NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10.15 – 13.30 on Wednesday, 6 February 2019
Seminar Room, Clinical Education Centre, Southport

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
TB021/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**10.15**
TB022/19 (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**		
TB023/19 (D)	**Minutes of the Meeting held on 9 January 2019** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB024/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB025/19 (P)	**Patient/Staff Story: Health and Wellbeing on Critical Care: Patients and Staff** To **receive** the presentation and **note** lessons learnt	**Michelle Kitson**	**15**	**10.25**
STRATEGIC CONTEXT				
TB026/19 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO including sign posting the following: • Mortality Report, including External Mortality Review • Quality Improvement Plan and CQC Progress • Financial Position – Forecast Outturn • Winter Plan • Acute Sustainability	**CEO**	**30**	**10.40**

	• Operational Plan 2019/20 To **receive** the report			
QUALITY & SAFETY				
TB027/19 (D)	**Quality Improvement Plan and CQC Progress Report** To **receive** the monthly report	**DoN**	**10**	**11.10**
TB028/19 (D)	**Monthly Mortality Report, including a summary report of the External Mortality Review** To **receive** the monthly report	**MD**	**20**	**11.20**
TB029/19 (D)	**Winter Plan Update** To **receive** the report	**COO**	**5**	**11.40**
PERFORMANCE & GOVERNANCE				
TB030/19 (D)	**Alert, Advise and Assure (AAAs) Reports from:** • Audit Committee • Finance, Performance and Investment Committee • Quality and Safety Committee • Workforce Committee	**Chairs**	**20**	**11.45**
TB031/19 (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**
TB032/19 (D)	**Risk Management** **Risk Register** To **receive** the monthly report on the Corporate Risk Register	**DoN** ***(With input from other Directors)***	**10**	**12.25**
OTHER REPORTS FOR RECEIVING				
TB033/19 (D)	**Financial Position at Month 9 including:** • Forecast Outturn 2018/19 • Proposed Control Total 2019/20	**DoF**	**5**	**12.35**
TB034/19 (D)	**Guardian of Safe Working** To **receive** the quarterly report	**Dr Ruth Chapman**	**5**	**12.40**
TB035/19 (D)	**Monthly Safe Nursing & Midwifery Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**5**	**12.45**

TB036/19 (D)	**Freedom To Speak Up Quarter 3 Report** To **receive** the quarterly report	**DoN**	**5**	**12.50**
APPROVAL & RATIFICATION				
TB037/18	**Items for approval/ratification** • To **ratify** the decision taken under Emergency Powers Section 4.3 of the Standing Orders to apply for an Uncommitted Revenue Support Loan for February 2019	**CoSec**	**5**	**12.55**
CONCLUDING BUSINESS				
TB038/19 (V)	**Questions from Members of the Public**	**Public**	**10**	**13.00**
TB039/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**5**	**13.10**
TB040/18 (V)	**Items for Forward Agenda - 6 March 2019** • New Draft BAF Model for 2019/20- incorporating new and/or refined strategic objectives and principal risks • Board Annual Business Cycle • Board Development Plan • Equality & Diversity Annual Report	**Chair**	**10**	**13.15**
TB041/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	**5**	**13.25**
TB042/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**	**5**	**13.30**
TB043/19 (V)	**Date and time of next meeting** **Wednesday 6 March 2019, 09.00am** Ruffwood Suite, Ormskirk District General Hospital	**Chair**		**13.30** **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

NHS Southport and Ormskirk Hospital NHS Trust

Register of Interests Declared by the Board of Directors 2018/19 AS AT 14 January 2019

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**
HANKIN Dr Terence	Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 January 2019**
MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB**	**CQC Holdings Ltd** (manufacturer of textile products)	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**3 December 2018**

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		NDLM Ltd **WYG Plc**								
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**

NHS
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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 6 January 2019

Clinical Education Centre, Southport, PR8 6PN
(Subject to the approval of the Board on 6 February 2019)

Members Present

Neil Masom, Chair
Jim Birrell, Non-Executive Director
David Bricknell, Non-Executive Director
Ged Clarke, Non-Executive Director
Juliette Cosgrove, Executive Director of Nursing
Julie Gorry, Non-Executive Director
Terry Hankin, Executive Medical Director
Silas Nicholls, Chief Executive
Therese Patten, Deputy Chief Executive/ Executive Director of Strategy
Steve Shanahan, Executive Director of Finance

In Attendance

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

Apologies:

Caroline Griffiths, Improvement Director, NHSI
Gurpreet Singh, Non-Executive Director

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB001/19	**Chair's Welcome and Note of Apologies**	
	Mr Masom, as Chair of the meeting, opened by welcoming the public and Board members to his first Board as Chair. He introduced Dr Terry Hankin as Executive Medical Director. He also welcomed Cath Hill from AQuA who was observing the Board as part of her role in undertaking a Well Led Review of the Trust. He also welcomed Miss Jessica Green from NHS Graduate Programme who was also observing the Board.	

	The Chair outlined what he considered to be the five major priorities for the Board meeting. They were: 1. Understanding winter performance in the light of the winter 2017/18 crisis 2. Mortality and improvements. 3. Quality outcomes and the financial position of the Trust 4. Strategic direction of the Trust; which would also be addressed in a strategic planning workshop following the Board meeting. 5. Spring 2019 and the anticipated CQC inspection: an examination of the leadership, Quality Improvement Programmes and the preparation for the inspection Apologies were received from Mr Singh, Non-Executive Director (NED) and Mrs Griffiths, NHS Improvement (NHSI) Director The Chair thanked Mr Birrell for chairing the last two meetings in Mr Fraser's absence.	
TB002/19	**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. *The Chair noted that from his own declaration, WYG Plc should have been noted as a public company instead of a private company. Dr Hankin's declarations would be added to the Register for the February 2019 Board*. There were no additions to the Register.	**CoSec**
TB003/19	**Minutes of the Meeting Held on 5 December 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 5 December 2018. Amendments made included: **TB280/18 Chief Executive's Report:** reference to *two* journalists should be '*the'* journalists **TB285/18 Integrated Performance Report: Financial Indicators** were covered in the Director of Finance Report **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendments.	

TB004/19	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **CEO Report: Human Resources Contractual Arrangement with St Helens & Knowsley (StHK)** Good progress was being achieved, with key appointments made for the recruitment team. Work was continuing and should be completed before 1st April 2019. **TB291/18: Any Other Business** Company Secretary *to establish if Dr Glackin had received Mr Clarke's thanks on behalf of the Executive Team*	**CoSec**
TB005/19	**Patient/Staff Story: Waiting Times – In/out Patient Areas**	
	A nurse from the Spinal Injuries Unit related an incident where an in-patient who had complex needs was required to attend an outpatient appointment in the Ear, Nose and Throat (ENT) Department. Due to the complexity of the patient's clinical needs a significant amount of preparation; equipment and staff, including multiple nurses and a consultant were required to facilitate it. On arrival at ENT the Receptionist was unable to advise how long the waiting time would be. The patient became distressed which resulted in a scene within the waiting area. There was no communication about the on-going waiting time and the delay amounted to 90 minutes. At that point the patient was very distressed and unable to tolerate all of the planned ENT investigations, which had resulted in a further appointment which of course meant further cost for the Trust. The Trust appeared to have not realised how distressing appointments could be for any patient, particularly those with complex needs and with a 90-minute wait adding to the pressure. Whilst delays did not always happen, the resources and costs of the appointment were significant. The nurse suggested that a system to advise inpatient staff about waiting times would be useful and would keep the inpatient in familiar surroundings until the appropriate time. A board in the waiting area advising on the length of wait would be useful and would help to reduce the expectation of potentially frightened and concerned patients. Communication would make potentially difficult situations better for all concerned. The Chair thanked the nurse and stated that he had asked Ms Cosgrove, Director of Nursing, to investigate waiting times within departments. He mentioned his own recent experience	

	at another hospital's outpatients and that had involved a wait, however, updates on the waiting time were given within the department, which went some way to reducing his concerns at the time. Mr Nicholls said that it was good to put a face to a name as the nurse had contacted him directly to raise the issue. *He apologised for the experience of both the inpatient and staff and commented that it was important that the internal process was right for our own patients and that he had asked Mr Christian, Chief Operating Officer, to look at the issue.* Mrs Gorry added that that experience was not unique. There were many potential quick-wins across the hospital which could be implemented and asked what plans were in place to address them. She added that in the absence of physical or electronic waiting time boards, staff should communicate with those waiting and update them. She added that if basic needs were not being met, the result would be the questioning of the standards of care. Mr Christian responded that his team would be working with experts including the nurse to co-design solutions to the issues and raise concerns as it was of vital importance that team members provide input into fixing the mechanisms which were required . Dr Hankin added that situations such as the experience related by the nurse could be resolved with inpatients being the first person to be seen in clinic, or the consultant and team from a department attended to the Spinal Unit. The nurse stated that the consultant from ENT was already doing that. Ms Patten stated that the strategic planning session scheduled for the afternoon of the Board could consider issues such as that. The Chair commented that the Board might take a view on 'big' things and forget things which were under its own nose. He thanked Ms Forrest for bringing the issue to the attention of the Board and would encourage anyone else to do likewise. He added that he and Dr Hankin were introduced to the Freedom to Speak Up Guardian, Martin Abrams, at their recent corporate induction, and he spoke eloquently and passionately about staff speaking up and staff should be encouraged to do so where there was a need..	**COO** **CoSec**

	Mrs Gibson added that it was good to hear the result of the stories which were brought to the Board and demonstrated a robust 'You said; We did' process. *The Chair agreed and requested that the next patient story could be that of a patient's experience in the Emergency Department, given the winter pressures it was currently experiencing.* **RESOLVED:** The Board **received** the presentation and **noted** the lessons learned	
STRATEGIC CONTEXT		
TB006/19	**Chief Executive's Report**	
	Mr Nicholls presented the report. Winter pressures had impacted on the Trust, with a combined 13% increase year on year, split between the CCGs with a 16% increase seen from Sefton CCG and 1% from West Lancashire CCG. Work would be undertaken to establish why that had occurred and to address it. The Trust was maintaining its position, with significant improvements seen in comparison with Winter 2017/18. The Emergency Department (ED) was not congested and ambulance handover was prioritised. Patients receiving treatment on corridors had fallen from 1,150 in November 2017 to 95 in November 2018, which was a significant improvement. Overall waiting times in ED were on average 2 hours quicker that the year previously. Mr Nicholls acknowledged that that did not mean that that was 'mission accomplished' and that the system remained fragile. Escalation wards had been opened with agreement with clinical colleagues and the risk of patient expectation in ED versus absolute safety was being balanced by active decisions. He thanked all staff for going above and beyond the requirements of their roles. They had been engaged and willing to support the Trust and grafted hard to ensure patients were safely and well cared for. He stated that he couldn't have asked for more. He also thanked Mr Christian and Ms Cosgrove for their personal leadership. They had been on site every day throughout the Christmas and New Year period, working long hours and weekends with their teams to keep the Trust safe.	

	Mr Christian stated that Mr Nicholls had summed up Winter to date completely and added his thanks to everyone for their effort and passion, which had inspired and driven him too. It remained a challenging environment with difficult circumstances. Ms Cosgrove added that the Mortality Report reviewed patients' year on year and learning from that had defined patient flow which was a significant issue. Some older patients would benefit from being treated at home rather than in a hospital setting. She and Mr Nicholls had spoken with the Care Quality Commission (CQC) on 7 January 2019 regarding safe care and patient flow and were reassured that the Trust was considered to be providing safe care. Mr Nicholls commented that the Trust was not out of the winter period and was only as good as the previous day's data and remained in a fragile state. Discussion took place on the financial implications of the 13% increase in winter pressures which would result in conversations with commissioners. The Chair observed that the information so far could suggest that he had joined the Trust as Chair at the '*wrong'* time, however it was the '*right'* time to see first-hand the effort and commitment by everyone, including the Assistant Directors of Operations. He added his thanks to Ms Cosgrove, Mr Christian and their teams for their work in dealing with a 16% increase from one CCG and reducing the time to be seen in the Emergency Department by a 2-hour average. A note of caution was that the Trust was currently only half way through the winter period and the comparative statistics were from a very poor base last winter. Ms Cosgrove added that increase in activity had been evidenced along with maintaining conversion rates, which had impacted on an increased bed base which would be safely and quickly closed as soon as feasible to return to the core bed base for the Trust. The Chair concurred that patient safety should be prioritised over the experience and asked how patients and families and carers were informed, bearing in mind the earlier related Patient Story. Ms Cosgrove replied that matrons were in place for 24 hours a day, 7 days a week to ensure communication took place as much as possible. Whilst some patients were not happy with their experience of being placed in the middle of	**COO/DoN**

	bays, some were accommodating and volunteered to be so placed in order to enable the reduction of ambulances waiting for handover. *The Chair requested that along with the communication about the reasons why patient experience might not meet expectation, patients and their families and carers should also receive an apology at the same time.* Mr Birrell added that the Trust should not be chasing targets but be focusing on a better experience and Mr Christian concurred, adding that a safe and calm Trust was the priority. **RESOLVED:** The Board **received** the report	
QUALITY & SAFETY		
TB007/19	**Quality Improvement Plan Progress Report, including Well Led (AQuA)**	
	Ms Cosgrove presented the report. The Action Plan update would be delivered at the February 2019 Board. Less activity had taken place for the *should dos/must* dos actions, due to winter pressures, however, four actions had improved since the previous report. The two-day Core Service Review in December 2018 was very good with: • No areas 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 would focus on detail not strategy. 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 were 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

Ms Cosgrove added that her team and Ms Patten's Estates Team had met to agree some '*quick wins'* to make the environment better, cleaner and safer. The Quality Summit at the end of January 2019 would examine the environment and practices further.

Ms Patten stated that the agenda for the Quality Summit week was being finalised and an invitation would be extended to the Non-Executive Directors to participate in the events. Mrs Gorry agreed that that was very useful and wanted to ensure that staff would also have the same opportunities to which Ms Patten stated she would be discussing that issue with Roy Lilley on 8 January 2019, to ensure engagement.

Ms Patten commented that Estates were looking into the challenge of storage and cleanliness in the interim.

Mrs Gorry asked if the out of date policies had been updated and completed by the end of November 2018, to which Mr Charles responded that following a conversation with Mr Nicholls, a dedicated resource would be allocated for that and the deadline extended to the end of February 2019. He assured the Board that not all policies previously listed as out of date were so as many of them were stored in a repository instead of being uploaded onto the Trust's intranet.

Well Led

Mr Charles referred to the project plan which was in place and included interviews with the Executive and Non-Executive Directors, plus other key operational and nursing senior managers. The Well Led element of the Provider Information Review (PIR) would produce most of the evidence required and

	in the last few days significant progress had been made in collating them. Mrs Gorry asked if a comparison of performance from 2017/18 had resulted from the exercise which had taken place on 5 December 2018 with AQuA and also questioned if the Trust was still considered inadequate, what actions would be taken to deliver improvement. Cath Hill of AQuA responded that the Well Led review would not impact on the outcome of the forthcoming CQC inspection. What it would do was to give an independent review to influence the subsequent inspection. That would incorporate bringing best practice to the Trust along with enabling staff and colleagues to help CQC assessors to understand the progress and improvements made. Mrs Gorry stated that a year ago, the Board understood that there were improvements to be made and needed to evidence improvement as business as usual. Ms Hill responded that previous CQC assessments differed from current assessments due to changes in guidance. The role of the Well Led AQuA/MIAA Review would be to assess the Trust from a zero baseline and provide a holistic way forward. It was commonly found that interrelationships existed within the eight Key Lines of Enquiry (KLOE's) and the net effect would be on the culture etc. The Trust now had an opportunity to utilise the skills and capabilities of AQuA to achieve that. Mr Nicholls added that a lot of work had already been done, which should not be lost sight of, and it would be disappointing if that wasn't recognised by the CQC. The preparation for the March 2019 visit was must be integrated as business as usual. It was good practice for Boards to review the whole process, not just the mechanics. Ms Hill commented that the timing was now right with the stability of all Executive roles being filled. The Board would need to consider how it would be viewed by the CQC with the PIR as an appropriate reflection of itself. The Quality Improvement Plan identified key themes: CQC core services and preparation for a CQC inspection in March 2019. **RESOLVED:** The Board **received** the report.	
TB008/19	**Monthly Mortality Report**	
	Dr Hankin presented the report. *Hospital Standardised Mortality Ratio (HSMR) – July 2018 data would be re-examined to assure the Board of its accuracy.*	**MD**

	The End of Life Policy would be reviewed to ensure that doctors of appropriate seniority complete Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)/have end of life discussions with patients and their families where relevant. *Dr Hankin added that the next Board report would be further streamlined.* The Chair observed that the report was much more substantive and Mr Clarke asked how the Trust could address trends and risks in deaths effectively if the 3-6 month adjusted monthly rate was the mechanism used. Dr Hankin stated that the rate was historical and that the monthly Integrated Performance Report would identify any areas for investigation. Ms Cosgrove added that concerns would also be flagged up by the Incident Reporting System. **RESOLVED:** The Board **received** the report.	**MD**
TB009/19	**Monthly Safe Nurse & Midwifery Staffing Report**	
	Ms Cosgrove presented the report. Overall fill rate for November 2018 was 95.76% compared to October 2018 which was 93.25%, compared to 91.99% in September. . • 90.45% Registered Nurses on days • 94.58% Registered Nurses on nights • 103.81% Care staff on days • 98.95% Care staff on nights **Trust whole time equivalent (wte) funded establishment versus contracted:** November 2018 data:	

	Funded WTE	Contracted WTE	Nov Total Vacancy
Registered	865.63	775	90.63
Non - registered	377.98	351.30	26.68
Total	1247.61	1126.30	117.31

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

	Ms Cosgrove noted that Appendix 1 Care Hours per Patient Day (CHPPD – November 2018) in the report identified that the 8-hour ideal was not always being achieved, which was being reviewed and addressed with daily staffing huddles etc. Appendix 2 related to Thornbury Nurse Agency, which had been used due to severe staff shortages, as it was a non-framework agency. The Appendix set out an overview of the current work to reduce and end the use of this agency. Appendix 3 identified there were areas of non-compliance in the Trust against the National Quality Board (NQB) 2016 recommendations which were being reviewed and addressed. Ms Cosgrove commented that the availability of the right level of workforce remained a concern and there were inappropriate governance arrangements and resources to manage them. Mrs Royds stated that her team was supporting workforce with agency staff and NHS Professionals (NHSP) and Thornbury would be used as a very last resort. Price Waterhouse Coopers (PWC) were concluding their consultation work on e-rostering. **RESOLVED:** The Board **received** the report.	
TB010/19	**Guardian of Safe Working Report to Board for Period: 1 August 2018 - 31 October 2018.**	
	Dr Ruth Chapman presented the report. The report was a little out of date due to not being presented at the November 2018 Board. The Chair asked Dr Chapman what action she wanted of the Board. Dr Chapman responded that most key issues had been addressed; however, people were still doing extra hours. There had been evidence of efforts to improve and even reduce them. Surgical locums remained a concern which she would raise with the Medical Director. The Doctors' Mess was progressing but needed to be furnished. She hoped that her successor would continue to receive support from the Medical Director and his team. The Chair thanked Dr Chapman for her time in the role and expressed regret at her departure. Dr Hankin stated that the trainee doctor forum had seen improved attendance and was being used to engage with them. Mr Nicholls added his thanks to Dr Chapman and observed that	

	previously, a lot of expectation was placed on her due to her capability of '*doing'* and getting stuck in, which was not always appropriate. The Executive Team and Clinical Leadership team would carefully examine what role Dr Chapman's successor should undertake and asked her and Dr Hankin to discuss it initially. *Mr Nicholls suggested that the re-named Doctors' Mess be known as the 'Dr Ruth Chapman Lounge' as testament to her legacy.* **RESOLVED:** The Board **received** the report.	**DCEO/DoS**
PERFORMANCE		
TB011/19	**Integrated Performance Report (IPR)**	
	Mr Shanahan introduced the report, details of which could be found in the Board Pack. They included a Dashboard, Executive Assurances and Key Performance Indicators (KPIs) with narratives. **a. Quality Indicators** Ms Cosgrove commented that MRSA and C-Diff were within target for safety. Further work was required on Infection Prevention Control. There had been no Never Events. The Quality & Safety Committee had considered fractured neck of femur at the last meeting, however, due to winter pressures no improvement had been evidenced. Trauma and Orthopaedic Wards were being focused upon to improve standards of care, particularly on Ward 14a. Duty of Candour had seen improvement. Dr Hankin commented that action plans were in place to reduce both Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). There had been 100% compliance with World Health Organisation (WHO) Safe Surgery. Stroke care was good and demonstrating improvement. Freedom to Speak Up had increased and would be rolled out to sessions within theatre environments. **b. Operational Indicators** Mr Christian commented that November 2018 was the fourth consecutive month which had seen year on year improvements despite increases in demand. Diagnostics performance was good, with 1.45% performance for November 2018, against the 2% six-week wait target, which was the first time since February 2018 the Trust had achieved this target. Overdue	

