018	18/01/2019	
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 31/01/2019	**Action Plan Rating**	Completed Moderate 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	19/12/2018	18/01/2019
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 Core service review identified some areas of improvement including openness of staff, Staff are caring, compassionate and there are examples of good practice, stability of leadership and no areas were considered to be 'inadequate' on both days				**Gaps in Assurance**	Engagement of key leaders from 'ward to board' reduced understanding of expectations of regulator prior, during and after inspections A number of gaps identified during core services review, these are being addressed through Quality Improvement Plan.	
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**	31/01/2019 31/01/2019 31/03/2019	**Action Plan Rating** Moderate 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	17/12/2018	17/01/2019	
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**	31/01/2019 31/01/2019 11/01/2019 31/01/2019 31/01/2019 29/03/2019	**Action Plan Rating**	Moderate Progress Made Little or No Progress Made Moderate 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 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 attend ED with mental health problems and subsequently require admission to a mental health bed are being delayed on a regular basis due to a lack of mental health capacity for both local providers. This poses a poor patient experience, delays treatment, preoccupies staff time with patients occupying cubicles which can be at the expense of management of patient flow through ED. Patients attending under section 136 may also be within the custody of the police as security both for the patient and other patients and staff in the department may require this additional input. This is a long standing issue which has resulted in regular never events whereby patients have not been allocated a mental health bed within 12 hours of decision to admit. Notwithstanding the patient impact, this has a detrimental impact on the Trust's reputation.							
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. There is already a significant shortfall in the medical and nursing staff establishment and the intensity of input and observations for a single patient can detract from the service's capacity to see all the patients within the 4hour standard 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	19/12/2018	18/01/2019
Assurance	Data for 4 hour standard, 12 hour breaches monitored daily and analysed and presented at PRB, Q&S, A&E Delivery Board and Trust Board NHSI Monitoring of ED performance with daily reporting 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**	12 hour breaches still occurring for mental health patients as provider capacity doesn't match need	
Action Plan	Establish office space to accommodate Mersey Care on site Mental Health Sub-Group of the A&E Delivery Board has been established to review and agree appropriate actions to support mental health patients An audit has been completed into the 12 hour breaches which is being reviewed at SIRG with a retrospective trend analysis to be completed by 20/12 to be shared with partners and NHSI. The actions associated with this audit will be monitored within our internal governance arrangements for our CBU and shared with the A&E Delivery Board. 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 30/04/2019 31/03/2019 02/04/2018 23/11/2018	**Action Plan Rating** Completed Little or No Progress Made Little or No Progress Made Completed Completed

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 Datix system in place to identify if there has been a harm of patients due to staffing levels in accordance with NICE 'red' flags						**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 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	17/12/2018	17/01/2019
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 further 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** Completed 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 on going. 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	19/12/2018	31/01/2019
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	19/12/2018	19/01/2019
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

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	TB014/19	Report Title	Timelines and Responsibilities-End of Year Documents
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The Trust has a statutory responsibility to produce a number of documents to be submitted to the Regulator, NHS Improvement. These documents are:

- Annual Report
- Annual Governance Statement
- Annual Accounts
- Quality Accounts

A lot of preparatory work is needed to ensure that strict reporting timelines are adhered to, not only to the NHSI but External Auditors (who will audit the documents before they are published), Board Assurance Committees and the Board itself. Because of publishing timelines the Quality Account may need to receive delegated powers from the Board to approve the final version after input from stakeholders such as Overview and Scrutiny Committee, Commissioners and Healthwatch.

Attached are:

- Submission timelines
- Structure of Annual Report with named Executive Leads and officers with responsibilities

Details for Annual Accounts and Quality Accounts timelines and distribution of responsibilities are being dealt with by the finance and nursing teams respectively.

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)*

Named leads and officers should ensure that submission dates are met.

Previously Presented at:

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

ANNUAL REPORT 2018/19 OUTLINE STRUCTURE WITH RESPONSIBILITIES AND TIMELINES

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
THE PERFORMANCE REPORT						
	Overview					
	As a minimum, the overview must include: • a short summary explaining the purpose of the overview section • a statement from the chief executive providing their perspective on the performance of the organisation over the period • a statement of the purpose and activities of the organisation, including a brief description of the business model and environment, organisational structure, objectives and strategies • the key issues and risks that could affect the entity in delivering its objectives • an explanation of the adoption of the going concern basis (see paragraphs 4.11-4.16 below) where this might be called into doubt (for example, by the issue of a report under Section 30 of the *Local Audit and Accountability Act 2014*24 for a CCG or an NHS provider), and • a performance summary.	3.15	**CEO/ Company Secretary**	Marketing & Communications Manager	20/3	15/5
PERFORMANCE ANALYSIS	As a minimum, the performance analysis must include: • Information on how the entity measures performance i.e. what the entity sees as its key performance measures, how it checks performance against those measures, and narrative to explain the link between KPIs, risk and uncertainty. • A more detailed analysis and explanation of the development and performance of the entity during the year and an explanation of the relationships and linkages between different pieces of information. This analysis is required to utilise a wide range of data including key financial information from the financial statements section of the accounts. • Non-financial information, including social matters, respect for human rights, anti-corruption and anti-bribery matters. • Information on environmental matters, including the impact of the entity's business on the environment. Entities must also comply with mandatory sustainability reporting requirements25. Reporting entities are expected to report annually on sustainability matters. Mandatory reporting requirements can be met by following the standard reporting format for NHS bodies produced by the Sustainable Development Unit. It is envisaged that reporting entities will produce a report that will be integral, with reference throughout the annual report and accounts and not a separate standalone report. • Performance on other matters raised during the year (for example, in Treasury PES papers): DHSC will notify group bodies of such additional requirements in FAQs.	3.17	**DoF**	Deputy Director of Finance/ Assistant Director of Finance	20/3	15/5
ACCOUNTABILITY REPORT	Auditors will review the Accountability Report for consistency with other information in the financial statements and will provide an opinion on the following disclosures which must clearly be identified as audited within the Accountability Report: • disclosures on Parliamentary accountability, as detailed in paragraph 3.61 • single total figure of remuneration for each director • CETV disclosures for each director • payments to past directors, if relevant • payments for loss of office, if relevant	3.20	**DoHR**	Assistant Director of Finance	20/3	20/4