	Follow Ups Backlog saw a reduction from 5,000 to 1,800 due to the reduction in outpatient clinics. Cancer 62 Day performance for October was above the 85% target at 90.3%, however, this was the first month for four months that the target had been met and only the second time in the last year. Bed occupancy at Southport had been 96%, which had been responded to with escalation areas. Mr Birrell noted that no patient had been waiting for over 40 weeks and only 32 had waited over 30 weeks. *Mr Christian added that the Did Not Attend (DNA) Rate had increased in November and an improvement programme and action plans were being developed with the Ms Roberts' Team.* *Theatre Utilisation data would be revised to reflect the accurate position.* **c. Financial Indicators** These were to be discussed in the Director of Finance report. **d. Workforce Indicators** Mrs Royds commented that sickness had decreased from 6.26% in October to 5.94% in November 2018. Return to Work interviews were being undertaken by the HR Teams to release operational staff for ward duties. Personal Development Reviews (PDRs) had increased to 70.48% in November 2018 and work was continuing to achieve 85%. Since October 2018, training had been offered to managers, to ensure that conversations were taking place, not just tick box exercises, which had been well-received. Mr Clarke asked if there was a correlation between the numbers of staff receiving the flu injection and the amount of sickness recorded, to which Mrs Royds replied that flu was not being reported as a cause for sickness. Ms Cosgrove added that the uptake of the flu vaccination would appear to demonstrate an engaged workforce, however, the volume of sickness would not. **Mandatory Training** The training rate continued to steadily increase and improve each month. In November 2018 the overall Trust rate was 84.43%. Work was ongoing to support managers to ensure rates were monitored and staff encouraged and given the opportunity to undertake mandatory training, whilst recognising that winter pressures may impact on this.	**COO** **COO** **DoN**

	Mr Clarke asked if there was an explanation for the 35 written complaints in November 2018, to which Ms Cosgrove responded that no theme had been identified however it may relate to the standards of perceived care in the escalation wards and was being examined. Dr Bricknell asked if the call for volunteers for extra shifts had seen success. Ms Cosgrove replied that a number staff including Corporate Administration had volunteered, however, this had not been reflected with Registered Nurses. The Chair and Mr Nicholls agreed that a *'Dunkirk'* spirit had been seen across staff and the issue of sickness would be discussed at the afternoon's planning session **RESOLVED** The Board **received** the report.	
TB012/19	**Director of Finance Report**	
	Mr Shanahan presented the report. At Month 8 year to date (YTD) the Trust's financial performance showed a deficit of £19.772 million which was £281,000 worse than plan. Income and activity continued to be above plan for A&E attendance and non-elective admissions. This included income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. Elective activity underperformance against plan continued in November 2018. Expenditure run rate was consistent with October but there were 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 contributed significantly to that as did the use of agency staff. In month the Trust saw a slight reduction in agency spend reversing the trend of previous months. There were a number of risks to delivering the year end deficit of £28.8 million: • **Contract sanctions**; Trust had made no provision to date as discussions had been taking place with Regulators and Commissioners; at month 8 total value to date was £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 was forecast to be £0.6 million less than the £7.5 million plan although additional schemes are expected to mitigate. • **Agency spend**; YTD spend was £5.2 million which meant the Trust was in breach of its NHSI agency cap set at £5.6 million. There had been a total of 99 shifts in December 2018, supplied by Thornbury and at the date of the Board, 92 shifts had already been supplied, indicating a larger potential breach. A report on Monday 14 January 2019 to the Executive Management Team would provide a further update. There was no plan at that stage to amend the forecast outturn from £28.8m deficit. The challenge of addressing enhanced rates of pay for existing staff, to encourage them to volunteer for extra shifts and therefore reduce the agency spend would be considered by the Finance, Performance & Investment Committee. **RESOLVED:** The Board **received** the report.	
GOVERNANCE/WELL LED		
TB013/19	**Risk Management:** **Board Assurance Framework (BAF) and Risk Register**	
	Mr Charles presented the report. He began by reminding the Board that at a Workshop in October 2018 it was agreed to integrated the KPIs into the BAF as part of the evidence for control; and assurances and that this BAF report was the first since the experiment. The Strategic Planning session for the afternoon, would discuss refreshing the strategic objectives and the principal risks in preparation for Strategic Plan. *After those discussions a new draft BAF Model for 2019/20 will be brought to the March 2019 Board.* The Chair commented that the work previously undertaken for Capital Fund Wave 4 and the potential work for Wave 5 may contribute to a further reduction of the SO1 Risk Rating. He added that linking work across the Trust would help to drive the route map of improvements and help deliver the reduction of Risk Ratings. Mr Birrell commented that it would be interesting to see the outcome of that and suggested that the Board's perspective must not be lost by integrating the process too deeply.	**CoSec**

	A question was raised as to the frequency of reports on the BAF, to which Mr Charles added that a bi-monthly report on the BAF would continue to be considered at the Quality & Safety Committee, Finance, Performance & Investment Committee, the Workforce Committee and also quarterly by the Audit Committee and the Board. Mr Nicholls commented that all actions would be mapped back to the appropriate statutory or assurance committee and would reflect the risks and issues in the BAF whilst enabling less static monitoring, assessment and change processes. The Chair stated that the BAF should be considered at the beginning of the Board, with sufficient time apportioned to it, to properly consider and understand it and the direction of travel for the Trust in that regard. **RESOLVED** The Board **received** the reports	
TB014/19	**Annual Report, Annual Accounts and Quality Accounts 2018/19**	
	Mr Charles presented the outline of the timeframe and key responsibilities in preparation and submission of the end of year documents for information. **RESOLVED** The Board **received** the outline	
TB015/19	**The 2017/18 Charitable Funds Accounts**	
	Mr Shanahan presented the report. As a Charitable Fund Committee had not been able to meet to recommend the sign-off of the Accounts, the Board was asked as Corporate Trustees to approve the 2017/18 Charitable Fund Accounts and Annual Report. The Accounts were not subject to a full audit but an independent examination and Mr Clarke stated that a full audit would have been ideal. Dr Bricknell asked if the Charitable Funds accounts should have been consolidated into the Trust's accounts. Mr Shanahan confirmed to Dr Bricknell that that was not done on the basis of materiality. Mr Birrell noted that the Trust was not actively generating charitable funds and therefore little spend was occurring. The Chair added that the Trust had the potential to have at least two strong charitable fund raising brands; Spinal Injuries and	

	Children's. Mr Shanahan stated that the Committee had previously considered a proposal from a marketing company which had previously re-branded St Helen's & Knowsley Trust's Charity. The post of a Fundraiser would also be required as part of the proposal. **RESOLVED** The Board, acting as the Corporate Trustee **approved** the 2017/18 Charitable Fund Accounts and Annual Report	**DoF**
TB016/19	**Items for approval/ratification**	
	Uncommitted Revenue Support Loan **RESOLVED** The Board **ratified** the decision taken under Emergency Powers to approve application for an Uncommitted Revenue Support Loan of £2.437m for January 2019	
TB017/19	**Questions from Members of the Public**	
	None	
CONCLUDING BUSINESS		
TB018/19	**Any Other Business**	
	Ms Cosgrove informed the Board that a Coroner's Inquest, relating to a death at the Trust in 2016 had concluded. The death had occurred after a patient presented at A&E with a head injury resulting from an assault and a fall. Following a two-hour delay in monitoring, the patient deteriorated and died. • The Trust had defended itself against neglect and was found to have had gross failings in care. • The Trust had avoided receiving a Regulation 28. • There had been no press interest. • Lessons learned had been identified Mrs Gorry stated that she was unaware of that death and the subsequent inquest and asked that the Board be kept abreast of such occurrences. *The Chair agreed that the Board should be regularly informed via a litigation report on the subject of claims, damages and liability expectations and reputational risk.*	**CoSec**
TB019/19	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • *Winter pressures* • *Year End Financial Outturn* • *External Mortality Review for February 2019 Board* • *CQC preparation* • *Length of waiting in outpatients*.	**Communications**

TB020/19	DATE, TIME AND VENUE OF THE NEXT MEETING	
	Wednesday 6 February 2019, 10.15am 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**
Neil Masom (Chair)										✓		
Richard Fraser (Chair)	✓	✓	✓	✓		✓	✓	A				
Jim Birrell	✓	✓	✓	✓		✓	✓	✓	✓	✓		
David Bricknell	✓	✓	✓	✓		A	A	✓	✓	✓		
Ged Clarke	✓	✓	✓	A		✓	✓	A	✓	✓		
Juliette Cosgrove			✓	✓		✓	✓	✓	✓	✓		
Julie Gorry	✓	✓	✓	✓		A	✓	✓	✓	✓		
Dr Terry Hankin										✓		
Dr Jugnu Mahajan	✓	✓	✓	✓		✓	✓	✓	✓			
Silas Nicholls	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Therese Patten	✓	✓	✓	✓		A	✓	✓	✓	✓		
Steve Shanahan	✓	✓	✓	✓		✓	✓	A	✓	✓		
Gurpreet Singh	✓	✓	✓	✓		✓	✓	✓	✓	**A**		
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓	✓	A	A		✓	✓	✓	✓	✓		
Audley Charles	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Steve Christian			A	A			✓	✓	✓	✓		
Jane Royds	✓	✓	A	✓		✓	✓	✓	✓	✓		
A = Apologies ✓ = In attendance, - = No response												

Public Board Matters Arising Action Log
as at 6 February 2019

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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	Apr 2019	**December 2018** ADHR was TUPEd and appointed as Director of HR in November 2018. **January 2019** Work and recruitment continues to transfer services back to the Trust by end March 2019.	**GREEN**
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** An email was sent by Mr Clarke on behalf of the Board with no response. (Dec 18) **February 2019 Update** • A further email was sent by CoSec on behalf of the Board, requesting acknowledgement or receipt. (Jan 19). • The Assistant to CoSec telephoned twice and left messages to establish receipt, but to date there had been no response.	**GREEN**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB005/19	Jan 2019	**Patient/Staff Story: Waiting Times – In/Out Patient Areas**	Chief Operating Officer was asked to look at the issue of communicating waiting times within outpatient departments.	**COO**	Jan 2019	Jan 2019	**February 2019 Update** The COO will ensure that this happens and will confirm at the March Board	**RED**
TB005/19	Jan 2019	**Patient/Staff Story: Waiting Times – In/Out Patient Areas**	The Chair requested that the next patient story could be that of a patient's experience in the Emergency Department, given the winter pressures it was currently experiencing.	**CoSec**	Feb 2019	Mar 2019	**February 2019 Update** Mrs Kitson (Matron – Patient Care) has been informed	**AMBER**
TB006/19	Jan 2019	**Chief Executive's Report**	Due to high escalation rates there was an impact on the availability of beds. As a result some patients were temporarily placed in a holding area. Some patients were not happy with their experience of being placed in the middle of bays. The Chair requested that along with the communication about the reasons why patient experience may not have met expectations, patients and their families and carers should receive an apology.	**COO/DoN**	Jan 2019	Jan 2019	**February 2019** Both Directors will ensure that this procedure is escalated and embedded to the relevant staff team.	**AMBER**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB008/19	Jan 2019	**Monthly Mortality Report**	Hospital Standardised Mortality Ratio (HSMR) – July 2018 data would be re-examined to assure the Board of its accuracy.	**MD**	Feb 2019	Feb 2019	**February 2019** MD has examined the data and confirms its accuracy	**AMBER**
TB008/19	Jan 2019	**Monthly Mortality Report**	The February Board Report would be further streamlined.	**MD**	Feb 2019	Feb 2019	**February 2019** The monthly report has been streamlined as requested	**AMBER**
TB010/19	Jan 2019	**Guardian of Safe Working Quarterly Report**	The re-named Doctors' Mess be known as the *'Dr Ruth Chapman Lounge'* as testament to her legacy.	**DCEO/DoS**	Feb 2019	Mar 2019	**February 2019** Deputy CEO to bring an update to the March Board	**AMBER**
TB011/19	Jan 2019	**Integrated Performance Report**	Investigation of the 35 complaints received in November to establish if there was a correlation with patients on escalation wards.	**DoN**	Feb 2019	Feb 2019	**February 2019** DoN to bring the update to March Board	**RED**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB011/19	Jan 2019	**Integrated Performance Report**	Due to an increase in Did Not Attend (DNA) rate, an improvement programme and action plan was being developed.	**COO**	Feb 2019	Feb 2019	**February 2019** This is a key work stream in the operational efficiencies. Booking Team hours have been extended to ring outpatients the evening before their appointment, for areas which high DNA occurs, to ensure attendance. The text message service has been extended to all patients where mobile numbers are available.	**AMBER**
TB011/19	Jan 2019	**Integrated Performance Report**	Theatre Utilisation data would be revised to reflect the accurate position.	**COO**	Feb 2019	Feb 2019	**February 2019** COO to update the Board in March	**RED**
TB013/19	Jan 2019	**Board Assurance Framework & Corporate Risk Register**	The draft BAF to be presented at the March Board in view of the updated and refreshed strategic objectives which were discussed at the workshop following the Board.	**CoSec**	Mar 2019	Mar 2019	**February 2019** This item is on the forward agenda for March Board.	**AMBER**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB015/19	Jan 2019	**Charitable Funds Committee**	The Charitable Funds Committee had previously considered a proposal from a marketing company which had previously re-branded St Helen's & Knowsley Trust Charity. The post of a Fundraiser would also be required as part of the proposal.	**DoF**	Feb 2019	Feb 2019	**February 2019 Update** Meeting arranged for 8 February 2019 with the marketing company.	**AMBER**
TB018/19	Jan 2019	**AOB**	The Chair agreed that the Board should be regularly informed via a litigation report on the subject of claims, damages and liability expectations and reputational risk.	**CoSec**	Mar 2019	Mar 2019	**February 2019 Update** This links with a request made by the Audit Committee for a full report on accessing external legal advice. This will take into account the subject of claims, damages and liability expectations and reputational risk. This will be brought to the March Board.	**AMBER**

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COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB002/19	Jan 2019	**Declaration of Directors Interests Concerning Agenda Items**	The Chair noted that from his own declaration, WYG Plc should have been noted as a public company instead of a private company. Dr Hankin's declarations would be added to the Register for the February Board.	**CoSec**	Jan 2019	Jan 2019	**February 2019 Update** Revision and addition made to Declaration of Interests Register 14 January 2019 and is included in the Board Pack	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	TB026/19	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 include the following:

- Staff rise to challenge of busiest winter ever
- Quality Improvement Plan and Preparing for our CQC inspection
- Patient mortality
- 2018/19 forecast outturn and financial plan for 2019/20
- Planning for the Trust's future
- So Proud Week – celebrating quality care

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)*

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 BOARD – FEBRUARY 2019

Staff rise to challenge of busiest winter ever

This is my first winter as Chief Executive and I'm hugely proud of how colleagues have risen to the challenge of caring at what is always a difficult time of year.

To date, it has been our busiest winter ever.

Christmas and New Year saw record attendances at A&E at Southport and Ormskirk hospitals. Twenty extra patients were seen each day compared to 2017, an increase of 16%.

Despite this staff treated, admitted or transferred 89.3% of patients within four hours of arriving in A&E – a near 10% improvement on the previous year. Patients also waited much less time for transfer into hospital from ambulance

Overall patients now spend two hours less on average in A&E than they did last year.

The £1.25m improving Southport A&E and more than £1m invested in additional clinical staff has certainly helped improve our performance. But it's the hard work, commitment and dedication of staff to the care and well-being of local people that has made the biggest difference.

Colleagues have shown imagination and flexibility to make sure the experience of the many additional patients we have seen is as good as it can be. The creation of a temporary Ward 1 at Southport hospital in physiotherapy outpatients is one such example.

Nonetheless, we have sometimes had to make some difficult decisions to make space for everyone who needs care.

I want to apologise to any patient or their family whose experience while staying with us has been affected by how busy we are.

Quality Improvement Plan and Preparing for our CQC inspection

Governance arrangements for infection prevention and control have been reviewed and there will be a focus on key areas including hand hygiene, source isolation, management of outbreaks and aseptic technique.

Director of Nursing, Midwifery and Therapies Juliette Cosgrove will take the role of Director of Infection Prevention and Control on an interim basis with Medical Director Terry Hankin taking over in quarter one 2019/20.

In relation to the deteriorating patient, NEWS 2 is being rolled out – a nationally validated track-and-trigger early warning score system that is used to identify and respond to patients at risk of deteriorating. The 24/7 outreach team has also been recruited and will commence in April. A concern with completion of observations at night and weekends is being investigated.

The Dementia Steering Group has been relaunched led by the Head of Older People's Care. Its initial focus will be the development of a dementia strategy.

The Quality Improvement Group held its first meeting during So Proud Week (see below). This group will oversee the quality improvement plan to deliver key actions for the Trust's 2020 Vision.

Nursing workforce metrics continued a gradual improvement in December and a programme of ward establishment reviews continues.

AQuA, the Advancing Quality Alliance, and Mersey Internal Audit Agency are continuing their well-led review and have attended a number of committees and interviewed a

significant number of key members of the senior management team and Trust Board members.

Each executive director will be reviewing their regulatory responsibilities and any potential key lines of enquiry in relation to the Care Quality Commission (CQC) and agreeing improvement plans where appropriate. These will be monitored at a weekly executive meeting chaired by the Director of Nursing.

The Quality and Safety Committee received a paper showing key improvement areas identified in the Core Service Review in December and plans for each service have been drawn up.

Infection control

The Trust has faced challenges this winter in the shape of patients presenting with norovirus (the so-called winter vomiting bug) and seasonal flu.

More than 80% of frontline staff – and many non-clinical staff too – had the free NHS flu vaccine which is helping keep both patients and staff protected from infection.

Andrew Chalmers, the Deputy Director of Infection Prevention and Control, is also leading on changes that includes flexible signage on ward side rooms where patients are an infection risk; introducing disposable patient wash bowls; and trialling disposable bed curtains.

Patient mortality

The importance of the external mortality review as presented in the Reducing Avoidable Mortality Workstream actions and Trust priorities today cannot be understated. It clearly challenges the Trust to improve the basic standards of care across the organisation.

To date, the report demonstrates the significant progress against actions described. The Medical Director has identified themes in terms of observations and documentation, escalation to key pathways and pneumonia that will be the focus of the reducing avoidable mortality group for the coming year.

Financial position – 2018/19 forecast outturn

The forecast outturn for 2018/19 remains unchanged at £28.8m deficit but there are a number of risks that need to be managed in order to achieve this:

- Contract challenge by commissioners for the over-performance of non-elective activity and income
- Agreement on contract sanctions being applied for A&E four-hour breaches on the basis of the local trajectory agreed with NHSI rather than 95% national target
- Closing the £0.6m CIP gap given the winter pressures in December and January

The run rate schemes related to agency reduction continue to deliver, however, they are being fully negated by the extra agency staff needed, with the reliance of an off-framework agency to fill nursing shifts, to cover the extra bed capacity.

Planning for the next financial year

The Trust is required to submit its Draft 2019/20 Organisational Operational Plan, which includes finance and workforce details, on 12 February. This builds on the initial activity submission made on 14 January.