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
	• "fair pay" (pay multiples) disclosures • exit packages, if relevant, and • analysis of staff numbers and costs					
	The Accountability Report is required to have three sections: • a Corporate Governance Report • a Remuneration and Staff Report • a Parliamentary Accountability and Audit Report.	3.21	**DoF/ DoHR**	Assistant Director of Finance/ Company Secretary	20/3	15/5
	Corporate Governance Report As a minimum, the Corporate Governance Report must include: • the directors' report • the statement of Accounting/Accountable Officer's responsibilities • the governance statement.	3.24	**CEO**	Company Secretary	20/3	15/5
	The directors' report The directors' report must include the following, unless disclosed elsewhere in the ARA, in which case a cross-reference may be provided: • the names of the chair and chief executive, and the names of any individuals who were directors of the entity at any point in the financial year and up to the date the ARA was approved • the composition of the board of directors (including advisory and non-executive members) having authority or responsibility for directing or controlling the major activities of the entity during the year • the names of the directors forming an audit committee or committees (recommended) • the details of company directorships and other significant interests held by members of the management board which may conflict with their management responsibilities (where a register of interests is available online, a web link may be provided instead of a detailed disclosure in the annual report) • information on personal data related incidents where these have been formally reported to the information commissioner's office • (NHS bodies) a statement to the effect that each director: knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.	3.25	**CEO**	Company Secretary	10/5	17/5
	Statement of Accounting/Accountable Officer's Responsibilities The Accounting/Accountable Officer must explain his/her responsibility for preparing the financial statements. The Accounting/Accountable Officer is required to confirm that, as far as he or she is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accounting Officer has taken all the steps that he or she ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. The Accounting/Accountable Officer is required to confirm that the ARA as a whole is fair, balanced and understandable and that he or she takes personal responsibility for the ARA and the judgments required for determining that it is fair, balanced and understandable.	3.26/3.27/ 3.28	**CEO**	Company Secretary	17/5	15/5

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
	Annual Governance Statement -AGS In preparing the statement, the Accounting/Accountable Officer should reflect the particular circumstances in which the entity operates. (NHS Trusts must follow guidance to be issued by NHS Improvement). • **The purpose of the system of internal control-Company Secretary** • **Capacity to handle risk-Company Secretary** • **The risk and control framework-Director of Nursing/Company Secretary** • **Care Quality Commission Regulatory Requirements-Jo Simpson** • **Pension Schemes-brief statement on how it is managed-Mark Wilson** • **Equality, Diversity and Human Rights-Rob Davies** • **Internal and external stakeholders and service user and carer Involvement-Gill Murphy** • **Quality Governance Framework-Paul Jebb/Jo Simpson** • **Information Governance-Stephen Brooks** • **Review of economy, efficiency and effectiveness of the use of resources-Company Secretary/Mark Wilson** • **Work of the Board of Directors-Company Secretary** • **Work of the Audit Committee-Company Secretary** • **Work of the Finance, Performance and Investment Committee-Director of Finance** • **CIP: Delivery Process/Governance Process/CIP Achievements in 2018/19/Success Factors/Next Steps-Turnaround Director** • **Financial Plans-Director of Finance** • **Annual Quality Report-Paul Jebb/Jo Simpson** • **Review of Effectiveness-Company Secretary with help from Executive Team** • **Director of Internal Audit Opinion-MIAA, Internal Auditors** • **Independent Review of the AGS-Mazars-ExternalAuditors**	3.29	**CEO**	Company Secretary	20/3	15/5
	Modern Slavery Act 2015 – Transparency in Supply Chains The *Modern Slavery Act 2015*[30] establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. Income earned by NHS bodies from government sources, including CCGs and local authorities, is considered to be publicly funded and is therefore outside the scope of these reporting requirements. Where NHS bodies engage in profit-making activities, these may still be sufficient to trigger the reporting requirements. This is likely to be the case where income is earned from non-government sources, such as private patients, and where this income exceeds £36 million in total. It is ultimately for individual NHS bodies to consider whether they have activities that require them to be treated as a commercial organisation for the purpose of the *Modern Slavery Act 2015*, and to produce the required statement accordingly. The Home Office have produced a practical guide on applying the reporting requirements, Transparency in Supply Chains etc. a practical guide[31]. Note that, where a slavery and human trafficking statement is required, the Act specifies that entities must publish this on their website if they have one. It is not a mandatory requirement to include the statement in an entity's ARA, but DHSC group bodies may nevertheless choose to do so.	3.30/3.31/ 3.32	**Company Secretary**	Company Secretary/ Jon Hannah	20/3	15/5
	Relationship between the remuneration report and exit packages, severance payments and off-payroll engagements disclosures In many cases, individuals who fall to be named in the remuneration report will also be included, although not individually identified by name, in the exit packages, non-compulsory departures or off-payroll engagements disclosures. Where this is the case, the remuneration report must provide the details of those agreements or payments on an individual by individual basis in a way that permits the user to cross-reference remuneration report data to that in the wider notes to the accounts.	3.33-3.57	**DoHR**	Assistant Director of Finance	10/5	17/5

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
	Remuneration policy Entities must disclose their policy on the remuneration of directors for the current and future years **Remuneration of Very Senior Managers (VSMs) – CCGs only** 3.42. Where one or more senior managers of a CCG are paid more than £150,000 per annum, the remuneration report must explain (not necessarily on an individual basis) the steps the CCG has taken to satisfy itself that this remuneration is reasonable. Pay for a part time senior manager must be compared against a pro rata of £150,000. For this disclosure, 'pay' should be considered to be columns (a), (b), (c) and (d) of the 'single total figure table' in the remuneration report (see *Chapter 3 Annex 2 - Salary and Pension disclosure tables: information subject to audit*). 3.43. A similar disclosure applies to NHS foundation trusts, set out separately in the *ARM 2018-19*. **Remuneration Report Tables** The tables for use as part of the remuneration report (the Single Total Figure, and Pension Entitlement tables) are '*Table 1: Single total figure table'* and '*Table 2: Pension Benefits'*, reproduced in *Chapter 3 Annex 2 - Salary and Pension disclosure tables: information subject to audit*. The figures relate to all those individuals who hold or have held office as a senior manager of the DHSC group body (CCGs – member of the Governing Body) during the reporting year or in the prior period. If seconded into the organisation at no cost to the organisation, disclose the arrangement. It is irrelevant that: • an individual was not substantively appointed (holding office is sufficient, irrespective of defects in appointment), or an individual's title as senior manager included a prefix such as "temporary" or "alternate", or • an individual was engaged via a corporate body, such as an agency, and payments were made to that corporate body rather than to the individual directly. In addition disclose: explanation of any significant awards made to past senior managers Calculations in the single total figure table (notably in column "e" – all pensions related benefits) may return negative values. Negative figures must not be shown in the table: a zero must be substituted. **Compensation on early retirement or for loss of office** If a payment for compensation on early retirement or for loss of office (paid or receivable) has been made under the terms of legislation or an approved Compensation Scheme, the fact that such a payment has been made must be disclosed, including a description of the compensation payment and details of the total amounts paid (the cost to be used must include any top-up to compensation provided by the employer to buy out the actuarial reduction on an individual's pension). **Payments to past directors** DHSC group bodies must provide details of any payments made to any person who was not a director at the time the payment was made, but who had been a director of the entity previously, unless already disclosed within a previous directors' remuneration report, the current year single total remuneration disclosure or within the disclosure of compensation for early retirement or loss of office. Only payments of regular pension benefits which commenced in previous years and payments in respect of employment for the entity other than as a director may be excluded **Fair Pay Disclosure** Entities must disclose the following information together with prior year comparatives: • the median remuneration of the reporting entity's staff (based on annualised, full- time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date)				10/5	17/5

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
	• the range of staff remuneration • the ratio between the median staff remuneration and the mid-point of the banded remuneration of the highest paid director, and • an explanation for any significant changes in the ratio between the current and prior years. NHS organisations must include a narrative highlighting the reasons for any variance in year-on-year multiples. This is because: • it describes the purpose of including the ratios, and what they mean • it ensures transparency in executive remuneration • it allows the public to hold government to account for their use of public funds • it provides an opportunity for entities to monitor their own remuneration and note any adverse or anomalous trends. It must then be followed by a concise and factual explanation of the changes on either side of the ratio, taking into account where relevant: • adjustment to the number or composition of the general workforce (for example, through restructuring, downsizing and outsourcing) • a change to the remuneration of the most highly paid individual. Entities should note that this may not necessarily be an increase to base pay, but a change in taxable expenses or allowances. Where the allowance is temporary (for example, relocation allowance), entities must note this and its likely impact on the pay multiple • a change of the most highly paid individual (for example, a new appointment, or the previously highest paid post having been vacated and/or eliminated) • the impact of any pay freeze on the multiple (for example, senior pay freeze that does not affect the majority of staff.) **Staff report** The staff report must include the following information: a) Where applicable, the number of senior civil service staff (or senior managers) by band. b) Staff numbers and costs – entities must provide an analysis of staff numbers and costs, distinguishing between 'permanently employed' staff and 'other' staff, which must state that the figures are subject to audit (see paragraph 3.20) Permanently employed' refers to members of staff with a permanent (UK) employment contract directly with the entity • 'Other' refers to any staff engaged on the objectives of the entity that does not have a permanent (UK) employment contract with the entity. This includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally. • In addition, DHSC only is expected to provide a further breakdown of benefits incurred under two additional categories (ministers and special advisors)				10/5	17/5

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
	[The figures must exclude non-executive directors/ lay Governing Body Members but include executive board members/Governing Body Members and staff recharged by other DHSC group bodies. The analysis of staff costs must additionally report by the accounts headings set out in paragraph 5.34. The analysis of staff numbers must additionally report by the functional categories of employees defined in NHS Digital's NHS *Occupation Code Manual*[32] The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The "contracted hours" method of calculating whole time equivalent number must be used, that is, dividing the contracted hours of each employee by the standard working hours. To note: Staff on outward secondment must not be included in the average number of employees] c) Staff composition – Entities must provide an analysis of the number of persons of each sex who were directors, senior civil servants (or equivalent) and employees of the company. d) Sickness absence data - NHS bodies are also required to report on staff sickness. The information is also required on the summarisation schedules for consolidation purposes and will be issued by DHSC after draft accounts submission. e) Staff policies applied during the financial year: ▪ for giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities • for continuing the employment of, and for arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company • **Other employee matters – other diversity issues and equal treatment in employment and occupation; employment issues including employee consultation and/or participation; health and safety at work; trade union** relationships; and human capital management such as career management and employability, pay policy etc. g) Expenditure on consultancy (see *Chapter 5 Annex 2: Consultancy definition*) h) Off-payroll engagements – Treasury requires public sector bodies to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements). i) Exit packages – The figures to be disclosed here relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts. The disclosure must state that the figures are subject to audit (see paragraph 3.20). **Parliamentary accountability and audit report** The Parliamentary accountability and audit report is required by those entities that report directly to Parliament. It is also required in the consolidated DHSC annual report. Entities that do not produce a Parliamentary accountability report must nevertheless include an audit certificate and report. DHSC group bodies that are not required to produce a Parliamentary accountability report may nevertheless include these disclosures within the annual report. Where an entity elects not to do				10/5	17/5

SECTIONS	SUB-SECTIONS	ARA Reference	Lead Executive	Lead Manager/ Officer	Drafts	Final
	this, it must include the disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges as notes within its financial statements There will be a need to collect data for the consolidated account via the summarisation schedules to assist the completion of this report. Therefore, regardless of applicability of this report, all DHSC group bodies must ensure the summarisation schedule is completed.					