Financial tariff and allocation guidance have now been issued in addition to control total details. We are now working out what this means for our financial and efficiency plan next year.

As part of our planning preparation, before Christmas all departments were asked to submit requests for investment next year. These cases are now being assessed against our agreed 2019/20 priorities and a reasonable investment envelope will be agreed.

Our submission on 12 February will include the impact in 2019/20 of our planned investments, NHS Improvement planning guidance and clinical commissioning group agreements. A summary of this will be agreed by the Trust Board in advance of this submission.

Planning for our future

The Trust continues to work on developing a sustainable model for acute care which comprises an urgent and emergency care-focused, digitally-enhanced, new-build community general hospital and a regional elective and treatment hub at Ormskirk.

We have agreed to take some time out in February to take stock and reset our acute sustainability programme. We will use expert clinical opinion we have sourced, the new NHS planning guidance with a focus on a joined-up system approach, and the NHS Long Term Plan as a basis for our programme reset work.

For this session we will extend the invitations to other colleagues across the area who will be able to help us focus on future opportunities and partnerships that we may not have considered to date.

So Proud Week – celebrating quality care

We celebrated quality care across the Trust in the final week of January with So Proud Week, sharing ideas about what makes great care for patients and each other. It included:

- The “Quality Street” trail with our quality partners AQuA who ran events at both hospitals showing staff how they are working with us over the next two years to support our quality improvement programme
- There were free activities for staff on “Wellbeing Wednesday” including meditation and yoga taster sessions as well as information about counselling, physiotherapy and other staff wellbeing support
- We were delighted to welcome health commentator Roy Lilley from the NHS Academy of Fabulous Stuff. He toured both hospitals hearing from staff about the improvements and innovations to patient care they’d made

The week concluded with a Quality Summit when we reflected and fed back on the lessons and learning from the week with partners from across the local NHS and health economy. We also launched our Quality Improvement Plan, Quality Priorities and feedback from the Core Services Review in December.

Centre of excellence for older people

As part of our Vision 2020 strategy, the Trust is on a journey to becoming a “centre of excellence” in caring for older people.

A quarter of hospital beds are occupied by people over the age of 65 with dementia. The condition affects one-in-three people over the age of 90 years and many people will someone with the condition.

We are in the process of reviewing the Trust's dementia strategy and will begin to put into action this work shortly.

In brief …

Parking. We continue to experience high demand for parking from patients, visitors and staff. I'm very sorry for the inconvenience and frustration this can sometimes cause.

To alleviate pressure on parking, the Trust is creating extra spaces at Southport hospital as well as relining existing spaces. The work is under way and progressing as fast as weather conditions allow. We have also secured additional parking for staff at nearby KGV College which is helping take pressure off the main hospital car park.

Wifi. Work is under way to improve wifi across the Trust to fully enable our strategy for digitally-enabled care. The work, once completed, will also make free wifi access available to patients and visitors.

Menopause café. Sexual health consultant Dr Paula Briggs is one of the few doctors in the region specialising in the menopause. She recently published a patient booklet on the subject.

To mark its publication, she held a "menopause café" at Ormskirk hospital in January, providing the latest information about treatment options and alternative strategies for coping. More than 70 women attended. She also held a smaller event for staff during So Proud Week.

Twins gift. Tina Thaw, whose dad Ray is porter at Southport hospital, gave birth to twins three months prematurely at Ormskirk in October. As a thank you to the Neonatal Unit, Tina presented the proceeds of her baby naming day to the unit at the team's last Neonatal Natter support group meeting before Christmas.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	PB027/19	Report Title	Quality Improvement Plan Progress Update
Executive Lead	Juliette Cosgrove, Director Nursing, Midwifery & Therapies		
Lead Officer	Paul Jebb, Deputy Director of Nursing 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.

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)*

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

NHS
Southport and Ormskirk Hospital
NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on the development of the Quality Improvement Plan (QIP) 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 QIP, has been developed and is currently being populated incorporating priorities from the CQC Must and Should Do recommendations and the Trust's key quality priorities and themes emerging from complaints, incidents, patient feedback, the MIAA ward audit, AQuA Well Led programme and the recent Core Services Review. The detail of the Must and Should do actions will be reported as an appendix to the QIP, high level updates against progress and risks to delivery identified through the internal governance process will be reported to this committee through a monthly report.

The QIP is an integral component of the Trust's Vision 2020 Programme. This means that in terms of the governance arrangements, the delivery of the QIP is monitored through Trust Board in the following way:

- The delivery of the programme is managed and monitored through the Hospital Management Board via the Hospital Improvement Board. Day to day management of the plan is managed through the Quality Improvement Group (QuIG) task and finish group
- Reports will feed into the Quality and Safety Committee to ensure appropriate assurance as part of the Trust's Quality and Safety Integrated Performance Report and Quality Improvement Plan Update.
- External governance is provided through the Southport and Ormskirk Improvement Board

The highlight assurance templates / progress reports are currently being developed, by the Interim Performance Manager in line with the Trust Integrated Performance Report.

3. REGULATIONS

The Quality and Safety Committee received information in relation to specific regulations outlined in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A summary of the Regulations applicable to the Trust and a description of the minimum standard registered providers and managers should meet was provided this also mapped across the requirement notices and regulatory actions identified at the 2017 core services and well led inspections and 2018 ED review. The Trust does not have any CQC Enforcement Notices to date.

The CQC have recently queried the Trust's compliance in relation to Regulation 20 'Duty of Candour', as a result the CQC reviewed the evidence we recently submitted and the trust's regulatory history. In their letter the CQC stated that they have decided in this case that although the organisation had breached the regulation, they felt a fair and proportionate response was needed, this will be in the form of carrying out enhanced monitoring

specifically against this regulation for six months. This means that this issue will be a standing agenda item at engagement meetings and that the trust is required to submit a monthly report providing assurance that regulation 20 is complied with.

4. 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. However, the panels are due to progress w/c 7 February 2019 and, the first panel will review the Regional Spinal Unit evident, followed by the Emergency Department and Maternity.

As with November, of the 96 improvement actions, 59 are currently rated amber (on track to deliver), 32 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	17	15	32
On track to deliver	38	21	59
No progress / Not progressing to Plan	0	0	0
TOTAL	59	38	96

BRAG rating monthly reported completion

Rating	Baseline	June 18	July 18	August 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19
Delivered and Sustained	0	1	1	1	2	5	5	5	5
Action Completed	0	0	6	22	21	19	34	34	32
On track to deliver	97	96	90	74	74	73	58	58	59
No progress / Not progressing to Plan	0	0	0	0	0	0	0	0	0

Key changes in January are due to CBUs reviewing and consolidating their actions and strengthening assurance and evidence. Additional actions will go to the assurance panels in February 2019.

5. 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 two 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, however there have been improvements in ambulance handover and triage times.

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	Dec 18	Jan 19
Delivered and Sustained	0	1	1	1	1
Action Completed	4	15	17	17	17
On track to deliver	21	9	7	7	7
No progress / Not progressing to Plan	0	0	0	0	0

The CBU are reviewing the ED evidence prior to the February assurance panels, addition evidence will be submitted to the next panel.

6. CQC REVIEW OF HEALTH SERVICES FOR LOOKED AFTER CHILDREN AND SAFEGUARDING IN SEFTON

Following a CQC Review of health services for looked after children and safeguarding in Sefton, the CCG set up a CQC Task & Finish Group of stakeholders, this group developed an action plan which was forward to the CQC. The CQC positively highlighting that the action plan clearly demonstrates shared activity planned over the coming months to drive improvement, and they also positively noted areas that have already been strengthened since the review. Within the action plan many of the actions are on track to be met within the target timescales. The CQC also highlighted that not all recommendations have a specific or child focused outcomes statement. The action plan will be overseen at future Task & Finish groups.

The CQC also advised that the action plan has been shared with the regulatory inspection relationship owners for each provider.

7. FEEDBACK FROM CORE SERVICE REVIEW

BACKGROUND

The Core Service Review was held within the Trust on the 11 and 12 December 2018. As reported previously to the Board, Our quality core service review involved staff from the

Trust, partner and stakeholder organisations as well as patient representatives who visited wards/departments as a team to speak to patients and staff and directly observe the care and environment delivered to patients.

This review aimed to provide us with an independent view of the care our patients are receiving. This will enable us to have a clear focus to identify any areas that we believe would further improve patient care and enhance patient and staff experience.

The quality core service review is based on the CQC's five core questions:

Is the service safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well led?

Core Services reviewed included:

- Medicine (including Older People's Care)
- Emergency Department (including ACU, CDU, SAU and EAU)
- Outpatients and Radiology
- Children and Maternity (including Emergency Department)
- Surgery (Theatres and Wards)
- Spinal Injuries and Critical Care

The review team was split to smaller teams and each team had a nominated team leader. The visits included:

- The review team was split into respective groups and roles defined and agreed (e.g. engaging with staff and patients). All team members were briefed on the key lines of enquiry, navigation around the site and how the feedback sessions will be conducted at the end of the review to the wider group.
- Review teams visited wards and departments and then regrouped to agree key messages to be feedback to the wider group.

Following the two day review feedback was given to the Executive team by the review chair. This feedback along with notes from the review teams has been collated to highlight areas of good practice, areas for improvement as well as areas that could be classed at quick wins to support the improvement within the key areas. (see Appendix 1)

8. TRUST QUALITY IMPROVEMENT PRIORITIES

To support the Trust Quality Improvement journey and the roll out of the Quality Improvement Plan (QIP), the Trust needs to identify quality priorities so to raise awareness amongst all our staff but also to clearly highlight to our wider stakeholders including the public what we will focus on in the coming year.

These areas will also enable our Quality Account to be more focused and to develop realistic key performance indicators that are SMART and will highlight our improvements.

The Executive Team have identified four Quality Priorities for Board awareness.

As a Trust we have continuously developed our QIP which has been developed incorporating priorities from the Trust's CQC Must and Should Do recommendations, existing quality priorities and themes emerging from complaints, incidents, patient feedback and the recent Core Services Review. Having reviewed all the feedback the four emerging priorities are:

- Care of the Deteriorating Patient
- Care of Older People
- Infection Prevention and Control
- Medicines Management

These Quality Priorities will support the aspirations laid out in Trust's Vision 2020 Programme namely:

- A CQC rating of "good" with no individual ratings of "inadequate"
- Meet or exceed the national standards for patient mortality
- Have a modern seamless pathway of care for frail older patients

We also need to be aware of the impact of organisational culture on these quality priorities and as the Trust OD work moves forward; there will need to be a link with these priorities as well as the development of an open, just and learning culture. This will bring in the work done by the Freedom to speak up Guardian (a reporting requirement of the 2018/19 Quality Account) and future developments within the speaking up safely agenda.

9. RECCOMENDATIONS

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

APPENDIX 1

NHS Southport and Ormskirk Hospital NHS Trust

Clinical Service Review

	Good Practice	Learning / Concerns	Quick Wins
Critical Care	• Teamwork / supportive • Focus on wellbeing • Matron leadership • Safety information and meeting supported by Practice Educators	• Bereavement care • Relatives room (environment) • Associate Practitioner role – clarify (linked to ATN)	• Update organ donation information • Update care plans • More visible Infection, Prevention and Control / hand hygiene information
Spinal	• Patient and family satisfaction – would recommend • Discharge improvement programme • Outreach and partnership working	• Environment and storage • Pool – not accessible • Separate notes	• Décor / update / personalise for patients • Update patient information / notices • Roll out new curtains
Accident and Emergency (Urgent Care	• Care and knowledge of patients • Staff keen to participate in review • Responsive to learning and feedback from review	• Care home patients do not have escalation plan • Lack of food and drink access to vending machine • Medicine storage – room temperature and fridges	• Implement uniform policy (no jeans or trainers) • Lack of O^2 cylinders for transfer and storage • Intentional rounding (frequency and documentation) • GP information including EOCC plan
Clinical Decisions Unit / Ambulatory Care Unit / Surgical Assessment Unit / Observation Ward	• Great OT with patient centred approach • Care standards • Teamwork	• Infection, Prevention and Control / Personal Protective Equipment • Documentation and care planning • Stock controls and rotation to prevent use of out of date items	• Red sepsis trolley with out of date items • More commodes • De-clutter and stock clock • Equipment – recalibrate
Surgery and Theatres	• Receptive, open and honest • Aware of improvement programme and very positive • Team work	• Communication – email cascade • Uniforms • Concerns about individualised care is compromised during winter pressures	
Outpatients Southport	• Positive feedback re maternity and improvement journey • Good team meetings	• Involve satellite services which use Ormskirk as base • Patient information and signage	• New appointment cards (replacing photocopies) • Drug temperature monitoring

APPENDIX 1

	• Shared learning in Outpatients • Considerate, caring staff	• IT system functionality and appointment letters	(fridge and room) • Promote walk and wait for Outpatient services • Update signage
Radiology Southport	• Medicine storage • Use of WHO checklist for intervention procedures • Team work	• Privacy and dignity (gowns) • Estates / flooding • Infection, Prevention and Control / Personal Protective Equipment roles and responsibilities • Workforce planning to meet demand	• Team communication, meetings • Weekend monitoring of medicines management • Review / check CQC action plan
Maternity	• Access to patient records (diagnostics) • Good cohesive team • Fast responsive services / calming	• Patient waiting area / facility / environment • Duty of Candour – awareness • Patient experience – not greeted at reception	• Clarify PGD's used • Name badges • Ligature cutters • Waste management and linen storage (environment)
Medicine	• MCA/documentation • Relatives facilitating • Caring, kind, compassionate staff	• Documentation not standard / fragmented • Board to floor communication • Infection, Prevention and Control / Personal Protective Equipment	• Daily checklist • De-clutter • Uniform compliance
NHSI Medical Director	• Over 70% flu vac rate • Appointed Interim Head of Older People Care **Peer Support from LTHT** • Older people's care • Board development re QI **IM&T Investment** • Board training undertaken on cyber security • Vitalpac extending to all areas including maternity, paediatrics and ED	• Bullying – significant work required with OD partner • FTSU – positive approach but significant issues re relationships between staff/behaviours **EOL up to 5 admissions/attendances per day** • Coordinated /team approach for alternatives to admission and fast track transfer to place of choice • Example of need for a partnership approach/working with both CCGs	• Developing consultant of the week • Improve student experience • Training programme to support required – continence, nutrition, dementia
All Areas	• Ligature cutters on Resus Trollies • Environment / cleanliness • Infection, Prevention and Control / Personal Protective Equipment compliance and practice • Uniforms and name badges		

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	**TB028/19**	**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 Liz Woollam, Programme Support Lead Mike Lightfoot, Head of Information		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Board is asked to receive the report for assurance of progress of Learning from Deaths activity driven by the Reducing Avoidable Mortality Project, supported by the roll out of the Structured Judgement Review and clarified with analysis of Trust mortality data.

Contents:

Learning from Deaths and Reducing Avoidable Mortality

An overview of the new Structured Judgement Review method is given along with the headlines from the External Mortality Review. Learning from Deaths data for Quarter 1 (April to June 2018) is also detailed.

Measuring Mortality

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

Reducing Avoidable Mortality (RAM) Project

Updates are given on activity for each of the six work streams alongside a revised list of milestones and risks

Recommendation:

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

Strategic Objective(s) and Principal Risks(s)

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

Strategic Objective	Principal Risk

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

Previously Presented at:

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

Mortality Committee Report

Southport & Ormskirk Hospital NHS
NHS Trust

Executive Summary

- HSMR and SHMI remain above the required target to provide assurance.
- SHMI is predicted to rise again in the next release (Sept 19), before an anticipated fall.
- Reduced crude mortality rate is beginning to be reflected in in-month HSMR, though this is affected by seasonal variation.
- Bronchitis and Lower Respiratory Tract Infection (rather than pneumonia) require further investigation.
- Mortality screening and SJR reviews are occurring, these require embedding and development of the process to support reviewers and extract the learning. Barriers to the completion of these reviews also require analysis so the system can support this valuable learning process.
- When the system can match its resource and the demands placed upon it, mortality rates improve. Efforts to improve patient flow and safe staffing should be a priority.

Key national and local mortality indicators

	2017/18				2018/19								Target
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	
Rolling 12 Month HSMR	116.1	118.8	123.1	123.4	121.2	120.6	118.3	117.9	115.7				*100.0*
Monthly HSMR	115.7	138.6	136.0	124.7	105.0	125.6	98.9	119.2	90.0				*100.0*
SHMI	114.2			118.0			115.5						*100.0*
Local HSMR Bronchitis	133.3	110.5	126.1	165.9	154.5	161.6	154.5	170.3	158.3				*100.0*
Local HSMR LRTI	134.6	111.5	127.2	167.4	155.9	163.0	155.9	171.8	159.6				*100.0*
Local HSMR Pneumonia	128.3	134.8	145.0	144.5	142.5	135.9	133.0	136.2	126.0				*100.0*
Local HSMR Septicemia	86.9	93.5	94.3	88.4	93.8	92.5	90.1	87.5	86.9				*100.0*
Local HSMR Stroke	141.9	145.1	139.0	139.1	135.4	136.6	127.7	123.0	125.6				*100.0*
Local HSMR UTI	113.1	114.2	108.3	131.2	131.6	127.5	126.1	126.7	114.3				*100.0*
Local HSMR Acute Renal Failure	85.3	90.2	106.4	124.2	121.5	109.0	108.0	107.5	102.3				*100.0*
Mortality Screens - %	94.12%	104.13%	91.01%	102.83%	106.76%	88.24%	90.77%	92.21%	72.73%	58.90%	53.45%	58.82%	*100.00%*
SJRs										33	21	13	*0*
2nd Review										0	2	0	*0*
SIs										0	0	0	*0*
In Hospital Deaths	85	121	89	106	74	85	65	77	66	72	59	69	*77*
In Hospital Deaths Crude Rate	35.5	48.8	39.3	41.4	30.4	29.0	22.2	26.6	21.1	22.2	17.4	20.6	*31.0*
LD Deaths	1	0	0	1	0	1	1	0	1	0	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

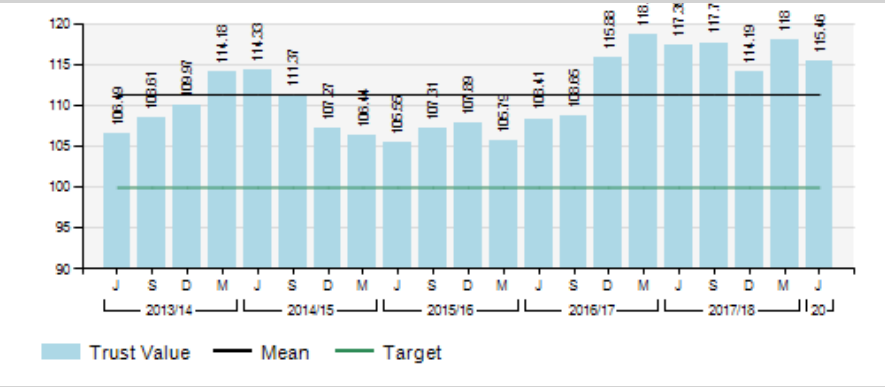
The above table summarises the current position. The next release of the SHMI is expected in September. The observed deaths from that reporting period are expected to rise. While the SHMI is also dependent on the expected deaths, from the data available it must be predicted that the SHMI value for the next reporting period will once again rise. As the observed deaths for the following reporting period show a substantial reduction; should the current rising trend in expected deaths continue, we should then see a fall in the SHMI.

The rolling HSMR is currently showing a successive fall. Two recent months have shown a SMR of less than 100. On further analysis of the contributory factors (see radar plot at the end of this report) between months with high and low HSMRs, it can be seen that the consistent factor to date is the indicators of flow in the accident and emergency department and the rates of staff sickness absence / safe staffing levels. With an upturn in safe staffing (especially within urgent care) and an improvement in AED flow we see a reduction in mortality rates. This most likely represents the system's ability to match its resource to its demands.