Southport and Ormskirk Hospital NHS Trust

REPORTING TIMELINE FOR ANNUAL REPORT, ANNUAL ACCOUNTS AND QUALITY ACCOUNTS 2018/19

	January	February	March	April	May	June	JULY
Annual Report/Annual Governance Statement (AGS)/Accounts/ Quality Accounts							
	DRAFT VERSIONS						
Annual Report	**Structure – ETM-7th** **Structure- Audit Committee 16th**	**Structure- Mazars- External Auditors-14th**			**Board of Directors-1st**		
Unaudited Annual Accounts				**Audit Committee- 10th**			
Quality Accounts			**ETM-21st HMB 21st Quality & Safety Committee-25th**	**Board-2nd Mazars-3rd Audit Committee- 10th**	**Board of Directors 1st**		
					Board of Directors 1st		
	January	**February**	**March**	**April**	**May**	**June**	**JULY**
Annual							

Report/Annual Governance Statement (AGS)/Accounts/ Quality Accounts							
Annual Governance Statement (AGS)			**ETM 21st HMB 21st Quality & Safety Committee 26th**	**Board 2nd Audit Committee-10th MAZARS 12th**			
	FINAL VERSIONS						
Annual Report (incl. AGS) Audited Annual Accounts Audited Quality Accounts			**Mazars 27th**	**Unaudited Annual Accounts to NHSI-26th**	**Audit Committee-AM - 29th Board-PM 29th Submit to NHSI-31st (Not QA)**	**Quality Account to Q & S 24th [QA approved via delegated authority] Quality Account-Board-5th for ratification**	**Publication of Annual Report/Annual Accounts & Quality Accounts 19th**

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

9th January 2019

Agenda Item	**TB015/19**	**Report Title**	**2017/18 Charitable Funds Accounts**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

Key messages:

- Net increase in funds in 17/18 of £95k.
- Significant increase in turnover in 17/18 due to a donation of £188k from a dissolving Community Interest Company and a one-off £155k legacy.
- The Charity wasn't able to fully utilise this additional income and this contributed to the net increase in funds.
- One of the main areas of spending was on dementia-friendly wards.
- This is the first year that there hasn't been a full audit instead an Independent examination was conducted by Mazars LLP.
- There are no matters from this independent examination to bring to the attention of the Corporate Trustee.

Recommendations:

It is recommended that the Board acting as the Corporate Trustee **approves** the 2017/18 Charitable Fund Accounts and Annual 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 Chief Executive is to sign the Statement of Financial Position and Annual Report. The Assistant Director of Finance to forward signed copies to Mazars LLP, the Trusty's External Auditors in order to obtain the signed Independent Examiner's Report.

The Assistant Director of Finance to submit the Accounts, Annual Report and Independent Examination Certificate as one document to the Charity Commission on line prior to the 31st January 2019 deadline.

Previously Presented at:

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

1 Introduction

1.1 The Trust Board acts as the Corporate Trustee of Southport & Ormskirk Hospital NHS Trust Charitable Fund (registered charity number 1049227).

1.2 Accounts relating to the financial year ended 31st March 2018 have been prepared, independently examined by Mazars LLP and are ready for submission to the Charity Commission. They must be filed by 31st January 2019.

1.3 Governance requires the Board acting as the Corporate Trustee to approve the charity's accounts.

2 Performance

2.1 There was a net increase in funds of £95k in 2017/18. This was largely driven by significant donations and legacies (£486k in 17/18 against £150k in 16/17) not being able to be fully spent in the financial year.

2.2 Turnover increased from £180k in 2016/17 to £519k in 2017/18. Note 2 of the accounts shows that this significant increase is from a £188k donation relating to the dissolving West Lancashire Health Partnership Community Interest Company (CIC) and a £155k legacy.

2.3 Ignoring the CIC's contribution then donations are running at £100k per annum which is consistent with the prior year.

2.4 The additional turnover allowed more monies to be spent on the charitable objectives – improving the patient experience, staff training and staff welfare/amenities.

2.5 Expenditure was £411k (including support costs) which was significantly more than the 2016/17 spend of £140k. Highlights of where this was spent are in the annual report but the most significant element was on dementia-friendly wards (£61k).

2.6 Investment income return of 3.6% was slightly above the target of 3.5% set by the Charitable Fund Committee.

2.7 This year there was a net loss on investments of £13k compared to a net gain in 2016/17 of £93k.

2.8 The overall value of funds, represented by the Statement of Financial Position has increased from £969k in 2016/17 to £1,064k in 2017/18.

3 Accounts preparation and independent review

3.1 The accounts and the annual report have both been produced in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) FRS102 and applicable UK Accounting Standards and the Charities Act 2011.

3.2 A full audit was not required as the turnover of the charity was less than £1m.

3.3 The charity requested quotes for an independent review from local firms and the Trust's external auditors.

3.4 Mazars LLP were selected to undertake the independent review as their quote was the lowest.

4 Authorisation process

4.1 The following documents are included:

- 17/18 accounts (appendix 1)
- Annual report (appendix 2)
- Independent examiner's report (appendix 3)

4.2 Unfortunately it was not possible to arrange a Charitable Fund Committee to recommend the sign off of these Accounts, however, assurance can be gained from Mazars' independent review.

4.3 There are no matters from the Independent Examination to bring to the attention of the Corporate Trustee.

5 Conclusion

5.1 The Accounts and Annual Report have been prepared under the latest accounting standards.

5.2 An Independent Examination of the Accounts and Annual Report indicates that there are no matters to bring to the attention of the Corporate Trustee.

6 Recommendation

6.1 It is recommended that the Board acting as the Corporate Trustee:

- **Approves** the Charitable Fund 2017/18 Accounts and Annual Report.
- **Approves an action** that the Chief Executive signs the appropriate documents (statement of financial position in the Annual Accounts and the Annual Report).
- **Approves an action** that the Assistant Director of Finance submits the final signed documents (this will include a signed Independent Examiner's Report) to the Charity Commission.