Since March 2018, the hospital crude death rate has shown consistent improvement, which we may be seeing starting to appear in the standardized indicators. Caution is exercised however due to the seasonal variation in these figures.

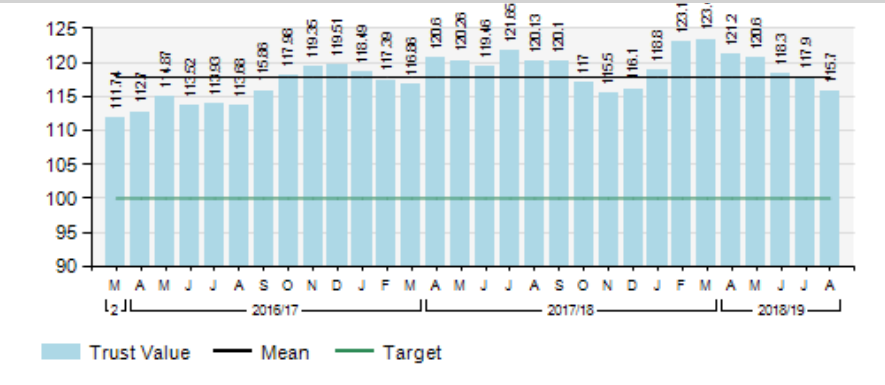
Bronchitis and Lower Respiratory Tract Infection are not following an improving trajectory, and further analysis is required to understand the reasons.

SHMI - Summary Hospital Level Mortality Indicator



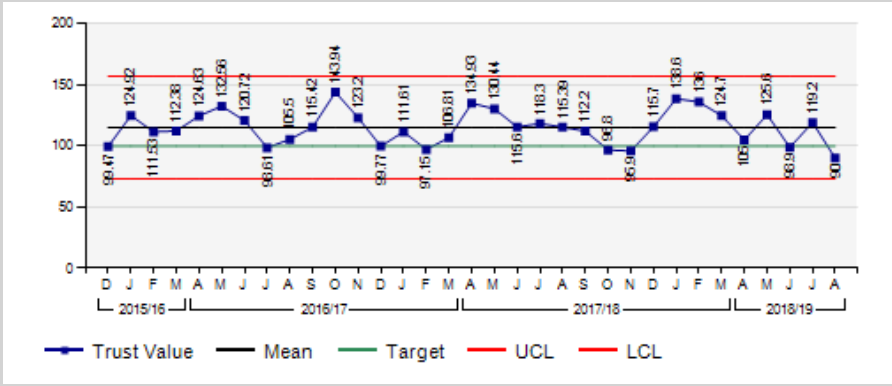
This is unchanged from the previous months report as this updates quarterly. As this is calculated on an observed over expected basis, work to increase the depth of coding or improve documentation predominantly affects the expected figure, while work on clinical pathways, timeliness of care or clinical responsiveness predominantly affects the observed figure. SHMI includes deaths within 30 days of discharge and therefore is also affected by what happens with discharge processes and in subsequent community based care. It is not affected by palliative care coding. Changes are slow over time.

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



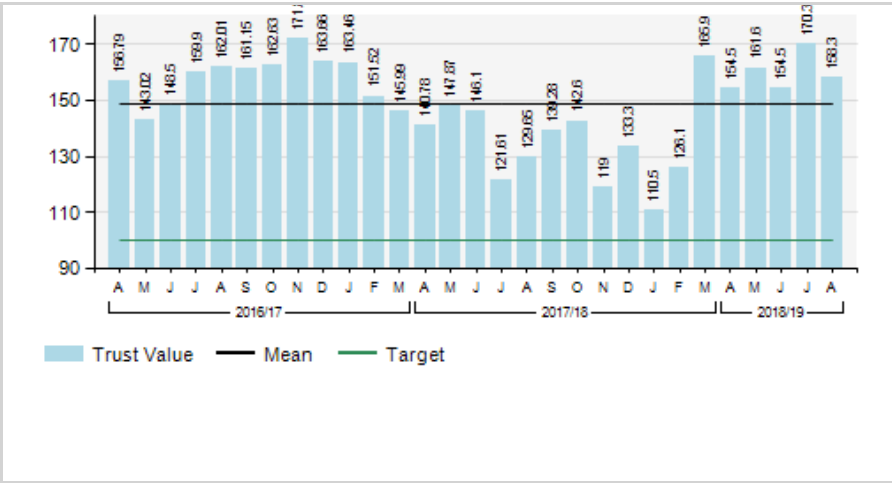
The most up to date rolling HSMR is 115 for August 2018 (down from a peak of 123) and sequentially improving. While this is also an observed over expected figure it is constructed differently to SHMI. Palliative care deaths are excluded. As the trusts coding of palliative care is now more accurate due to a system change, this is likely to be a key driver in the improving HSMR.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



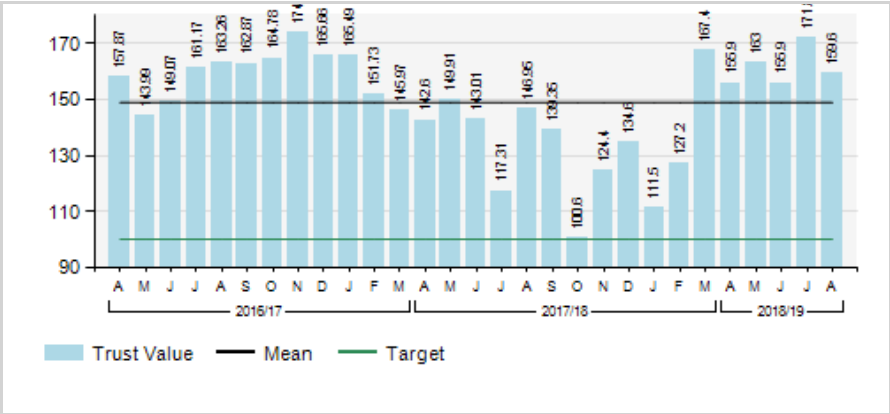
The most up to date figure is 90 for August 18. This is an improved position on recent performance, and compares well with historical best figures for the same month in previous years, or indeed any month in previous years. Referring to the radar plot below it can be seen that with improvements in safe staffing and flow we see improvements in mortality figures.

Local HSMR Bronchitis



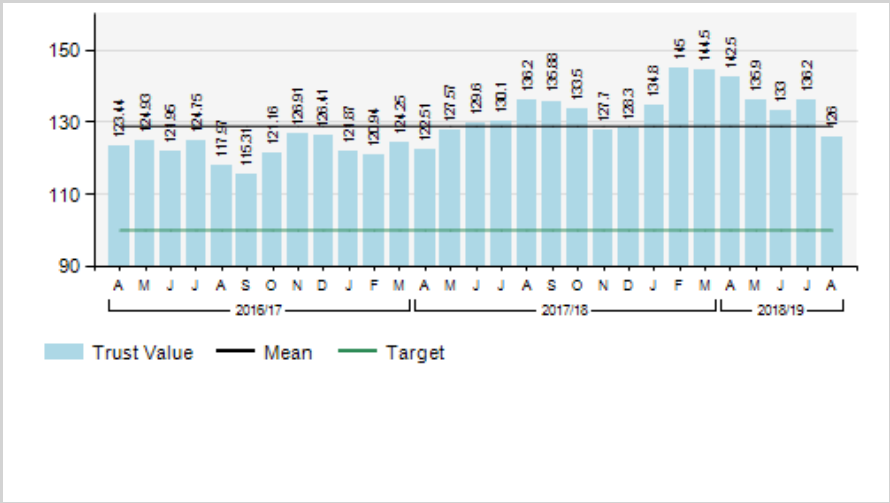
Also with respect to data up to august 2018, the HSMR for bronchitis was 158 (from 172). Bronchitis (and LRTI) is a diagnosis made when a patient has a symptomatology that is consistent with respiratory infection but does not have the chest x-ray findings to be considered pneumonia. In order for a patient to be hospitalised with such a condition it is likely that the patient has either significant co-morbidity or frailty, which has been decompensated by the infection, or the diagnosis is incorrect. The reduction in SMR in this month is accompanied by an increase in coding conflict for the condition, potentially by correctly diagnosing more serious conditions. Further work will involve analysing this coding conflict to ascertain how the diagnosis changes and hence which diagnostic processes require improvement.

Local HSMR Lower Respiratory Tract Infection



LRTI and Bronchitis are clinically analogous, their mortality profile is identical and the actions include the above investigation of diagnostic conflict to improve diagnostic processes and work with system partners to identify where appropriate community care is preferable to hospital admission.

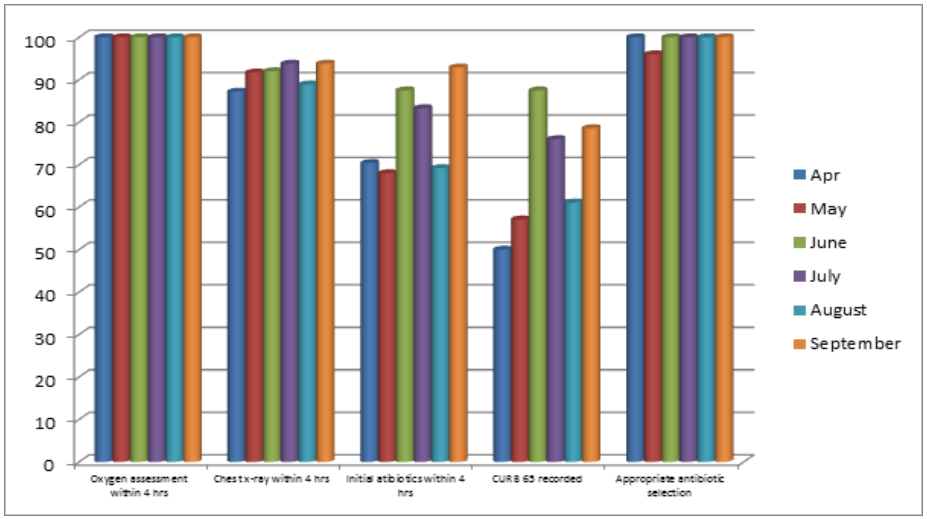
Local HSMR Pneumonia



Local HSMR Septicemia

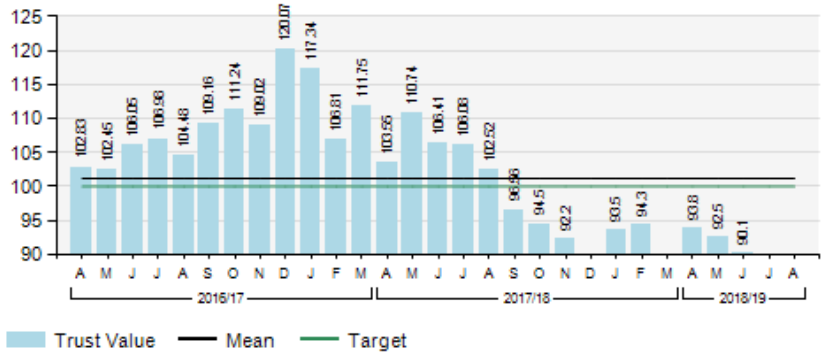
The rolling HSMR for pneumonia has dropped below the mean for the first time in 2018 (data from August) this also compares favourably with August 2017. The SMR remains elevated and remains an area of concern. Work is ongoing to improve the whole pathway of care and improve the accuracy of diagnosis. Preventative work including the uptake of flu vaccination in the care home population and others should continue to be supported (to reduce the prevalence of severe supper-added bacterial infection). Ongoing work to improve mobility of hospital inpatients, access to speech and language therapy and the work of the nutrition task and finish group is expected to have an impact on hospital acquired pneumonia and aspiration pneumonia.

Our AQ sepsis performance against regionally agreed clinical performance targets is summarised below:

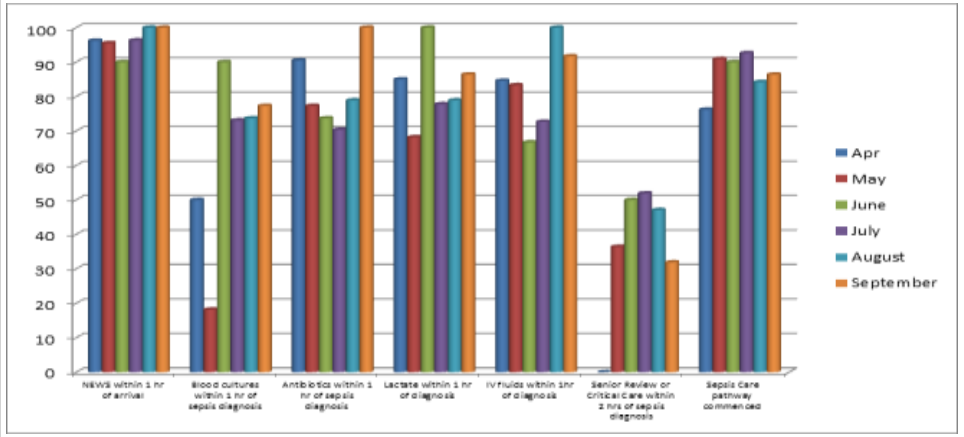


AQ Pneumonia compliance indicators

Local HSMR Septicemia

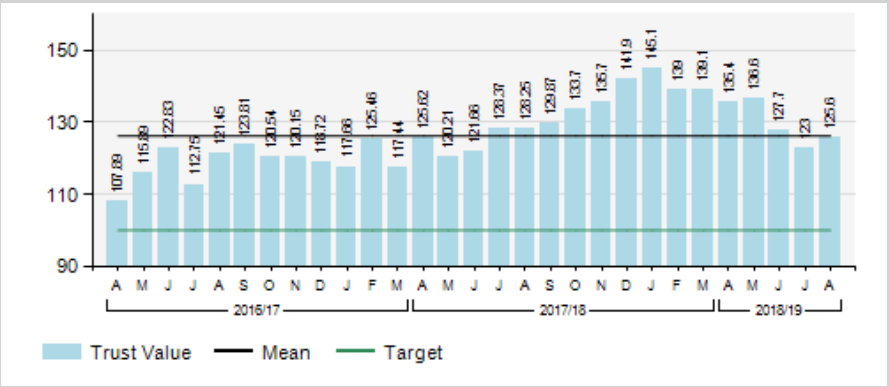


The recorded sepsis performance is good. Work on sepsis continues, AQ data presented below describes our performance against regionally agreed clinical targets:



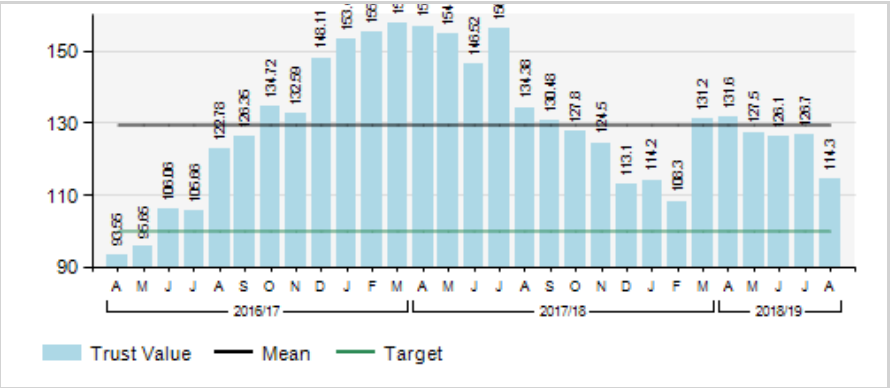
As can be seen, our priority area is improving the timeliness of senior (ST3+ or critical care outreach practitioner) review.

Local HSMR Stroke



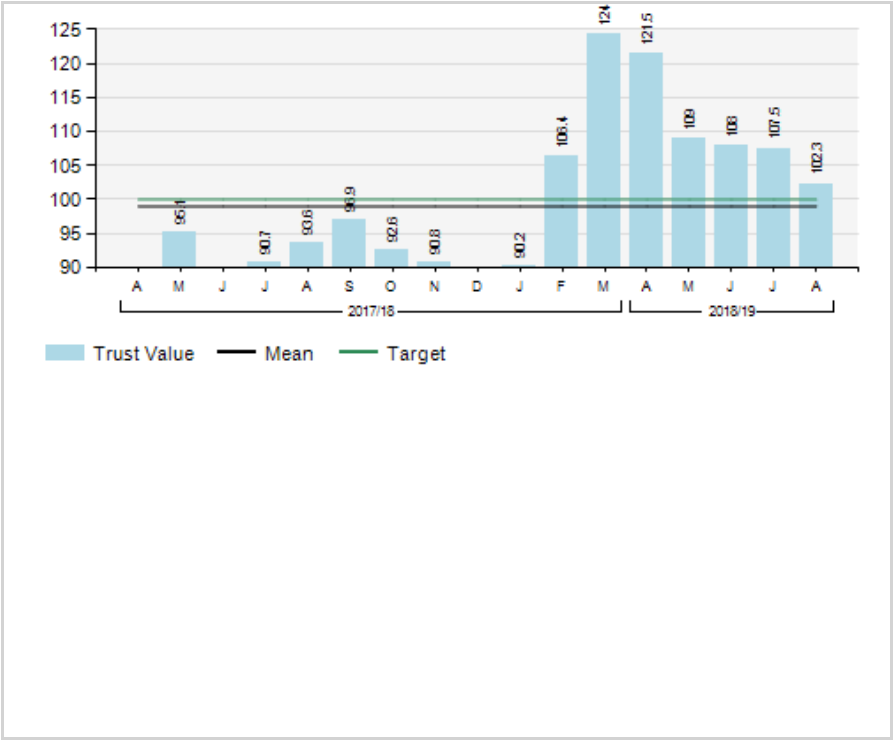
The annual SSNAP audit calculates our stroke specific SMR as 100 (reflecting the high number of severe strokes in our population). The improved trajectory in the Dr Foster SMR may be related to the increase in palliative care coding. The next SSNAP report will be analysed on receipt.

Local HSMR Urinary Tract Infection

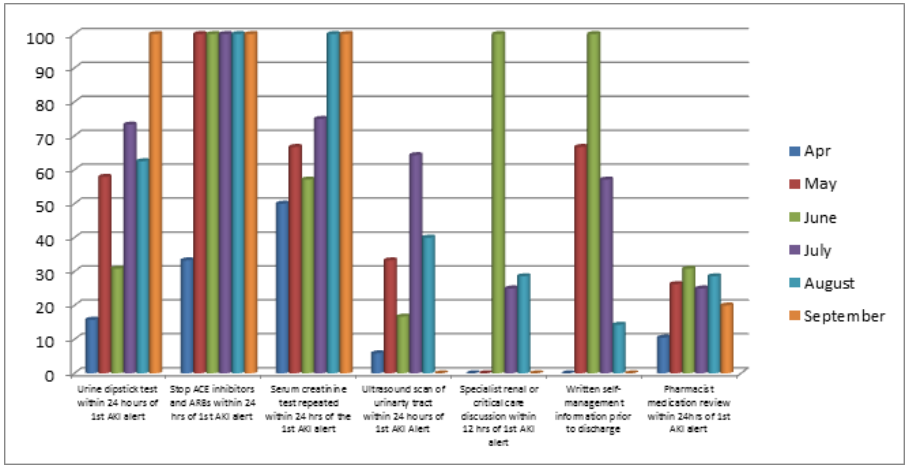


Previously a high SMR for urinary tract infection has reflected a missed diagnosis of septicaemia of urinary origin. It is therefore reassuring that the recent fall in the SMR for urinary tract infection has not been mirrored by a commensurate rise in the SMR for sepsis. This is a common diagnosis made in the very frail to explain deterioration, often based on absence of clinical evidence or misinterpretation of test results. Work is planned to aid diagnostic accuracy. Other work to improve mobility, continence, hydration and avoidance of urinary catheterisation is on-going through the falls and nutrition groups.