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CHARITABLE FUND

Statement of Financial Activities for the year ended 31 March 2018

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2018	Total Funds 2017
		£000	£000	£000	£000
Income and endowments from:					
Donations and legacies	2	362	124	486	150
Investments	7	7	26	33	30
Total income		**369**	**150**	**519**	**180**
Expenditure on:					
Charitable activities	4	(204)	(187)	(391)	(130)
Other	3	(8)	(12)	(20)	(10)
Total expenditure		**(212)**	**(199)**	**(411)**	**(140)**
Net gains/(losses) on investments	6	(4)	(9)	(13)	93
Net income/(expenditure)		**153**	**(58)**	**95**	**133**
Transfer Between Funds		40	(40)	0	0
Net Movement in funds		**193**	**(98)**	**95**	**133**
Reconciliation of Funds					
Total funds brought forward		80	889	969	836
Total funds carried forward		**273**	**791**	**1,064**	**969**

The notes on the following pages form part of these accounts

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CHARITABLE FUND

Statement of Financial Position at 31 March 2018

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2018	Total Funds 2017
		£000	£000	£000	£000
Fixed Assets					
Investments	6	240	666	906	918
Total Fixed Assets		**240**	**666**	**906**	**918**
Current Assets					
Debtors	8	2	6	8	9
Cash at bank and in hand	9	43	127	170	64
Total Current Assets		**45**	**133**	**178**	**73**
Liabilities					
Creditors: Amounts falling due within one year	10	(12)	(8)	(20)	(22)
Total net assets		**273**	**791**	**1,064**	**969**
The Funds of the Charity					
Funds	11	273	791	1,064	969
Total Charity Funds		**273**	**791**	**1,064**	**969**

The notes on the following pages form part of these accounts

Signed

Date

Name & position

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CHARITABLE FUND

Statement of Cash Flows for the year ended 31 March 2018

	Total 31 March 2018	Total 31 March 2017
	£000	£000
Cash flows from operating activities:	**74**	**(67)**
Net cash provided by (used in) operating activities	**74**	**(67)**
Cash flows from investing activities:		
Dividends, interest and rents from investments	33	30
Proceeds from sale of investments	32	256
Purchase of investments	(33)	(245)
Net cash provided by (used in) investing activities	**32**	**41**
Cash flows from financing activities		
Repayments of borrowing	0	0
Cash inflows from new borrowing	0	0
Receipt of endowment	0	0
Net cash provided by (used in) financing activities	**0**	**0**
Change in cash and cash equivalents in the reporting period	**106**	**(26)**
Cash and cash equivalents at the beginning of the reporting period	64	90
Change in cash and cash equivalents due to exchange rate movements	0	0
Cash and cash equivalents at the end of the reporting period	**170**	**64**

Reconciliation of net income/(expenditure) to net cash flow from operating activities

	31 March 2018	31 March 2017
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	95	133
Adjustments for:		
(Gains)/losses on investments	13	(93)
Dividends, interest and rents from investments	(33)	(30)
Loss/(Profit) on sale of Fixed Assets	0	0
(Increase)/decrease in stocks	0	0
(Increase)/decrease in debtors	1	0
Increase/(decrease) in creditors	(2)	(77)
Net cash provided by (used in) operating activities	**74**	**(67)**

Analysis of cash and cash equivalents

	31 March 2018	31 March 2017
Cash in hand	170	64
Notice deposits (less than 3 months)	0	0
Overdraft facility repayable on demand	0	0
Total cash and cash equivalents	**170**	**64**

1. Accounting Policies

1.1 Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) FRS102 , applicable UK Accounting Standards, the Charities Act 2011 and the organisation's Charity Commission registration.

The accounts are prepared on a going concern basis. In making this assessment the Corporate Trustee has taken into account all the information available including about the future and can confirm that the charity is a going concern.

1.2 Funds structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

Unrestricted funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects.

1.3 Incoming resources

All incoming resources are accounted for once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of the incoming resources can be measured with sufficient reliability.

1.4 Incoming resources from legacies

Legacy income is recognised on a receivable basis when there is sufficient evidence to provide necessary certainty that legacy income will be received and the value of the incoming resources can be measured with sufficient reliability. These criteria will normally be met following probate or confirmation and once the executor(s) of the estate have established that there are sufficient assets in the estate, after settling liabilities, to pay legacy income.

1.5 Resources expended

All expenditure is accounted for on an accruals basis. It is recognised once there is a legal or constructive obligation committing the charity to the expenditure.

Grants are only made to related or third party NHS bodies and non NHS bodies in furtherance of the charitable objects of the fund.

1.6 Irrecoverable VAT

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

1.7 Allocation of overhead and support costs

Overhead and support costs have been allocated on an appropriate basis between Charitable Activities and Governance Costs as per note 3.

1.8 Costs of generating funds

The costs of generating funds are the fees charged by the nominees who manage the investments of the fund.

Quarterly management fees are offset against commission charges. Fees that exceed the commission charge are deducted from the funds on deposit (see other expenditure in note 3).

1.9 **Charitable activities**

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs comprise direct costs and an apportionment of overhead and support costs.

1.10 **Governance costs**

Governance costs comprise all costs incurred in the governance of the charity. These costs include costs related to the independent examination of the accounts together with an apportionment of overhead and support costs.

1.11 **Fixed asset investments**

Investments are stated at market value at the statement of financial position date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

Quoted stocks and shares are included in the statement of financial position at mid-market price, excluding dividend.

1.12 **Net gains/(losses) on investments**

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.13 **Estimation techniques**

The value of potential legacies stated in the contingent asset (note 15) is estimated using information received from solicitors and current property market valuations.

1.14 **Critical judgements in applying accounting policies**

Funds relating to specific areas of the hospital e.g. to individual wards are considered restricted whereas the general funds (monies received without a donors' wish) are treated as unrestricted.

1.15 **Key assumptions regarding the future**

The charity is a public benefit entity and will continue to be. The charity's main assets are held in investments spread over fixed interest government stock and equity shares. An ethical investment policy is in place and this is reviewed annually. Investment advisors are also engaged and their performance is reviewed throughout the year. This approach helps to reduce the risk of significant valuation adjustments caused by external market and worldwide factors.

1.16 **Trustee remuneration and benefits**

None of the Board members of the Corporate Trustee have been paid any remuneration or received any other benefits from the charity.

1.17 **Amounts paid to key management personnel**

No staff are directly employed by the Charity and there is a service level agreement (SLA) in place with Southport & Ormskirk Hospital NHS Trust which includes management services. The value is disclosed in note 13 related party transactions.