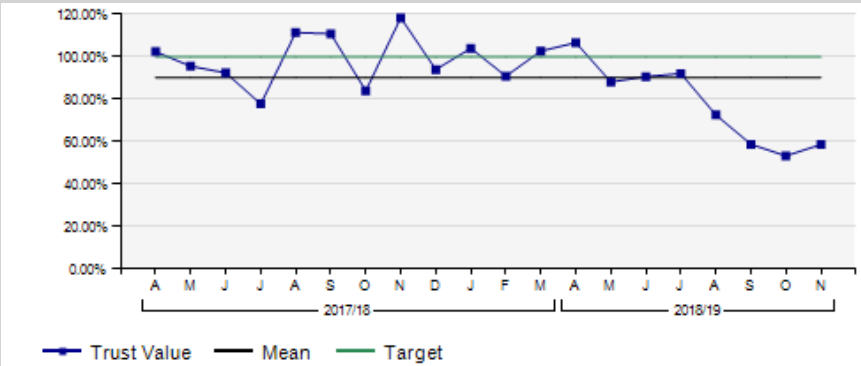
Local HSMR Acute Renal Failure



Improving performance in patients with acute kidney injury is most likely driven by the increased awareness of the diagnosis and its severity due to recent well publicised critical incidents. Awareness has also been raised by the production of local pathways and the formation of the AKI steering group. This group will be reviewing the AQ performance data below. Automatic alerting of AKI electronically is now feasible and is being implemented through the vitalpac project.

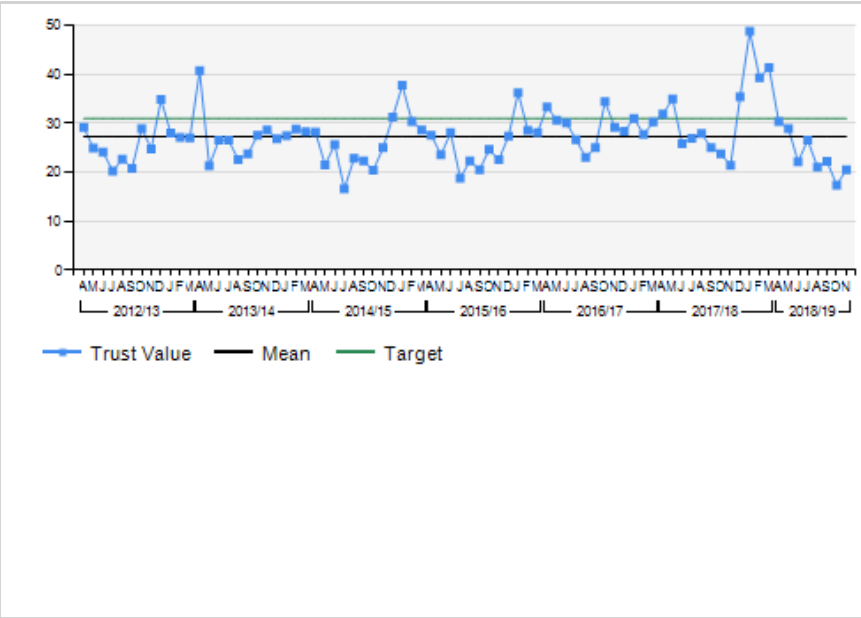


Mortality Screens - % Deaths Screened



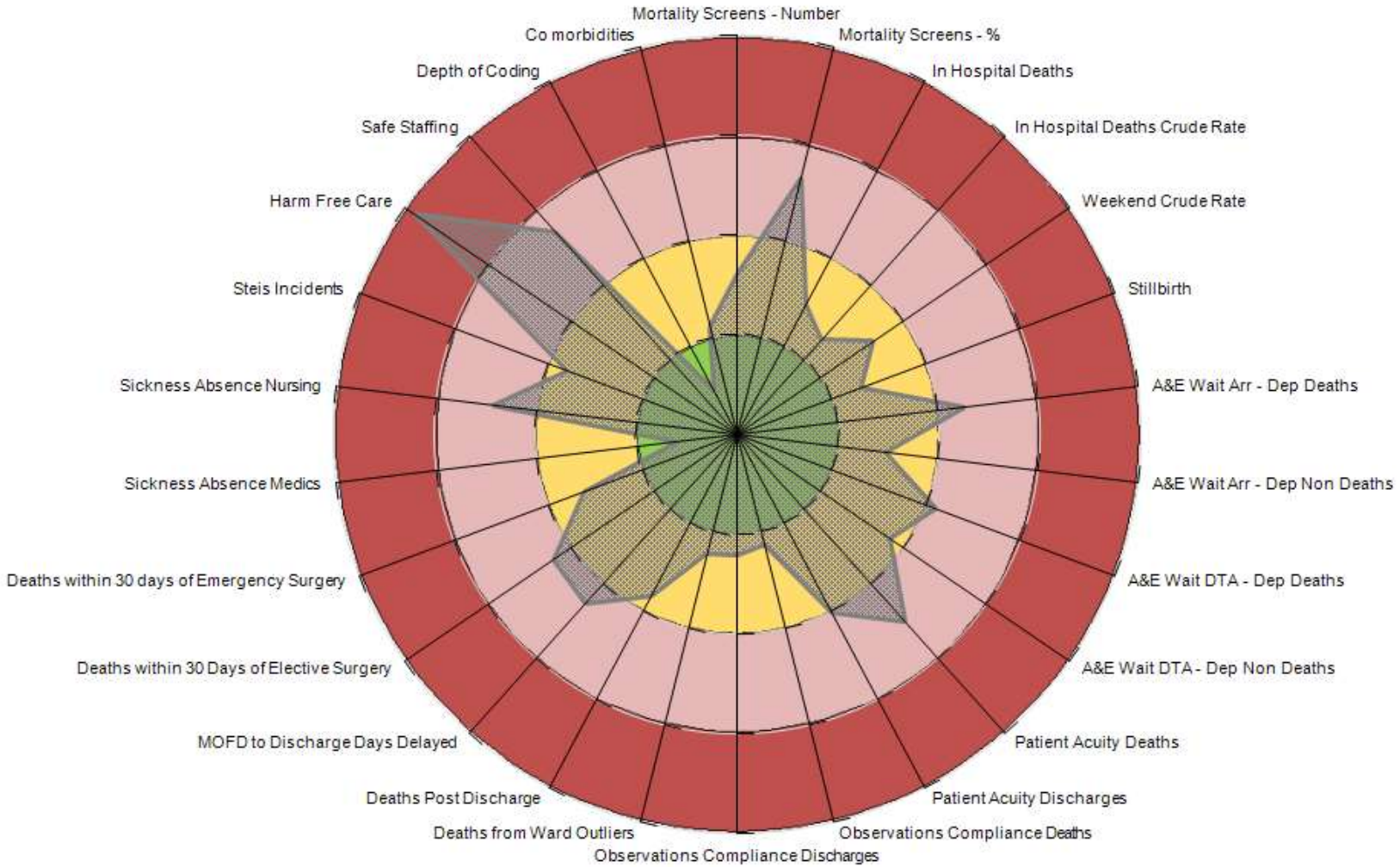
The rate of screening requires improvement. This is mainly performed by junior doctors. It has become clear that many do not understand that this is a mandatory process as a part of clinical governance. This is being tackled through multiple means. Communication verbally though the junior doctors forum, via e-mail, through mortuary staff, through trust induction for medical staff and through amendments to the junior doctors handbook from August 2019 as agreed with the Director of Medical Education.

Crude Mortality Rate (*Crude rate per 1000 discharges (excluding day cases)*



The crude rate is currently running at less than last year's statistical average. This is accompanied by a fall in actual deaths, suggesting this is not solely an effect of increased activity. Traditionally, this increases during the months December – February, so caution is exercised in interpretation of these figures.

Performance Distribution for August 2018/19
HSMR Value in Month: 90



Project Highlight Report

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

Project Manager	**Rachel Flood-Jones**
Quality Portfolio Lead	**Donna Lynch**
Project Reports to	Mortality Operational Group & Quality & Safety Committee
Report Date	21st January 2019
Reported to	Mortality Operational Group & Quality & Safety Committee

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

Project Objectives

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	**Comments**		**Status Update**	**Status**	**% Completion**
1. CARE PATHWAYS: To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care and produce evidence to assure quality of delivery, by August 2018.	**Deteriorating Patient Trolleys**		Deteriorating Patient Trolleys are in place on the wards across the Southport site apart from Ward 10B. A Deteriorating Patient box is now in place on the Medical Day Unit. Four Trolleys are to be rolled out at Ormskirk.	G	57
	Care Pathway Compliance		Compliance audits will start and will be reported through the new 'Smart Sheet' Programme Software (transfer of project information to Smartsheets is behind track due to resources). Compliance reporting of AQUA measures is to be included in QSC and Board reports from Feb 2019.	A	0
	Pneumonia Pathway		The Pneumonia Pathway, written by Joanne Houghton, Respiratory Nurse and Drs. Chris McManus, Respiratory Consultant and Chris Goddard, AMD for Patient Safety has been approved by the Clinical Effectiveness Committee and is now to be sent to the external printers. Activity has been delayed due to winter pressures.	A	50
	UTI Pathway		**To be tabled for December RAM Meetings:** Talks took place on 19th October with Andrew Chalmers, Infection Control Lead to support the work that he has delivered under the UTI collaborative to reduce avoidable UTI and associated cases of deterioration. A further consultation is required to scope the next steps before the end of October (to look into the use of cathetar care plans, the HOUDINI method & a potential Trust pathway document).	G	5
	AKI		RAM Project is to link into the upcoming AKI Steering Group to understand opportunities for quality improvement activity. The next meeting has been arranged for Wednesday 6th February.	G	0
	IV Fluid Therapy (NICE 174)		The new IV Fluid Therapy Drugs Chart went live on 10th September. IV Fluid Guidelines have been uploaded to the Intranet. This has been communicated through Trust News and by means of a Screen Saver. **Laura Gibson, Interim Deputy Chief Pharmacist has reported that more embedding is required for awareness and implementation - communications are ongoing.**	B	100
	External Mortality Review: 'Developing Trust Capacity & Approach to Learning from Deaths' to review Pneumonia & Stroke deaths from May 2017 to April 2018.		**A paper pertaining to the findings of the EMR is to be presented to public board in February 2019.**	G	60
	VitalPac Upgrades (3.5 & 3.6)		Testing for V3.6 (to be deployed into our UAT environment) is to start in September with completion date of v3.6 Go Live is 26/11/2018. As part of the v3.6 deployment NEWS2 / Sepsis & A&E will be included as modules which means a big deployment with a lot of change. (NEWS 2 is a module on of VitalPac 3.6 which is required by April 2019 in A&E for the purpose of Sepsis CQUINs). The AKI module is dependent on OCRR being rolled out Trust wide which is currently in progress so far we have Ormskirk Outpatients & Wards and Southport Outpatients live with OCRR. Therefore, due to the resource v3.6 will require AKI is planned in for completion in May 2019.	G	20
	Timely Emergency Surgery / Surgical Assessment Unit		Surgical Assessment Unit (SAU) opened on Monday 10th September. The next step is to look at a process to return minor surgery patients to parent ward after surgery.	G	100

2. EFFECTIVE ESCALATION (IT, Safety Hub & Comms)	**Safety Hub Go Live: Bed Meetings, Operational & Medical Handover Meetings. CCOT and Resus Team in situ.**		Teams are in place and meetings are taking place. Work is now being undertaken is to develop improved handover, smarter ways of cross team working, more efficient escalation and management of, in particular deteriorating patients. This activity has started and will continue to evolve using QI methodology throughout the life of the project.	B	90
	Safety Hub Reporting		IT and Information Teams met on the 18th September to confirm the plan to link Ward Boards to the screens in the Hub. There has been a delay to the follow up meeting for October due to resourcing. Two further meetings: one with clinicians and IT/ Information and one with the subgroup will scope & sign off the functionality in October/November.	A	60
	Pathways for escalation to be designed and rolled out.		This will be fully developed once NEWS2 has gone live (December) / the reporting function through Ward Boards is up and running.	A	10
	Policy for the Policy for the Clinical Ownership and Review of Outlying Patients		To be returned to Clinical Effectiveness Committee with amendments for final approval. Upload and promotional activity then required.	G	70
	Ensure **optimum use of Careflow / VitalPac** to improve patient safety.		Meetings are being coordinated with Ted Adams, the Safety Hub Team and VitalPAC Team for July and August to discuss opportunities for improvement and maximised used of the system functionality	A	0
3. LEARNING CULTURE	**Roll out of the Structured Judgement Review Method**		SJR method live in the Trust as 2nd July 2018, levels of compliance were 38% in July to 58% in August and 59.7% in September.	B	100
	Communication to embed the SJR method		Communications, posters and training have been used to promote the new method to the Trust. Ongoing communications will be required until there is full compliance. To be captured in the RAM Project Communications and Promotions Meeting monthly.	G	70
	Link Risk and Mortality Data: Formal process for triangulation of SJR method, Serious Incidents and Mortality Data		Updated draft process currently circulated for comments and reported through to relevant committees for information. Progress required, has been escalated to the RAM Communications Subgroup. **Work Rescheduled for December onwards.**	A	60
	Lessons Learned and Learning from Excellence		New approaches are being looked into for effective communication with clinicians and nursing staff. Use of IT such as Whats App groups being considered alongside research into methods used by other Trusts.	A	5
4. FUTURE CARE PLANNING: Implement care planning for those patients identified as approaching end of life (GSF) that encourages appropriate levels or intervention and enables communication with the patient and their families by April 2019	**Anticipatory Clinical Management Planning**		Dr Fraser Gordon (Lead Consultant Geriatrician) has created a ACMP model which is in place on the Frail and Elderly Short Stay Unit (FESSU). The next stage of project is to review and implement this though an education session to help others to begin to have similar conversations with patients and their families and develop similar plans. This is to be rolled out across the health economy.	A	20
	Advance Care Planning: training and awareness is to rolled out across the Trust.		Training Sessions have been run by the NW Learning Collaborative Network out of Queenscourt Hospice: 8th August, 13th September and 12th October. Training sessions have been promoted to staff through Trust News.	A	70
	Alternatives to admission: to be developed as part of a second stage of project: to involve Clinical Commissioning Group partners.		NWAS Community Paramedics are now attending MDT Meetings with the Specialist Palliative Care Team to monitor patients who have Anticipatory Clinical Management Plans or who are on the Gold Standard Framework and have been admitted.	G	10
	Rapid End of Life Transfer		Queenscourt Hospice are in dialogue with the NWAS Paramedics to find ways to facilitate ambulance transfers home for those at end of life.	A	70
	Reduce time to discharge for patients Medically Fit for Discharge for patients already on the Gold Standard Framework (GSF) Registered.		The objective to reduced time to discharge patients who are MOFD is part of the work that is currently being undertaken to improve Length of Stay with Karen McKracken and the NHS network ECIST (the Emergency care intensive support team).	A	10

5. INFORMATION: Produce one version of reporting on mortality by October 2018 that provides clear and consistent information to inform different groups of leaders and clinicians	**Understand and Communicate Mortality Data:** Mortality Reporting to QSC and Trust Board to be reviewed and updated		Mortality reporting continues to be scrutinised for effectiveness; meetings and email converstations continue with Dr Foster and AQUA to find opportunities for improvement in what we report and the way that we report it.	B	100
	Understand and Communicate SJR Mortality Data:		Once Structured Judgement Review is embedded the findings will be factored into mortality reporting. It will be triangulated with existing mortality data and serious incidents in order to provide a robust apporach to learning from deaths to improve care and practice.	G	20
	Increase depth of coding		Data sharing arrangements (including intermediate work around solutions) are being sought by the Trust and the CCGs. A fuller picture of the patient's medical history and comorbidities will provide the required information for increased depth of coding.	A	10
WORKFORCE: Establish the proposed workforce model to deliver agreed clinical outcomes which will include a tangible 24/7 Outreach Team by September 2018	**Establish a 24/7 Outreach Team**		Recruitment for the new workforce for the 24/7 team commenced in mid October. The business case is being reviewed by the Finance Team.	R	70
	Embed Full Utilisation of Safe Staffing Tools		Improvement work to fully optimise the use of safe staffing tools will recommence once the CCOT 24/7 Team / the Ward Boards and Safety Hub Reporting is in place.	A	30
	Increase Access to & Prioritisation of Skills Training		Strategy to be developed with Training and Development and key stakeholders for access to training to support and inform a strategy to ensure managerial prioritisation and release of staff for training. Discussions have started with Training and Development	A	10

Key Milestones

Key Milestones	Start date	End date	BRAG	Comments
Safety Hub Set Up	10th March 2018	10th March 2018	B	The Safety Hub has been set up with required IT equipment and the current Outreach Team is installed.
Safety Hub Go Live	30th June 2018	30th June 2018	B	Escalation Nursing Meetings, Medical Handover and Bed Meetings are now running in the Hub.
Surgical Assessment Unit Opens (SAAT Project)	14th July 2018	14th July 2018	G	The SAU opened on 10th September 2018. (Output of the former Safe At All Times Project).
Go Live of Structured Judgement Review Method	3rd July 2018	3rd July 2018	B	The SJR Method went live a day early on 2nd July.
100% compliance - adoption of SJR Method	3rd July 2018	31st January 2019	A	Current levels of compliance are 59.7% - further embedding work is required.
Triangulation of Serious Incident, SJR Outputs & Mortality Data	1st June 2018	30th August 2018	R	Work has been rescheduled to commence December 2018.
Go Live Lessons Learned and Learning from Excellence	1st June 2018	29th September 2018	R	Work has been rescheduled to commence December 2018.
Joint Working Transform Palliative Care and Outreach Team	2nd July 2018	30th August 2018	B	This is nowbusiness as usual
Established 24/7 Outreach Team	1st March 2018	30th September 2018	R	Recruitment has been delayed by two months but has now commenced (October 2018).

Top Risks and issues to achieving programme objectives

Risk	RAG	Mitigation Activity	RAG After Mitigation	Comments
The timely recruitment of the full 24/7 Critical Care Outreach Team	R	Joyce Jordan to consult Carol Fowler (Workforce) and the relevant HR Manager to expedite requirements and navigate any systemic blockages encountered.	A	The recruitment process has now begun (mid-October).
The ability to provide robust reporting in the Safety Hub for Escalation / Bed / Resus and Outreach meeting based upon a deficit of information put into Medway at ward level.	A	A workstream subgroup has been set up to drive the Ward Board and Safety Hub reporting requirements and configuration. (Commenced August 2018).	G	Meetings were held in August and September, there has been a delay to the follow up meeting for October due to resourcing. Two further meetings: one with clinicians and IT/ Information and one with the subgroup will scope & sign off the functionality in November.
If clinical staff cannot be released for training then pathway education will not be embedded and objectives will not be achieved.	A	The key to this issue is staffing levels and doctor's rotas which are being dealt with outside of the RAM project.	A	This issue requires a more robust mitigation strategy, this is to be escalated to the October Mortality Operational Group. *Training funding is also an issue which is to be addressed in the same forum.*
Delays occuring to Learning Culture workstream	R	Issues of availability of required owners / contributors. A misconception that the SJR process has to be significantly embedded before work can be fully commenced.	G	Clear recommunication of the objective, outputs, activity required and timelines to deliver. Engagement of revised and wider group to deliver the required outputs.
Timely organisation of subgroup meetings & the transfer of the project to new Smartsheets System	A	Work to be undertaken to ensure that the ownership of subgroup activity be driven by Workstream Leads. New Band 4 PMO support for CIP to assist in the transfer of RAM project to Smartsheets.	G	There has been an impact to the pace at which the RAM project is being delivered, attributable to the increased number of prioritised projects.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	TB028/19	Report Title	External Mortality Review
Executive Lead	Terry Hankin, Medical Director		
Lead Officer	Dr Chris Goddard, Associate Medical Director of Patient Safety Elizabeth Woollam, Programme Support Lead Mike Lightfoot, Head of Information		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

An external review was commissioned, by the Medical Director, with the purpose of supporting and developing its capacity and approach to Learning from Deaths using a specific cohort of cases to learn lessons about the quality of its care across the respiratory and stroke pathways.

34 cases of poor care and 7 cases of very poor care were identified by the review. All 7 cases of **very poor care** are being investigated through the STeIS process to identify lessons learned and avoidability. An action Plan has been created in response to the 34 cases of **poor care** mapped against the recommendations of the report.