1.18 **Financial instruments**

The charity recognises basic financial instruments as follows: cash, bank deposits, debtors and creditors. Their initial measurement is:

Financial instrument	*Measurement on initial recognition*
Cash	Cash held
Bank deposits	Cash amount of deposit
Investments	Originally at cost and then by market value
Debtors	Settlement amount
Creditors	Settlement amount

2. Analysis of donations and legacy income

	Unrestricted Funds £000	Restricted Funds £000	Total 2018 £000	Total 2017 £000
Donations	191	97	288	96
Legacies	171	0	171	40
Grants	0	27	27	14
	362	**124**	**486**	**150**

In April 2017 the charity received a material donation from West Lancashire Health Partnership CIC (£188k). This Community Interest Company (CIC) was a joint venture between Southport & Ormskirk Hospital NHS Trust and West Lancashire GPs out of hours service. On dissolution of the CIC, funds can only be transferred either to another CIC or to a charity. Therefore, the Trust opted to transfer its share of profits to the charitable fund.

In addition a material single legacy of £155k was also received in the financial year and again this was unrestricted.

3. Other expenditure

	Unrestricted Funds £000	Restricted Funds £000	Total 2018 £000	Total 2017 £000
Governance Cost				
Financial Administration	1	3	4	4
Independent examination fee	1	0	1	5
	2	**3**	**5**	**9**
Support Cost				
Management fee	1	4	5	1
Other Cost				
Transfer to other	5	5	10	0
	8	**12**	**20**	**10**

Southport & Ormskirk Hospital NHS Trust provide full administration support to the charity and this is embodied in an annual service level agreement.
This agreement breaks down the various service elements and it is this that it used to determine how costs are apportioned between charitable activities and governance. The majority of services relate to charitable activities.

The accounts are not subject to a full audit but rather an independent examination. The costs of this are wholly allocated to governance.

The apportionment of charitable activity support costs is disclosed in note 4.

Financial investment and advice is provided by Quilter Cheviot. Their fee is shown as Investment Management costs.

Other costs relate to the transfer of non-material funds held by the charity to another charity run by Lancashire Care NHS Foundation Trust.

4. Analysis of charitable activities

The charity pursued its charitable activities by making grants. Support costs have been apportioned across the categories of charitable expenditure on the basis of the number of individual transactions and the associated transaction cost incurred by the charity.

	Grant funded Activity £000	Support Costs £000	Total 2018 £000	Total 2017 £000
Contribution to Capital Expenditure	77	6	83	34
Other Expenditure	0	0	0	0
Patients welfare and amenities	205	15	220	70
Staff welfare and amenities	31	2	33	11
Staff training	51	4	55	15
	364	**27**	**391**	**130**

5. Analysis of grants

All grants are made to the Southport and Ormskirk Hospital NHS Trust. The total cost of making grants is shown on the face of the Statement of Financial Activities, and the actual disbursement for each category of charitable activity is disclosed in note 4.

6. Fixed asset investments

Movement in fixed asset investments

	2018 £000	2017 £000
Market value brought forward	918	836
Add : acquisitions at cost	33	245
Less: disposals at cost	(31)	(190)
Unrealised gain / (loss) on carrying value of the investment	(14)	27
Market value at 31 March	**906**	**918**
Unrealised gain / (loss) on carrying value of the investment	(14)	27
Profits / (loss) on sale of investments	1	66
Total realised and unrealised gains (losses) for year	**(13)**	**93**

Analysis of fixed asset investments	Market Value 2018 £000	Market Value 2017 £000
Listed equity investments	721	726
Fixed interest investments	185	192
Other investment funds	0	0
	906	**918**

Analysis of material investments		Market Value 2018 £000	%
Interest	(UK Govt Of) 4.75% Stk 07/03/2020 GBP0.01	41	4.7
Interest	(UK Govt of) 1.75% Bds 07/09/22 1p	41	4.7
Equity	Charities Prop FD	38	3.9
Equity	I Shares	38	4.1
Equity	Kleinwort Benson I	43	4.9
		201	**22.2**

For the purpose of this analysis, materiality of investments is considered to be those with a market value greater than £30k.

7. Gross income from investments

	2018 £000	2017 £000
Listed equity investments	26	24
Fixed interest investments	7	6
	33	**30**

8. Analysis of debtors

	2018 £000	2017 £000
Trade debtors	0	0
Prepayments	0	1
Accrued income	8	8
	8	**9**

Accrued income is in respect of Quilters Q4 dividend received in April 18

9. Cash at bank

	2018 £000	2017 £000
Royal Bank of Scotland High Interest Account	168	56
Quilter	2	8
	170	**64**

10. Analysis of current liabilities

	2018 £000	2017 £000
Trade creditors	7	20
Accruals and deferred income	13	2
	20	**22**

The Trade creditor figure represents a sum owed at the end of the year by the charity to a third party (£0.5k) and sums owed to a related party, Southport and Ormskirk Hospital NHS Trust (£6.5k). These are for costs incurred by the related party on behalf of the charity.

11. Analysis of funds

Material restricted funds	Balance 31 March 2017 £000	Incoming resources £000	Resources expended £000	Balance 31 March 2018 £000
Critical Care	48	5	(22)	31
Leukaemia	88	3	(6)	85
Medical Day Unit	57	24	(5)	76
Neonatal	47	25	(28)	44
Opthalmology	36	1	(6)	31
Pharmacy	36	5	(3)	38
Rehab Patients	87	14	(47)	54
SIU General	92	17	(21)	88
Others	286	314	(358)	242
Unrealised (Losses) Profits	112	25	(35)	102
	889	**433**	**(531)**	**791**
Unrestricted funds	65	537	(340)	262
Unrealised (Losses) Profits	15	10	(14)	11
	80	**547**	**(354)**	**273**

For clarity and consistency all figures have been shown gross before the allocation of unrealised profits in total. For the purpose of this analysis, materiality of restricted funds is considered to be funds with a closing balances greater than £30k.

12. Amount held on behalf of associated party

There are no amounts held on behalf of associated party

13. Related party transactions

During the year none of the Board members of the Corporate Trustee or members of the key management staff or parties related to them has undertaken any material transactions with the Southport and Ormskirk Hospital NHS Trust Charitable Fund. (2016/17 NIL)

Neither the Corporate Trustee nor any member of the NHS Trust board has received honoraria, emoluments or expenses in the year from charitable funds and the Trustee has not purchased trustee indemnity insurance. (2016/17 NIL)

The charity has made revenue and capital payments to the Southport and Ormskirk Hospital NHS Trust where the Board members also represent the charity as the Corporate Trustee.

The value of transactions with Southport & Ormskirk Hospital NHS Trust amounted to £377,596 in 2017/18 (£153,389 2016/17). The majority of these transactions related to recharges for equipment / services procured via the Trust's ordering system.

Only £30,386 in 2017/18 (£30,086 2016/17) has been recorded as expenditure (shown in notes 3 & 4) and this is for a service level agreement to provide financial administration services to the charity. This figure is split between governance and support costs.

14. Financial instruments

Financial assets	2018	2017
	£000	£000
Cash	170	64
Trade debtors	0	0
Investments	906	918
	1,076	**982**

Financial liabilities	2017	2016
	£000	£000
Trade creditors	7	20
	7	**20**

15. Contingent Assets

	2018	2017
	£000	£000
Legacies	41	41
	41	**41**

Potential legacies not yet received that have been identified from Wills and Testaments have an estimated value of £41,000.

16. Events after the reporting period

There are no adjusting events after the reporting period, however, it should be noted that these Charity accounts have not been consolidated into the main accounts of Southport & Ormskirk Hospital NHS Trust due to materiality. The following text was included in the main Trust accounts:

Although the charity is under common control of the NHS Trust an assessment of materiality has concluded that the charity's figures should not be consolidated into the Trust's accounts. There are two elements to the materiality assessment - quantitative and qualitative. Firstly on the quantitative side the value of the charity's income, expenditure, assets and liabilities all fall below 1% the value of the Trust's. Secondly on the qualitative side omission of the charity figures in the Trust accounts would not affect a user's understanding of the accounts. As such the Trust has not consolidated the charity's figures into these accounts as they are not material.

TRUSTEE'S ANNUAL REPORT FOR SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CHARITABLE FUND FOR THE YEAR ENDING 31ST MARCH 2018

FOREWARD

The Corporate Trustee presents the Charitable Fund Annual Report together with the Financial statements for the year ended 31st March 2018.

The Charity's annual report and accounts for the year ended 31st March 2018 have been prepared by the Corporate Trustee in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) FRS102 and applicable UK Accounting Standards and the Charities Act 2011.

The accounts and the annual report of the charity are subject to independent review rather than a full external audit.

OBJECTIVES AND ACTIVITIES

The Charity's objectives are as follows:

"The Trustee shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service".

The Charity is funded by donations and legacies received from patients, their relatives, outside organisations and the general public. As far as is reasonably practical donated funds are utilised in accordance with the donors' wishes. Where the donation has been made for a specific purpose this is accepted as being binding and will be treated as a restricted fund.

The overall strategy of the charity is to provide support to the Trust by means of grants.

The Trustee confirms that they have referred to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the aims and objectives and the making of grants. The grants made during the year are detailed below. As a result of these grants the public attending the hospital either as patients or visitors will benefit from the enhancement of equipment and services funded by them.

Patients' Welfare	-	Purchase of small pieces of equipment and enhancement of services and facilities over and above that normally provided by the NHS.
Staff Welfare and Education	-	Enhancement of staff facilities and by providing education over and above that would normally be provided by the NHS.
Capital Equipment	-	Purchase of equipment in addition to or an enhancement of that which would be normally provided by the NHS.

ACHIEVEMENTS AND PERFORMANCE

Income was significantly more than last year due to two key events. Firstly a £188,000 donation received from a dissolving Community Interest Company (West Lancashire

Health Partnership) and secondly from a single legacy of £155,000. Both of these were classified as unrestricted.

These significant amounts enabled the charity to increase its spending but due to timing issues it was not able to fully utilise funds in year. In fact commitments remaining at 31st March 2018 amounted to £183,000.

Overall the net movement in funds was an increase of £95,000.

In total grants of £364,000 (excluding support costs) were awarded. Detailed below are the areas where these grants made the most difference:

- Alterations to a number of wards to make them dementia-friendly, this including painting, door finishes and signage.
- Reclining chairs in maternity so partners can stop overnight to support mother and child.
- A caleo incubator for neo natal babies.
- Combiliser and stand aid to support the early mobilisation of critical care patients.

FINANCIAL REVIEW

Resources (donations, legacies and investment income) were significantly higher than in the previous year at £519,000 (£180,000 in 2016/17). Donation figure includes a one-off £188,000 from a dissolving Community Interest Company. The legacy figure includes a single high value legacy of £155,000.

Investment income was higher than in the previous year at £33,000 (£30,000 in 2016/17).

The table summarises the resources received:

	2017/18	**2016/17**
	£'000s	**£'000s**
Donations	288	96
Legacies	171	40
Grants	27	14
Investment income	33	30
	519	**180**

During the year no payments were made to the Trustee.

Grants made during the year totalled £364,000 (excluding support costs) as shown in note 4 to the accounts.

Details of these grants are as follows:

1. Capital expenditure

Grants were made of £77,000, (2015/16 £185,000). This includes a caleo incubator for the neonatal unit (£14,000), a sonosite ultrasound machine (£10,000) and dictation software for palliative care (£8,000).

2. Staff Welfare and Amenities

The grants totalled £31,000 (2016/17 £9,000). These were made to improve the environment and working conditions for staff. This included a contribution of £8,000 for the Pride awards, £4,000 on staff lockers, £4,000 on staff GO bottles and £1,500 on furniture for the junior doctors mess.

3. Staff Education and Training

Grants totalling £51,000 (2016/17 £12,000), funded courses and conferences across a range of service areas and specialities. This included a number of Masters courses for advanced nurse practitioners.

4. Patients Welfare and Amenities

Grants were made of £205,000 (2016/17 £56,000). These were made to improve the quality of patients' stay in the hospitals. This includes the provision of various pieces of small medical equipment.

Note the largest area of spend was on the creation of dementia-friendly wards (£61,000). Also included in this section are the maternity reclining chairs for partners (£23,000), the combiliser and stand for critical care patients (£21,000) and patient trolleys (£11,000).

Reserves policy

The reserves policy is reviewed every financial year and is based on the value of unrestricted funds that the Committee believe the charity requires. For 2017/18 there were no changes and this remained at £50,000. At 31st March 2018 the value of reserves was higher than target at £273,000.