This paper includes the report from this review including recommendations. The review and Reducing Avoidable Mortality (RAM) programme are closely aligned however some actions require broader support and development through the Trusts operational plan and Vision 2020 plan.

The paper concludes with recommendations for the Board in terms of ensuring an appropriate and comprehensive response to the review and implementation of the RAM and linked programmes.

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)*

Previously Presented at:

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

1. Background

The Trust monitors mortality through a wide range of clinical indicators including a range of mortality data sets. This has proved to be major catalyst for improvement in the way clinical services are organised and delivered. The National Quality Board published its National Guidance on Learning from Deaths in March 2017. The Trust is compliant with the Guidance and as such monitors and identifies trends across a range of clinical conditions and the factors associated that increase the risk of death in hospital.

National indicators include:

- Summary Hospital-level Mortality Indicator (SHMI) the Trusts 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.
- Hospital Standardised Mortality Ratio (HSMR) is provided nationally by 'Dr Foster' and applies to in-hospital mortality (excluding palliative care). The 12 month rolling HSMR for August was 115.7 while the in-month HSMR has dropped below the national average of 100 to 90.

The Trust has used this intelligence to inform and develop a programme for the improvement in care of the deteriorating patient and to look at the contributory factors to the outlying mortality position.

The project approach was initially developed by the Associate Medical Director for Patient Safety in November 2017 and whilst it had strong clinical leadership it did not receive project management support until February 2018, when the Reducing Avoidable Mortality Project (RAM) was formalised. A monthly Mortality Operational Group Chaired by the Associate Medical Director of Patient Safety was also established overseeing delivery of the project over the last 11 months. Actions identified and delivered *prior* to the external review being undertaken include major structural and procedural changes which include but are not limited to:

- The co-location of patient flow, critical care outreach and resuscitation services in a purpose designed facility (The Safety Hub) as part of a previous trust project 'Safe at All Times' in now well established.
- The commissioning of a 24/7 critical care outreach service which has been fully recruited to and will be operational from April 2019.
- The roll out of the Royal College of Physician's Structured Judgement Review (SJR) method across the Trust. This has been supported by the implementation of the Trust's in-house mortality screening tool which identifies deaths which require an SJR.
- Sepsis, acute kidney injury and pneumonia pathways of care have been revised with a focus on presenting the clinician with the correct guidance, equipment and escalation process for each clinical pathway. Currently the sepsis and acute kidney injury pathways have been operational since 2017 and 2018 respectively. The Pneumonia pathway has been authorised by the clinical effectiveness committee.
- The roll out of the Royal College of Physician's Structured Judgement Review (SJR) method across the Trust. This has been supported by the implementation of the Trust's in-house mortality screening tool which identifies deaths which require an SJR. In December 17% of Trust deaths screened have triggered an SJR which is within the Royal College of Physicians recommended range of 10% – 20%.

On reviewing the Trust mortality metrics and data, the Mortality Operational Group and Quality and Safety Committee identified a cohort of in hospital deaths with a respiratory illness or stoke diagnosis significantly over expected levels of mortality in May 2017. This triggered the commission by the Medical Director of an external mortality review aimed at developing the Trust's approach and capacity to learn from deaths, and inform the next stages of the RAM programme.

The Board should also note that the Secretary of State also identified the RAM programme as one of the Trust's six priorities when the substantive Chief Executive Officer was appointed in April 2018.

2. External Mortality Review – Supporting capacity for Learning from Deaths

The purpose of the external review commissioned by the Trust was;

'To support and develop capacity and approach to Learning from Deaths using a specific cohort of cases to learn lessons about the quality of its care across the respiratory and stroke pathways.'

The cases selected for review were 200 patients who died from either stroke (50) and respiratory disease including pneumonia, lower respiratory tract infection / acute bronchitis (150) between May 2017 and April 2018.

External clinicians including consultants and nurses, worked in conjunction with Trust clinicians to review the cohort using the SJR method and a standardised terms of reference. The objective was to enhance the Trust's capacity for undertaking reviews whilst providing quantitative findings, highlight case studies to illustrate specific learnings and to support the Trust replicate best practice and make improvements where required.

The review took place between the 31st May 2018 and the 3rd July 2018. Concerns identified during the review were raised at the time with the Medical Director and Director of Nursing at the time. 7 cases of very poor care were identified and subject to the Trust serious untoward incident review (SUI) process, which involved a root cause analysis investigation.

Feedback on the findings of the review were given in June 2018 and again in November 2018 at clinical and board development sessions.

In depth investigations of the seven cases of very poor care have been subject to external support from the Trust's solicitors Hill Dickinson who have produced case timelines. The results of the process will be examined by a team of internal and external clinicians by the end of January 2019. During this period the Trust must ensure it undertakes all regulatory requirements whilst supporting and communicating fully with relatives and carers whilst ensuring an improvement ethos where lessons are identified.

The review has identified strengths and weakness in the caring process across the two pathways, stroke and pneumonia, from admission to end of life. This has highlighted opportunities / themes for learning and improvement.

3. Alignment of External Mortality Review (EMR) Recommendations and Reducing Mortality Action Plan

The Trust has reviewed the recommendations, cross referencing them against the RAM programme and workstream actions that were already in place. The review was based on a period which included deaths which occurred before the development of the RAM programme it is important to note the progress and changes implemented or included in the RAM programme;

Key actions delivered:

- Implementation of a new sepsis pathway which includes rapid bolus administration of antibiotics within with 1 hour across the emergency department and inpatient wards. Effectiveness of this is confirmed by ongoing Advancing Quality audits and mortality data.
- Development of the 'Deterioration Trolley' where staff can access pathways and equipment for treatment of key medical emergencies such Sepsis and acute kidney injury (AKI). Other key pathways will be added as completed. Trolleys have been rolled out across all wards and departments throughout the Trust.
- Implementation of new vital signs monitoring equipment in spinal injuries, the stoke unit, critical care and Accident and Emergency Department (AED), future proofed to allow automatic uploading to the trust electronic observation system (VitalPAC) when that is operational in all areas.
- Establishing a Safety Hub in April 2018 which co-locates the proven aspects of patient safety – Flow, Critical Care Outreach and resuscitation services. IT infrastructure has been developed in house to enable the patient flow team to monitor and report. Improvements to patient flow have been seen as a result of this. Clinical Handover has been transferred to this location, allowing easy clinical access to the AED, SAU and EAU.
- Secured funding and recruitment for the development of the Critical Care Outreach Team (CCOT) to provide a 24/7 service commencing in April 2019. This provides the clinical capacity to respond consistently to elevated EWS and provide consistency to handover of patients between ward teams and the critical care unit.
- Establishment of the Critical Care Outreach operational group which meets fortnightly to identify and improve critical pathways of care based on front-line feedback (using PDSA method). This approach has generated 14 improvements to the sepsis pathway. The same group is providing operational delivery of NEWS2 by designing policy, flowcharts, clinical response and managing the technical / clinical interface with the VitalPAC team and System C.
- Establishment of ward-level link nurses to support the delivery of NEWS 2 and clinical pathways. These staff will be released to attend quarterly updates lead by critical care outreach.
- The training of clinicians to perform Structured Judgement reviews. 39 senior clinicians have received practical training in the methodology and are now performing SJRs under the guidance of identified departmental leads, supported by the AMD for patient safety.
- Implemented with the Risk and Governance Department the Datix IQ solution for the recording and analysis of structured judgement reviews. This system was co-developed by the trusts Datix Manager and the company, including the design and implementation

of a bespoke screening tool for mortality screening using the comments and knowledge of the trusts junior doctors.

- Supported the improvements in depth of coding by supporting the trial period for the Clinical Engagement Manager in the clinical coding department to ensure that the complexity of patient's illness is appropriately reflected. This has led to a sustained improvement in the accuracy of our information and will be reflected in future versions of SHMI.
- Instituted a sub-committee of Quality and Safety to evaluate the factors underneath mortality. This committee has been supported by externally praised information which has allowed key drivers to be identified including:
    - Deaths within 30 days of discharge accounting for 40% of monthly deaths – further investigation by the Palliative Care Team has demonstrated that 88% of these deaths are in patients known to palliative care services.
    - Deaths within 24 hours of admission reflecting 15-20% of all deaths – further evaluation provides a signal that these are often frail patients attending hospital in 'crisis' which could have been avoided with better end of life consideration by the whole health economy.
    - A spike in AKI related deaths, which had led to AKI pathway changes and the development of an AKI steering group to manage the AQ indicators for AKI. This is now on an improving trajectory.
    - Raised mortality rates due to UTI, leading to engagement with the Head of Care for Older People and Head of Dietetics around reducing urinary catheter usage, improving hydration, improving and maintaining mobility.
    - Triangulation with serious incident data to improve care for patients receiving artificial feed through the Head of Dietetics and reducing falls with harm through supporting the creation of and liaison with the falls steering group.
    - Monitoring and supporting the impact of work to improve patient flow on mortality. The committee has noted the correlation between reduced time from admission to medical review, time from decision to admit to leaving AED and safe staffing levels have on monthly mortality. This has supported clinicians and organisational leaders in their calls for a focus on staffing.
    - Review and quality assurance of VitalPAC data, which required System C to correct inaccuracies. The reports from this have been iteratively developed to combine, EWS compliance, number of patients, ward level acuity and ward level safe staffing. Now providing this data in context for ward leaders.
- Provided clinical engagement for the prioritisation of the clinical IT strategy including; :
    - Improvements to the hospital Wi-Fi to allow mobile clinical systems.
    - VitalPAC upgrades to allow NEWS 2 uptake. Expected March 2019.
    - Prioritising the implementation of VitalPAC in A&E and paediatrics. Expected Nov 2019.
    - Establishing projects to alert to AKI from the trusts laboratory system into VitalPAC. Expected May 2019.

    - Creation of an electronic system for board rounds, handover and ward-based clinical alerting.

- Creation of a dedicated Workstream of the RAM programme, 'Future Care Pathways' to improve end of life care. This has been led by the Consultant in Palliative Care at Queenscourt Hospice who has driven the following change:

    - Improved access to a specialist nurse in palliative care for hospital inpatients every day of the week.

    - Increased access to the Transform team, who are now working within the care home sector to support Advanced Care Planning (ACP) and Anticipatory Clinical Management Planning (ACMP).

    - Working with the coding team to better identify patients receiving palliative care.

    - Results:
        - Increase in ACMP from 40 to 140 in the past 12 months
        - Increased recognition of palliative care input to approximately 40% of all deaths.

Further work in progress:

- Plan to use Careflow instant messaging function of VitalPAC in future to alert/ trigger medical response to the deteriorating patient. This form of communication allows both junior level communication and senior oversight in one message.

- Use of contextual VitalPAC data with the launch of NEWS2 to drive escalation and improve observation compliance.

- Revise 'Hospital at Night' once the 24/7 Critical Care Outreach Team (CCOT) service is in place to drive consistency of handover and implementation of key clinical pathways and escalation decisions.

- Extending the Information obtained from SJR reviews to Clinical Business Units and departments to generate 'learning from deaths' and care pathway improvements.

- Collaborate with the Palliative Care Team to provide:

    - An educational package to hospital consultants, Specialty and associate specialist (SAS) Doctors and Doctors in training, to increase knowledge and awareness of excellent end of life care.

    - Joint rounding with CCOT and Transform (Palliative Care Team) on patients with different escalation pathways to support ward care and appropriate escalation

- Work with Clinical Commissioning Groups (CCGs) and community services, frailty and palliative medicine to create a seamless process for ACP/ ACMP across the health economy.

- Extend learning from deaths to include data from other reviews such as Child Death Overview Panels (CDOPS), Learning Disability Mortality Reviews (LeDeR), hip fracture, emergency laparotomy and stroke. The Terms of reference of the Mortality Operational Group are being amended to allow this.

- Improve access to simple point of care interventions and diagnostics by training key people including the CCOT in venepuncture, cannulation, arterial blood gas analysis and chest x-ray interpretation.
- Train the CCOT to become nurse prescribers, using Patient Group Directives to allow delivery of antibiotic therapy as an interim step.
- Provide training to the AED triage team in chest x-ray requesting to improve time to diagnosis of pneumonia and hence improve time to treatment.
- To support the management of the deteriorating patient, Ward Boards and Board Rounds are being redesigned in conjunction with Safety Hub.
- Working with clinical IT and the wider system to deliver:
    - Access to clinical information cross setting.
    - Electronic clinical noting
    - Central collation of EWS and escalation status information to provide a rapid and consistent response.

Trust Investment in Workforce:

It is also of significant note that the Trust has (independently of the review) made the following investments and changes to staffing and cover since September 2018; which will serve to support the RAM Programme and the EMR Action Plan:

- Additional medical cover for Medicine:
    - Four additional SAS doctors have been agreed, the interviews for a fifth were held in January.
    - Eight Clinical Fellows were approved in September 2018 (six posts have been filled while two outstanding posts are to be filled from the remaining 20 candidates).
    - Additional Locum Consultant and junior support has been approved to support the Acute side on the Rehabilitation Ward (7B).
- In additional to the above additional resource within medicine the following steps have been taken to maximise medical staffing resources available. This has included:
    - Change of shift times for on call junior doctors (F2).
    - Additionally rostered junior doctor (F1) at weekends to support ward work.
    - Rostering of a middle grade doctor on Saturdays and Sundays to carry out acute reviews, undertake a Critical Care Unit round, in addition to supporting the junior teams and enabling discharges.
    - Weekly scheduling meetings with the Clinical Director and management team to review ward cover for the forthcoming week to try and mitigate the impact of any foreseen shortages.

4. Next Steps:

The Trust has undertaken a detailed comparison of the review recommendations and the RAM programme to identify where existing actions and timescales need to be implemented or additional actions are required. (This is demonstrated in the table below). Reducing Avoidable Mortality Workstream actions and Trust priorities have also been included in the comparison to ensure strategic alignment and potential identification of agents of change.

Three major priority areas have been identified from the External Mortality Review Action Plan going forward:

1. Documentation and observations.
2. Escalation to appropriate pathway; Critical Care Review or ‘end of life’.
3. The management of Pneumonia.

A full action plan will be monitored by the Quality & Safety Committee; a **high-level summary** is shown in the following table:

Priority Area	External Review Recommendation	Reducing Avoidable Mortality Workstream actions and Trust priorities	Further Actions to be Included in the Trust Programme
2	Improve patient flow so that patients requiring admission do not have to wait for an appropriate bed and are not nursed on corridors. Focus on comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders	• Developing discharge model including criteria led discharge and resources • Policy for the Clinical Ownership and Review of Outlying Patients • Supporting development of discharge model for key pathways incorporated in patient flow programme including SAFER, Red to Green and reducing length of stay • Development of the 'Safety Hub' for central oversight of clinical deterioration and extending Critical Care Outreach 24/7. • Revision of escalation track and trigger protocols to compliment NEWS2. • Building escalation level conformation into every senior board and ward round. • Agreement and buy-in to the professional standards model proposed.	• Engage system though commissioning plans and System Improvement Board (SOIB) re community and primary care collaboration. • Complete and approve business cases for ambulatory emergency care and frailty assessment
1	Improve awareness of Sepsis 6 guidelines and monitor adherence	• New pathway implemented • KPIs monitored and benchmarked through AQuA • Outreach team to improve pathway compliance and senior review.	Nothing added
3	Review and/or establish a pneumonia pathway to ensure that it meets national guidelines and embedding them within clinical pathways.	• Development of new pathway due for implementation including antibiotic prescribing • Develop capacity to order chest x-rays at triage	• Capacity plan for diagnostics and senior clinical review to be developed
	Review antibiotic guidelines to ensure that they meet recent national guidelines.	See above • New guidelines implemented May 2018	• Include compliance in audit and benchmarking

2		• Development of 'Safety Hub' function as planned for oversight. • Extending CCOT and function as planned • Workforce modelling against RCP standards is being undertaken to inform a gap analysis. • Business case under development to provide an orthogeriatric service. • Recruitment to medical and orthopaedic senior grades including dedicated medical middle grade doctors to enhance ward cover has been successful. Awaiting start dates. • Orthopaedic senior working patterns changing to provide a consultant of the week model.	• Development of a plan to become compliant with Guideline for the provision of Intensive Care Services (GPICS) levels of critical care consultant cover. Improvement in onsite availability of daytime critical care consultant and increase overnight resident clinical cover. • Critical care senior and resident medical workforce is high risk and a plan to rectify is being developed at pace
1	Review standards of documentation to ensure that staff always sign and date their entries and that handover of care is clearly documented including the responsible Consultant.	• Planned developments of Medway clinical noting and VitalPAC/careflow. • Electronic daily board rounds taking information directly from Medway.	• Trust wide improvement priority following December Clinical Service review including Trust wide documentation standards • Establish Trust wide documentation standards
1	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.	As Above	As above • Review nursing and AHP documentation and streamline assessments
1	Ensure prescribing is legible, clearly signed and in line with national existing guidelines for care. Focus initially on opiate prescribing in line with recent Gosport report.	As Above • Establish electronic prescribing. • Opiate prescribing audit performed by Palliative medicine – awaiting report.	• Trust review of Gosport findings and recommendations

2	Review escalation and ceilings of care policies to include timely access to critical care and end of life care. Include a focus on training of all staff in accurate calculations of Early Warning Scores (EWS), interpretation and contextualisation of EWS and a shared understanding of when to escalate care and consider a structured communication approach such as Situation, Background, Assessment, Recommendation (SBAR).	• Development and use of the Safety Hub • Development of extended CCOT facility/support • Implementation of NEWS 2 and ward outreach link nurse programme • VitalPAC rollout to all areas • Use of daily board rounds to confirm escalation thresholds and enable escalation decisions. • Joint working between critical care outreach and palliative medicine.	• Training programmes to support implementation • Include in audit programme
2	Review end of life policy to ensure that doctors of appropriate seniority complete DNACPR forms, with confirmation by consultant at the earliest opportunity if less senior initial decision maker, and that senior doctors have end of life discussions with families and patients.	• End of Life Care requirements and inputs from the Clinical Lead incorporated in the Mortality Operational Group • Build escalation review as standard into board round and at multiple levels of the clinical pathways	• Review policy • Confirm roles and responsibility for DNACPR and end of life discussions
2	Ensure that individual end of life care plans are commenced promptly and that the care plans are well documented including preferred place of care. Consider wider use of Emergency Health Care Plans to prevent re-admission for patients approaching the end of their life.	As above • Rapid End of Life transfer • Increase training in and awareness of Anticipatory Clinical Management Plans and Anticipatory Care Planning. • Board rounds to enable end of life questions to be asked.	• Review policy • Training programmes to support implementation • Engage system though commissioning plans and System Improvement Board (SOIB) re community and primary care requirements
Stand alone	Ensure development of a more robust mortality review process with central reporting. There should be an emphasis on dissemination of learning from deaths across all specialties with involvement from medical, nursing and allied healthcare professionals. and including colleagues from Primary Care.	• Reducing Avoidable Mortality Programme • Development and implementation of SJR process and use of DATIX • Mortality Operational Group	• Communication workstream linked to Quality Plan. Vision 2020 and governance framework required to support lessons leaned • Consistency in terms of

			approach across Clinical Business Units to be included in performance reviews and quality governance requirements • Review Mortality Operational Group • Review RAM reporting and dashboard metrics

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
6 February 2019

Agenda Item	**TB029/19**	**Report Title**	**Winter Plan Update 2018 / 19**
Executive Lead	Steve Christian, Chief Operating Officer		
Lead Officer	Steve Christian, Chief Operating Officer		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Board is asked to note the progress of the Trust's management of winter 2018/19 and the on-going actions to support de-escalation of the Southport site.

The NHS is facing a very challenging winter (2018-2019) and national performance against the four hour standard has dropped significantly. At Southport and Ormskirk there is a similar picture and whilst 4 hour performance remains one of the best in the Cheshire & Mersey region, the Trust has had to take significant escalation steps to maintain safe patient flows across the Southport site to avoid crowding in ED - which we know has significant adverse outcomes for patients and staff. To support the above and as part of the Trust's overall winter plan the team introduced a SAFER start campaign in the New Year for the month of January.

The Trust has made significant improvements to maintain the function and safe running of the hospitals across winter. Whilst there are many positives to take from this years' experience regarding the Trust's management of winter the increased demand on hospital services has created imbalances between demand and capacity which has created bottlenecks and delays in the hospital.

Due to increased volumes of patients coming into the hospital and the worsened performance for stranded patients (due to delays in discharge) has meant the Trust has had to increase physical bed capacity to maintain safety of the hospital. This has resulted in the Trust having to take escalation actions to maintain a safe ED which has included increasing the number of escalation beds as physical capacity.

The additional physical bed capacity needs to be de-escalated as a matter of urgency however based on the challenges in demand and discharge the Trust need support from the system partners to ensure appropriate patient flow across the pre and post hospital

processes / pathways.

A system-wide Chief Officer meeting was requested from the Trust for immediate support to urgently de-escalate the Southport site. The meeting outcome was that the Accountable Officer of Sefton CCG commissioned the CCG Chief Nurse to oversee a system wide coalition effort of system leaders to identify the plan for de-escalation of the system. The system de-escalation plan is required for Friday 1st February 2018 with immediate implementation.

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	✓ Legal

✓ Engagement and Communication ✓ Equality ✓ Finance	✓ 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 Trust will continue to support system partners in determining solutions to assist whole system patient flows in order to release the pressure contained and being consumed on the Southport site of the Trust.	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ✓ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

WINTER PLANNING UPDATE FOR 2018/ 19

1. Purpose

The Board is asked to note the progress of the Trusts management of winter 2018/19 and the on-going actions to support de-escalation of the Southport site.

2. Background

The NHS is facing a very challenging winter (2018-2019) and national performance against the four hour standard has dropped significantly. At Southport and Ormskirk there is a similar picture and whilst 4 hour performance remains one of the best in the Cheshire & Mersey region the Trust has had to take significant escalation steps to maintain safe patient flows across the Southport site to avoid crowding in ED. As part of the Trusts winter plan the team introduced a SAFER start campaign in the New Year for the month of January.

Below are some top, evidence-based principles that the SAFER start campaign applied:

- Preventing crowding in emergency departments improves patient outcomes and experience and reduces inpatient length of stay
- Getting patients into the right ward first time reduces mortality, harm and length of stay
- Patients on the urgent and emergency care pathway should be seen by a senior clinical decision maker as soon as possible. This improves outcomes and reduces length of stay, hospitalisation rates and cost
- Daily senior review of every patient, in every bed, every day, reduces length of stay and costs of care

The practical actions that have been undertaken to achieve this are:

- Ensuring board rounds happen - with a firm focus on agreeing the necessary actions (red to green) to ensure every patient has a plan to progress their care towards discharge
- Early and daily senior review of all inpatient care plans from admission – clearly communicated and documented with the ward MDT on the required criteria for discharge.
- Use the discharge lounge to create flow and work hard to get those patients that can go home today away as soon as possible
- Early completion of TTOs and booking of transport for discharge
- Referrals made by ward MDT teams are actioned promptly (e.g. therapy, radiology, pharmacy)
- The introduction of a Gold command arrangement which involved a senior leader being allocated to every ward to support addressing delays to discharge.
- Enhancing the availability of streaming into same day emergency care pathways to support alternatives to hospital admission

The key success factor however has been the commitment, passion and dedication of our staff who have been inspirational throughput. The staff displayed courage and conviction in ensuring the hospital stays safe and that we offer our patients the best experience possible.

3. Progress

The Trust has made significant improvements to maintain the function and safe running of the hospitals across winter 18/19 in comparison to the previous year. The overall headlines are:

- Increased demand at the front door (16% increase at Southport)
- Improved 4 hour standard performance at Southport contributed by increased use of the assessment wards in line with best practice and CQC recommendations
- Reduced the conversion rate of "full" admissions
- Significant improvement against safety & quality metrics such as reductions in 12 hour breaches, corridor care and ambulance handover > 60 mins
- Challenges remain on reducing stranded patients and the Trust continues to work with system partners in identifying solutions to accelerate discharge from hospital
- Through planning we have protected at best the elective and day case programmes by not compromising Ormskirk to support emergency flow at Southport.
- To facilitate emergency flow in Southport resource was proactively reallocated from the outpatient programme. This was a forecasted and managed intervention which has only been achieved through decreasing waiting times in the build up to winter and maintaining an excellent RTT position
- For January we are currently third best performance in the Cheshire & Mersey region for the 4 hour standard. Last year the Trust was second worst performer.

Appendix 1 offers a full brief on the metrics that have been monitored to review the effectiveness of our management of winter. Due to increased volumes of patients coming into the hospital and the worsened performance for stranded patients (due to delays in discharge) has meant the Trust has had to increase physical "escalation" bed capacity to maintain safety of the hospital.

Since the turn of the New Year the Trust has been operating between 25 – 45 escalation beds to support patient flow which has included the temporary opening of ward 1. The use of escalation areas has resulted in a need to increase the numbers of doctors, nurses and allied health professionals to maintain timely and safe care. This has resulted in a significant cost pressure to the Trust at an estimate of £60k - £90k per week. The Trust has had to open the additional capacity in order to keep our hospitals safe, and to ensure that A&E and ambulance services are not compromised – the CCG, CQC and regulatory bodies have all been briefed throughout our management of winter. The additional physical bed capacity needs to be de-escalated as a matter of urgency.

4. Next steps – Southport site de-escalation

The additional “escalation” bed capacity needs to be de-escalated as a matter of urgency; however based on the challenges in demand and stranded patients we need support from the system partners to ensure improved patient flows.

A system-wide Chief Officer meeting was requested from the Trust for urgent de-escalation of the Southport site. The meeting outcome was that the Accountable Officer of Sefton CCG commissioned the CCG Chief Nurse to oversee a system wide coalition effort of system leaders to identify the plan for de-escalation of the Southport site. It has been widely acknowledged by the CCG and system partners that there is a recognised gap in community provision and in particular the responsiveness to safely discharge and transfer patients from the Southport site.

The de-escalation plan is required for submission and immediate implementation for Friday 1st February 2018 with a firm focus on closing ward 1. The regulatory bodies have requested a copy of the de-escalation plan in order the system can provide assurance that a solution will be delivered. It is intended the plan will be overseen on a day-to-day basis led by the CCG Chief Nurse with updates provided to the Accountable Offices.

5. Summary

The Trust is focused on the de-escalation of the Southport site and will continue to implement the good practice actions contained within the Trusts internal winter plan which we know are proving successful. The Trust will continue to support system partners in determining solutions to assist whole system patient flows in order to release the pressure contained and being consumed on the Southport site of the Trust.

Appendix 1

Data analysis to provide comparison of this year's performance against last year

January 1st to January 29th	Jan-18	Jan-19	% Change	Rating
Overall Trust Performance	80.70%	85.40%	5.82%	↑
Overall Trust Attendances	9314	9516	2.17%	↑
Type 1 A&E Performance	69.90%	79.20%	13.30%	↑
Type 1 A&E Attendances	5914	6612	11.80%	↑
SDGH A&E Performance	55.20%	69.70%	26.27%	↑
SDGH A&E Attendances	3911	4457	13.96%	↑
SDGH Total Conversion Rate (Inc Ass Wards)	33.50%	46.40%	38.51%	↑
SDGH Conversion Rate (Full Admissions)	24.49%	22.95%	-6.29%	↓
SDGH Full Admissions Avg Per Day	134.96	133.68	-0.95%	↓
12 Hour Breaches	62	11	-82.26%	↓
Corridor Care	1044	346	-66.86%	↓
Ambulance Handovers > 60 Minutes	139	74	-46.76%	↓

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Audit Committee 16 January 2019
Lead:	Ged Clarke, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Internal Audit Progress Report have issued a limited assurance in respect of Duty of Candour
- Overall there was a 52% increase in all security incidents
- There was a 44% increase in violence and aggression incidents towards staff

ADVISE

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

- All staff involved with Duty of Candour process should be reminded of the importance of ensuring all actions are recorded and completed in a timely manner

ASSURE

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

The Internal Audit Report issued substantial assurance for:

- Freedom to Speak Up
- Core Financial systems.
- Mazars, the External Auditors have issued their External Audit Plan
- The Board can be assured that frontline staff receive regular conflict resolution and posters regarding zero tolerance are displayed

New Risks identified at the meeting

No new risks were identified as areas included in Alerts were already on the Risk Register.

Review of the Risk Register

No

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 28 January 2019
Lead:	Jim Birrell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Trust's winter escalation beds remain open but the CCGs have agreed to commission additional community capacity, which would enable Ward 1 to be closed.
- Emergency Care performance over December and January is much improved compared with the same period last year. However, the significant rise in A&E attendances has added to the operational pressures facing the Trust.
- An audit of the Trust's reference costs suggests that little assurance can be placed on historic costing data. Steps are being taken to improve both the reference costs and Service Level Reporting data for 2018/19.
- The new centralised procurement system could initially cost the Trust, but over time it is predicted that purchasing costs will reduce.

ADVISE

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

- A report on the processes underpinning data validation will be presented to the next FP&I Committee.
- The Trust remains on course to achieve its £28.8m deficit plan in 2018/19, although discussions are ongoing regarding potential commissioning sanctions and contract challenges.
- A comparison of staff in post shows that medical numbers have increased by 7.5% and nursing numbers by 3.2% over the last twelve months, which represents a significant investment in improving quality.
- The Cost Improvement Programme is expected to deliver £6.9m this year, (against a target of £7.5m). Work on the 2019/20 CIP is underway and it is anticipated that a large part of the programme will comprise transformational projects. The Model Hospital Team has agreed to work with the Trust in analysing baseline costs and identifying opportunities for greater productivity/cost reductions.
- A bid is being prepared for central funding of an electronic Prescribing & Medicines Administration (ePMA) System.

ASSURE

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

- The Committee complimented the Activity & Income Assurance Group on the work undertaken this year. It was also supportive of further investment in the team if it results in further improvements in the quality of patient case notes.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**28th January 2019**
LEAD:	**MRS JULIE GORRY**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Committee received the Drugs & Therapeutics Committee (Medicines Optimisation) Annual Report 2017/18. The Committee asked the Chief Pharmacist to provide further assurance regarding the policies and procedures around the safe and appropriate use of controlled drugs. The Chief Pharmacist was asked to attend the Committee in March 2019 to present his report.
- Concern was expressed at the effectiveness of the Committee's sub-groups structure, partly because of the number of meetings that are poorly attended and/or cancelled and partly because of business being transacted. This will discussed in more detail, at a meeting to be arranged within the next couple of weeks, with Mrs Gorry, Mr Birrell, Mr Singh, Mrs Cosgrove and Dr Hankin.

ADVISE

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

- Performance on isolating at-risk patients within 2 hours has deteriorated from 71% in Quarter 1 to 46% in Quarter 3.
- There was some uncertainty over whether the Speech & Language Therapy Services was functioning fully (see November QSC AAA Report for more information). An update will be provided at the next meeting.
- The planned Peer Review Mock Well-Led Review has taken place and the findings of the exercise are being collated into the Trust's action plan for the forthcoming CQC visit.
- The Committee plans to look in more depth at the content and the degree of assurance that can be taken from the key risks overseen by the group. It is anticipated that this may necessitate changes to the Committee's planned work programme.
- Mortality – The Committee were advised that HSMR and SHMI remain high but show a downward trend. The findings from the External Mortality Report and the robust actions and focus is being taken to the Public Trust Board in February.

ASSURE

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

- Following a Serious Incident, regarding the insertion of Peripherally Inserted Central Catheters (PICC lines), a Root Cause Analysis has been completed and Lessons Learnt have been identified and are being reinforced.
- The Committee received encouraging quarterly updates on Infection, Prevention & Control and Palliative Care & End of Life plus the annual report from the Drugs & Therapeutics Committee.

New Risk identified at the meeting	• It was agreed that the Committee's request for further information on the effective security and management of

	controlled drugs be brought to the attention of the Audit Committee.

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

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 24 January 2019
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Policy Approval

It was highlighted that there is a significant delay in some of the policies going via the PRG, being published post approval. This has been raised before and is an alert to ensure that the delay is identified to ensure that policies are published for use in a timely manner.

In addition the approval process for policies requires review. At the moment there is an onerous burden placed on some of the assurance committees to approve policies when they may not hold the relevant expertise or have clarity on the changes made to an existing policy.

Mandatory Training Decisions

There are some issues with mandatory e-learning training that need urgent review. This is the remit of the Risk and Compliance Committee. Raised as an alert to ensure this is addressed as it impacts time and resource.

ADVISE

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

Sickness Absence

Sickness absence has continued to reduce for the 3rd month in a row, which provides some level of assurance. There is a lot of activity underway to support line managers with sickness absence management process and conversations. More importantly there are initiatives underway to shift towards supporting attendance rather than managing sickness absence. In particular Staff Side have been proactively supportive and attended in partnership the various training and education sessions. This continues to require support from everyone on the Board.

Safe Staffing

Whilst this remains an extreme risk on the register there is some progress being made and we reported safe staffing at 93.61% for December, against the national average of 90%. This slight decrease from November is due to sickness and vacancies. There is now an improvement plan in place to address the gap analysis to be compliant with NICE, 2016 and we continue to work with PWC who are focussed on a deep dive exercise.

ASSURE

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

Apprenticeship Levy
We continue to make excellent progress in utilising the apprenticeship levy spend for 2018/19. We have registered 99 apprenticeship programmes to the value of £764,000. We are currently on track to meet our target of 68 in a year, with 57 definite and a further 16 expressions of interest. We are outstanding in this regard when compared to the local trusts and Staff Side have been vocal in commending this achievement.

Workforce/OD Strategy and Plan
We continue to make really good progress against plan and that is commendable. In September we highlighted the importance of this being owned by the Organisation and not HR. This is a critical requirement and we ask that everyone engages and executes this with their staff. It will make a huge cultural contribution to Vision 2020 and beyond.

Productive Ward Programme
Trust to consider supporting the implementation of Productive Ward programme.

New Risk identified at the meeting	None

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2018

Agenda Item	TB031/19	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 contained the following components:

- Performance Dashboard
- Executive Assurance
- KPI Graphs and Narrative

Recommendation

The Board is asked to **review** 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)*

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

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 February 2019

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Board Report - December 2018

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	0	8	0			
Never Events	0	0	2	0			
VTE Prophylaxis Assessments	95%	97.2%		119			
Harm Free (Safety Thermometer)	94.99%	98.4%	97.2%	6			
Falls - Moderate/Severe/Death	1	2	0	2			
Patient Safety Incidents - Low, Near Miss or No Harm		568	5089	568			
Safe Staffing	90%	93.6%		N/A			
Fractured Neck of Femur	90%	70.4%	72%	19			

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	115.7	115.7	N/A			
WHO Checklist	99.9%	100%		1			
Stroke - 90% Stay on Stroke Ward	80%	81.8%	78.5%	4			
Sepsis - Timely Identification		100%	96.5%	N/A			
Sepsis - Timely Treatment		100%	80.8%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	15	88	15			
Written Complaints	44	19	206	19			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	92.3%		49			

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%	88.6%	1036			
Accident & Emergency - 12+ Hour trolley waits	1	1	17	1			
Ambulance Handovers <=15 Mins	99%	53.2%	44%	733			
Diagnostic waits	1.01%	1.8%		51			
14 day GP referral to Outpatients	93%	95.4%	94.6%	37			
31 day treatment	96%	98.2%	98.3%	1			
31 day treatment (Surgery)	94%	100%	96.7%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	70.5%	76.9%	9			
62 day GP referral to treatment	85%	70.5%	79.3%	9			
Referral to treatment: on-going	92%	95.8%	95.8%	429			
Bed Occupancy - SDGH	93%	93.9%		N/A			
Bed Occupancy - ODGH		29.3%		N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	85.7%	80.6%	1			
Duty of Candour - Evidence of Letter	100%	85.7%	62.5%	1			
I&E surplus or deficit/total revenue	-1%	-18%	-19%	N/A			
Liquidity	-23	-53	-53	N/A			
Distance from Control Total	0%	0.3%	-7.9%	N/A			
Capital Service Capacity	-2.423	-2.623	-3.559	N/A			
% Agency Staff (cost)	5.6%	6.8%		N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	34.4%	-5.6%	N/A			
Staff Turnover	0.76%	1.3%	6.8%	N/A			
Vacancy Rate - Medical		6.4%	6.4%	N/A			
Vacancy Rate - Nursing		9.1%	9.1%	N/A			
Sickness Rate	3.9%	5.9%	5.7%	N/A			
Personal Development Review	85%	70.9%	70.9%	N/A			
Mandatory Training	85%	84.8%	84.8%	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
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month		45		45			
DTOC - Number of Beds lost per month		4		3.57			
Length Of Stay		6.8		N/A			
New:Follow Up	2.64	2.3	2.4	N/A			
DNA (Did Not Attend) rate	8%	8%	7.3%	1433			
Cancelled Ops	0.61%	0.2%	0.2%	3			
Theatre Utilisation - SDGH	90%	52.3%	56.1%	N/A			

Reporting Frequency is monthly except for SHMI which is quarterly.

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Executive Assurance

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

Overview

Vision 2020

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

Delivery of the Well Led Review as part of the Secretary of State for Health & Social Care priorities is on track.
Significant developments include substantive appointment to executive and non-executive roles.

Assured/Most Improved

Board Leadership & Development and Fitness to Govern

The Board Development Programme was approved by the November 2018 Trust Board. There is a schedule of masterclasses up to May 2019. A programme dealing with organizational culture is scheduled for 6 April and will be led by Professor West of the University of Lancaster and the Kings Fund. Board members and Senior Leaders from neighboring NHS organisations have been invited to join us.

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 2018.
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 at the Audit Committee and the Board. Two-monthly updates of relevant strategic risks are discussed at the assurance committees.. The BAF 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

A Risk and Compliance Group, reporting into the Audit Committee, has been formed and will hold its first meeting in February 2019. The purpose of the Group is to promote effective risk management, regulation and compliance and to maintain a dynamic Board Assurance Framework, risk registers and compliance and regulatory registers through which the Board can monitor the arrangements in place to achieve a satisfactory level of corporate integrated internal control, safety and quality.

The Group will promote local level responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement .

There is a draft Assurance Strategy which will come to the Board in March

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
Risk and Compliance Group.

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

2a – Quality & Safety Plan
Reviewed governance arrangements for Infection Prevention & Control (IPC) and will be commencing monthly IPC meeting with Matrons
Roll-out of MCA & DoLs pathway documentation commenced
NEWS2 training programme in place, Outreach Team will commence 24/7 from April 2019
Relaunch Dementia Steering Group who are reviewing Dementia Strategy
Quality Improvement Group – inaugural meeting planned in January 2019

2b – QI Methodology
AQUA training plan in progress with session planned within 'Quality Week'
Theatre team participating in NHS I Pressure Ulcer collaborative
SJR tool in place

2c – Safe Staffing
Ward nurse establishment review in progress to be completed in February/March

2d – Medical Workforce Engagement
Medical Engagement Survey improvement plan in development

2e – Quality & Safety Governance
Ward Co-ordinator & Ward Manager checklist in draft form to commence mid February 2019

Performance in Harm Free Care (98.39%), VTE (97.2%), sepsis screening, Care Hours Per Patient Day (93.61%) is positive.
There have been no C. Diff. in December 2018
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
Eight patient pressure ulcers have been reported in December; 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. An action plan for improvement is being developed, drawing upon best practice both regionally and nationally. There were 2 pt falls being graded as moderate or above harm Safeguarding – potential reduction in L3 Children's training compliance following 'deep-dive' of process of training data collection. Recovery plan in place.

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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.
The rolling HSMR shows a successive fall, down to 90 for August 2018.
The SHMI is down to 115.7.
Improvements are demonstrated both in hospital deaths and crude death rates for the reporting period September to November 2018.
Clinical pathways to improve quality of care are being developed and rolled out.
Structured Judgement reviews methodology for Learning from deaths is now being used across CBUs
External Mortality review will be presented to the Public Board on the 6th February 2019
Work streams under the Reducing Avoidable Mortality project are being progressed.
Critical care outreach team has been appointed to and will go operational 24/7 in April.

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 and 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
The reducing mortality action plan has been reviewed and organized across three principal domains for improvement over the coming year, Pneumonia, Observations and Documentation, and escalation to an appropriate pathway.
Improvements have been made in Sepsis management with reduction in Sepsis related deaths.
Critical care outreach team has been appointed to and will go operational 24/7 in April.
Acute renal failure HSMR continues to improve reflecting the impact of improved pathways and the AKI steering group.

Not Assured/Most Deteriorated

Mortality screening requires improvement.
Pneumonia pathway not embedded in acute admission pathways.
LRTI and Bronchitis HSMR remains unacceptably high, diagnostic criteria remain unclear.

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 December was 89.5%, December 2017 it was 80.3%.
- This is mainly due to performance at Southport which has improved in the year from 52.8% to 78.4%, despite an increase in attendances of 556 patients in the month.
- This is the fourth consecutive month that performance has been better than last year and January is so far continuing this trend despite further increases in demand as we continue the winter period.
- December was also the second time in a row that the Trust has beat the trajectory target agreed with NHSI.
- The Trust was ranked 35th nationally out of 135 acute Trusts

Ambulance Handover Times

- The Trust had 44 ambulance handovers greater than 1 hour in December 2018. In December 2017 this was 219 – an improvement of 80%.
- 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

- December 18-week performance was 95.8% which, although a small drop from November is still well above target.
- The ongoing waiting list has stayed the same though and currently is 10,144 – with a target to reduce back down to 9,000 by the end of March 2019.
- There are no patients waiting over 40 weeks, the number of 30+ week waiters has grown marginally but this has been planned for to manage winter pressures.
- Despite this performance level there are still challenges in Community Paediatrics, Vascular Surgery, Oral Surgery and Pain Management

Assured/Most Improved

Length of Stay

- Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 6.83 days in December, with patients on assessment wards staying an average of 7 hours. We continue to see small improvements in length of stay despite entering the winter period when acuity is expected to increase.
- Improved length of stay is also evident in the improvement made in the Stranded patients metric which shows that December has 11% fewer stranded patients and 21% fewer super stranded patients than last year

Overdue Follow Ups Backlog

- Despite a reduction in outpatients activity in December the number of overdue follow up patients has not grown and remains under 2000.

- December 2017 this number had breached 3000 so the reduction seen this year is still being maintained.
- The CBUs have been requested to confirm the risk stratification process SOP that is undertaken to assure safety of the patients that form part of the waiting list

Diagnostics

- Performance for December against the 6-week-wait target was 1.8%. This is the second month performance has been below 2% and continues the massive improvement from the rest of the year when it has been as high as 4%.
- Last year in December 2017 diagnostic performance was much worse at 2.8%.

Not Assured/Most Deteriorated

Cancer 62 Day

- Performance for November was below the 85% target at 70.5%, despite October showing great improvement this has not been sustained and performance has dropped again to a similar level as seen in September.
- This is also a drop from last year's performance when the target was met in November at 85.4%.
- An urgent meeting is being setup between Medical Director, Chief Operating Officer and senior managers to review progress on the improvement actions and confirm next steps.

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 9

Month 9 financial performance was £0.2m off plan so the YTD adverse variance is now £0.5M. Both income and expenditure levels were consistent with month 7 and 8. There are a number of risks that will impact on whether the Trust will deliver the planned deficit of £28.8M as follows:

- NHE/NHSI recommended to the Trust and Commissioners that the following actions are taken
  - ACU/CDU tariff should be paid following findings of expert determination/MIAA review.
  - Regarding other activity over-performance, the CCG should pay the Trust for this, and if they don't agree with the average price/growth, the recommendation is the CCG follow the appropriate contractual mechanisms for resolving. In the meantime the CCG should pay for the patient activity undertaken by the Trust.
  - The Trust should respond to any outstanding contract queries by the 19th January 2019

- This is reflected in the month 9 position as well as recognising that sanctions will be deducted with £1.1m being provided for with A&E based on agreed trajectory with NHSI.
- Commissioners have challenged the average unit price charged for non-elective activity.
- Pressures from winter demand on services, 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

- December monthly deficit was in line with forecast discussed with NHSI..
- Clinical income continues to over perform across all points of delivery (POD) with the exception of electives which continues to under-perform against plan (11.7% YTD).
- The cost of agency staff was slightly lower compared to November, with nurse agency spend down £32,000 in month which reflects concerted effort by the nursing team to reduce the use of Thornbury agency which was successful until Christmas week when it increased considerably from an average of 14 shifts a week prior to 24th December rising to 33 shifts week commencing thereafter
- 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.
- 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

- Non elective income and activity still subject to CCG contract challenge.
- Elective activity is under plan in month and, despite recent improvements, continues to deteriorate.
- PAG compliance and effectiveness has improved but 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, there are 25 projects with an outstanding QIA. All are booked into the QIA Panels by mid February. All outstanding schemes progress is monitored by Executive Directors on a 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 70.91% in December which is a slight improvement. Work continues to achieve target of 85%, and ultimately beyond this target. CBUs and Corporate Services are currently reviewing their compliance trajectories to ensure an ongoing increase which will continue to be challenged at Performance Review meetings. All CBU's have revised their PDR performance improvement trajectories and have given assurance that they will meet the PDR compliance target of 85% by February 2019.

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 this, new documentation will be launched in the next few weeks, which should result in continued improvement. Additionally, further training on the policy will be provided by the HR Team in the near future.

Mandatory Training

Mandatory training rates continue to steadily increase and improve each month. In December the overall Trust rate was 84.76%. 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.

Reducing Agency Spend

The Trust escalation position over winter has led to an increased requirement for temporary staffing which has been monitored on a daily basis and has been supported through monitoring regional rates for both bank and agency to maximise the financial opportunities for the Trust. Off framework utilisation through Thornbury Nursing Services has increased over this period and the Trust is discussing options with alternatives agencies to extract from off framework utilisation and encourage the transfer of staffing to framework lower cost agency and bank. Monitoring of NHSP supplier performance continues to ensure that bank fill is being maximised and high cost agency minimised; this has included the identification of the need to source HCAs from alternative sources which has been successfully implemented in January. AHP bank development discussions continue with a proposed recruitment to bank campaign to commence in February 2019 to support this staffing group. The Trust is actively involved in the collaborative work across Cheshire and Merseyside addressing the temporary staffing challenges on a system wide basis with a new medical commission cap rate card implemented across the region from 21 January providing the opportunity to make further savings and move agency rates towards the NHSI cap.

The transfer of the HR service remains on plan for 1 April and is supported by the commencement of 3 members of the recruitment team at the end of January to ensure that recruitment is transferred safely and substantive recruitment pressures are addressed minimising the requirement for high cost agency spend.

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 2018 was very well attended and feedback positive. There is a weekly commitment by the Organisation to focus on staff Health & Wellbeing which the organisation has branded as’ Wellbeing Wednesdays’

The Flu campaign was a success with 81% of staff having obtained the vaccinations.

Organisational Development

Work has begun to deliver activities identified in the Workforce & OD Plan and an update will be provided to Workforce Committee in January 2019. HR/OD will work with NHS Elect over the next 12 months to deliver a cultural change programme based on compassionate leadership, building on our SCOPE Values & establishing a Behavioural Framework, whereby all staff know “how we do things around here”

Payroll Services
The transfer of HR services on 1 April does not include the transfer of payroll and transactional services. A working group has been established including HR, Finance and Procurement to ensure that the best service for the Trust is maintained and an options paper will be presented in February setting out the longer terms options for the service to meet the Trust's requirements.

Workforce Planning
The national workforce plan submission is scheduled for Mid-February with final submissions due in April 2019. A working group including Finance and HR are developing and reviewing the plan alongside business planning submissions submitted as part of star chamber business planning processes to ensure that the plan supports the strategic direction of the Trust.

Not Assured/Most Deteriorated

Sickness Absence
Sickness absence has decreased again in the month of December 18 to 5.86%, from 5.94% in November 18. This is the third consecutive month whereby sickness absence has reduced in month.
This is one of the main areas of focused support provided to services by HR.

Support includes:

- Review and challenge of monthly performance sickness data
- 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 scrutinise sickness and its management
- Managing sickness absence training is delivered regularly by the HR Team to managers across the Trust. This will continue on an ongoing basis.
- Reviewing sickness absence over the Christmas period and analysing any patterns

The new Supporting Attendance Policy has been agreed and ratified for use and will be launched on 28th January 2019.

A focussed action report of sickness absence will be presented to Workforce Committee in January 2019.

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KPI Graphs and Update

Board Report - December 2018

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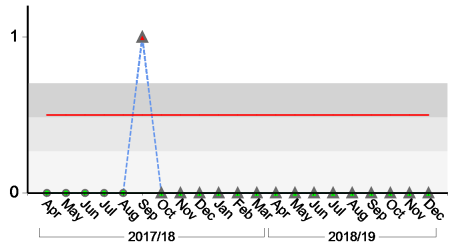
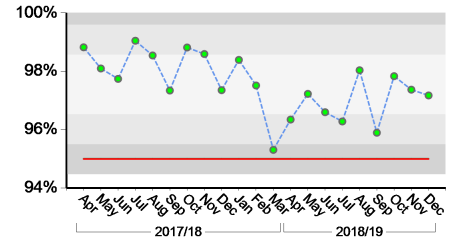
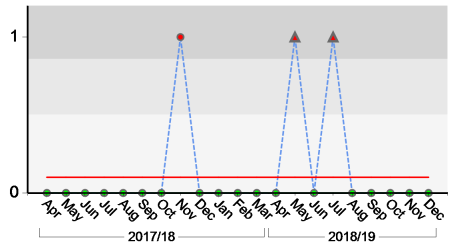
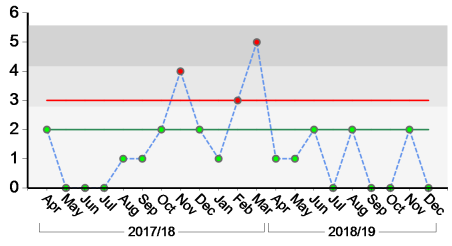
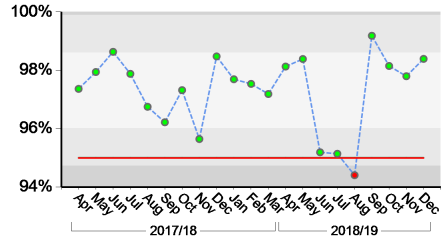
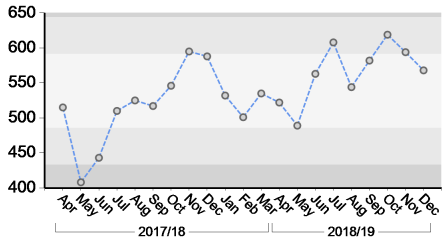
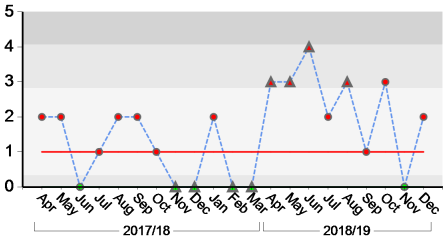
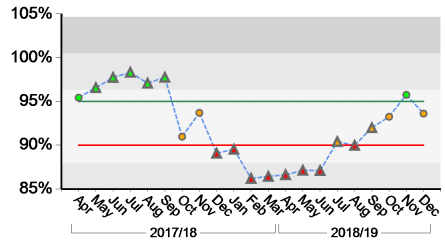
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	There has been zero MRSA bacteraemia since September 2017 - There is continued provision of training/education on the importance of cannula maintenance. Cannulation Stickers are now in cannulation packs for completion and insertion into case notes.	
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	December performance of 97.17% is only marginally lower than November (97.37%) and remains compliant - Compliance levels are within normal variation	
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 were 0 Never Events in December - There have been 2 never events in the last 12 months - both were in the current financial year in May and June.	
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 Zero Hospital C diff cases in December - The Trust is 7 cases below trajectory for the stretch target and 18 cases below the NHSI target.	

Board Report - December 2018

NHS
Southport and Ormskirk Hospital
NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance is above threshold of 95% harm free care for December 2018 at 98.39% - During the census period the Trust reported 8 x new patient harms which were made up of : 2 x new grade two HAPU on wards 14a and 7a, 2 x low harm falls on wards 14b and 9a, 1 x catheter associated UTI on ward 7b and 3 x VTE which occurred on 11b, 7a and 14b further Investigation and any subsequent actions are the responsibility of the respective CBU's	
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 has been a slight decrease in the reporting of lower level incidents during December for the Trust, 571 reported compared to 594 last month - for December there were 17 near miss incidents, 483 no harm and 71 low harm incidents. The categories with the top 3 highest reported incidents relate to safeguarding (non pressure ulcer) - 47 of these were DoL's, accidents and bed management.	
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 two reported falls categorised as moderate/major/death in December 2018 - Case 1 - On 22/12/18 (Ward 14B) a patient had an un-witnessed fall in the bathroom, resulting in #NOF. Patient was a known falls risk, Falls Care Plan was in place and falls risks mitigated appropriately. The case was reviewed at SIRG on 02/01/2019 - decision not made to STEIS as it was unclear why the patient did not use the call bell. Due to be reviewed back in SIRG 15/01/2019 with staff statement and further details Case 2 - On 20/12/2018 (Ward 15B) - patient called for help and found in side-room lying on left side resulting in # to pubic rami. Patient was noted to be confused at the time of the fall or known faller. Patient reviewed - no surgical intervention patient to mobilise as pain allows. Patient has severe osteoarthritis and will be followed-up by orthopaedic team. STEIS reported on 03/01/2019.	
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%.	Although performance declined in December at 93.61% compared to 95.76% in November, this is within tolerance and so is flagged as 'amber' status. - There has been a slight decrease in our overall fill rate due to sickness and the underlying vacancy position.	

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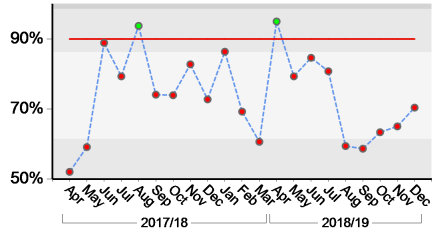
NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance continues to improve for the fifth consecutive month due to two new consultants now being in post. In December performance was 70.37% (19/27 patients) compared to 65% (13/20 patients) in November -	

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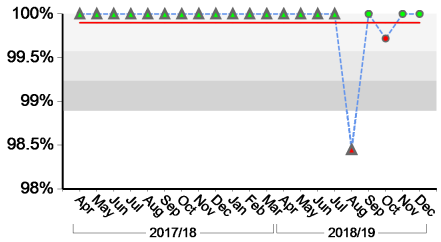
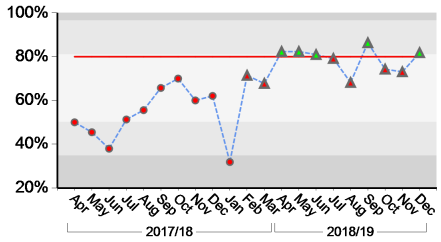
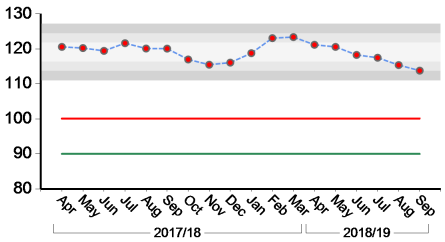
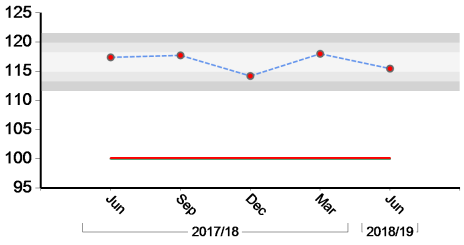
NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
WHO Checklist	WHO Checklist.	WHO checklist compliance is reported as 100% in December. - Audits of compliance continue	
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 remains consistently within range - and achieved target in December, where 81.82% of Stroke patients received their treatment on a Stroke ward for at least 90% of their stay.	
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 continues to steadily reduce and was 113.8 in September. This is the lowest figure since November 2017 - 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 from 118 in Q4 2017/18 to 115.46 in Q1 2018/19 and is lower than June 2017 which was 117.39. Please refer to HSMR for action planning	

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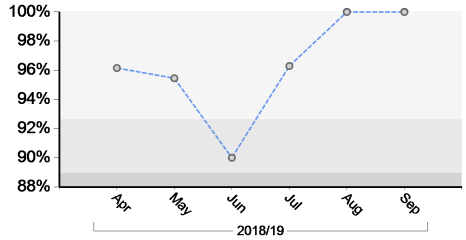
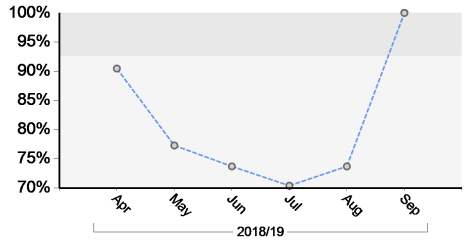
Effective

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 all of whom received the diagnosis within one hour of arrival - this is the latest available data	
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 whom were treated with antibiotics within one hour of the diagnosis. - this is the latest available data	

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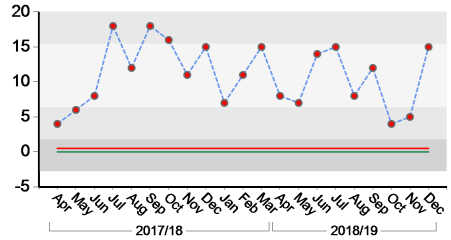
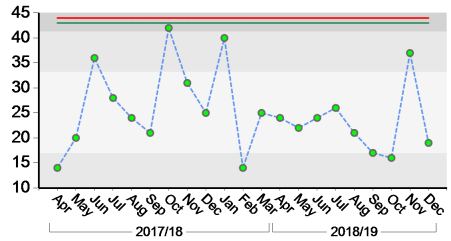
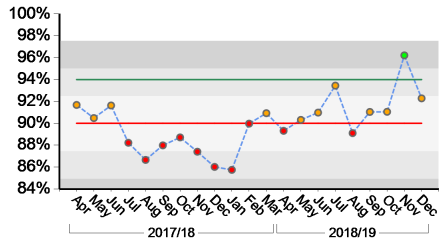
Caring

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.	DSSA breaches were significantly higher in December than the previous two months. There were 15 breaches. - Increased focus and surveillance continues at the daily bed management meeting which ensures a discipline is put in place to step patients down within the required timeframe. In addition, the operational leadership team is assessing estate to determine any opportunities to redesign to support performance improvement.	
Written Complaints	The total number of complaints received. A lower number is good.	There were 19 complaints in December. This is significantly lower than November (37) but within the normal range. - The incident themes were as follows 1) Poor standard of care 2) Lack of communication 3) Staff attitude 4) Discharge issues The number of complaints received suggests that patients are aware of the complaints procedure. The complaints continue to be reported in the Quality and Safety reports for each Clinical Business Unit and in the Integrated Governance Report presented at Q&S Committee for complaints analysis such as trends, themes and responsiveness.	
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance of % that would recommend has decreased by 3.94% compared to previous months data. - FFT response rates remain low at 6.93%- business case in development for implementation of SMS text and interactive voice messaging providing a blended approach to support an increase in responses. Work continues supporting the pledges within the patient experience strategy. 17/18 Sefton Healthwatch listening report received in Oct-18. Action plan developed and returned to Healthwatch in Nov-18. Results of the National Maternity survey reviewed in Dec-18 and action plan in development.	

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NHS
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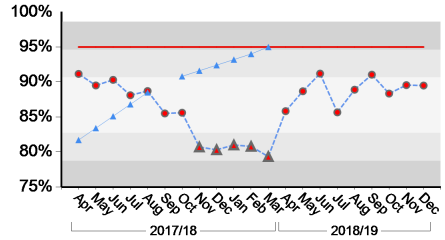