Risk Management

The major risks to which the charity is exposed have been reviewed and systems or procedures have been established to manage those risks. The most significant risks identified were the security and application of income, the approval procedures for expenditure, control of funds and the management of investments. The activities of the Charity are subject to both the Charity's own governance procedures and scrutiny from internal audit. It can be concluded that the charity has mitigated any risks both from its income and expenditure perspective as well as its balance sheet investments to a level that is considered acceptable.

Investment policy

The purpose of the investment policy is to ensure that the charitable fund portfolio is effectively managed by providing a framework to the Investment advisors that sets out the allocation to each asset class within the constraints set by the charity.

The current strategic allocation of the portfolio is as follows:

Asset Class	Allocation	Tactical Variance	Total range
UK Sovereign Debt	30%	+/-10%	20% to 40%

Cash	0%	+15%	0% to 15%
UK Equity	50%	+/-10%	40% to 60%
Overseas Equity	15%	+/-10%	5% to 25%
Alternative Assets (hedge, commercial property, commodities)	5%	+/- 5%	0% to 10%

An income generation target of 3.5% of the average annual portfolio value was set for 2017/18. Actual performance was £33,000 which represents 3.6% so the income generation target was achieved.

The following ethical investment constraints have been set by the Trustee, which means that investments in those companies involved wholly or substantially in the following are excluded:

1. Tobacco.
2. Armaments.
3. Alcohol.
4. Betting/gaming.
5. Payday loans.

Note that wholly or substantially is defined as more than two thirds of the core business.

PLANS FOR FUTURE PERIODS

The Trustee will continue to regularly review spending plans to reflect the changing needs of the NHS service within Southport and Ormskirk. The objective is to enhance facilities for patient care, ensuring that both service needs and the objectives of the Charitable Fund are met.

Currently the charity is considering whether a permanent fundraising post is required.

STRUCTURE, GOVERNANCE AND PERFORMANCE

The Charity was created by a Declaration of Trust on the 1st September 1995 as The Southport and Formby NHS Trust Charitable Fund.

The name was changed to The Southport and Ormskirk NHS Trust Charitable Fund by a Statutory Instrument dated 1st April 1999 and Resolution dated 26th November 1999.

The Executive and Non-Executive Directors of the Trust Board are responsible for ensuring that the NHS body fulfils its duties as Corporate Trustee in managing the charitable funds.

Non-Executive Directors are appointed by the Appointments Commission. Executive Directors are appointed by the Board of the NHS Trust.

On appointment Executive and Non-Executive Directors take part in an induction programme and they are made aware, as Board members, of their responsibilities as the Corporate Trustee of Southport and Ormskirk Hospital NHS Trust Charitable Fund. The induction also includes an overview of the aims, objectives, and the recent performance of the charitable fund. The Board members are also updated regularly with any changes in Charitable Fund legislation.

The Board of the Southport and Ormskirk Hospital NHS Trust has delegated responsibility to manage the charitable funds on behalf of the Corporate Trustee to the Charitable Funds Committee.

The Director of Finance is responsible for the administration of the charitable funds, reporting to the Charitable Funds Committee. He has particular responsibility for ensuring that all expenditure is in accordance with established criteria and approved in line with the Standing Financial Instructions.

Annually the Charitable Fund Committee will review the Investment Policy of the charitable fund, as to asset allocation, cash requirements and ethical investment policy. The external investment advisors quarterly report will be examined by the Committee to ensure that they are operating within the criteria laid down in this policy.

REFERENCE AND ADMINSTRATION DETAILS

Charity name: Southport & Ormskirk Hospital NHS Trust Charitable Fund

Registered Charity No: 1049227

The principal address of the Charity is:

Southport and Ormskirk Hospital NHS Trust
Corporate Office
PO Box 134
Southport
Merseyside
PR8 6PT

Trustee Arrangements:

The Southport and Ormskirk Hospital NHS Trust is the Corporate Trustee of the charity. The members of the NHS Trust Board who served during the financial year were as follows:

K.Jackson - Interim CEO
A Farrar - Interim CEO
TA.Patten - Chief Operating Officer
R.Fraser - Chair @
S.Shanahan - Finance Director **
CE.Baxter - Non-Executive Director
GJ.Clarke - Non-Executive Director
AC.Pennell-Johnson - Non-Executive Director
PA.Burns - Non-Executive Director
J Birrell - Non-Executive Director
J Gorry - Non-Executive Director **
P Gibson - Non-Executive Director
S.Fowler-Johnson - Non-Executive Director
S.Lloyd - Nursing Director

R.Gillies - Medical Director
Professor A.Guha - Interim Medical Director
J Mahajan - Interim Medical Director

@ Chairman of the Charitable Fund Sub-Committee
** Members of the Charitable Fund Sub-Committee

Banker:

Royal Bank of Scotland
Lord Street
Southport
PR8 1PH

Investment Advisor:

Quilter Cheviot
5 St Paul's Square
Liverpool
L3 9SJ

Independent Examiner:

Mazars LLP
Salvus House
Aykley Heads
Durham
DH1 5TS

Signed on behalf of the Corporate Trustee.

…….. On this day ……..……

Silas Nicholls
Chief Executive

Statement of Trustee responsibilities in respect of the Trustee's annual report and the financial statements

Under the corporate governance manual of Southport & Ormskirk Hospital NHS Trust and charity law, the trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and regulations. The trustee has elected to prepare the financial statements in accordance with FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the charity rules, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustee is required to act in accordance with the rules of the charity, within the framework of trust law. They are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

Independent examiner's report to the Trustee of Southport and Ormskirk Hospital NHS Charitable Fund

I report on the accounts of the Charity for the year ended 31 March 2018, which are set out on pages '1' to '9'.

Respective responsibilities of trustees and examiner

The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- to state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustee as a body. My work has been undertaken so that I might state to the charity's trustee those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- (1) which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section 130 of the 2011 Act; and to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or
- (2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Signed:

Name: Cameron Waddell (CPFA) for and on behalf of Mazars LLP

Relevant professional qualification or body: CPFA

Address: Salvus House, Aykley Heads, Durham DH1 5TS

Date: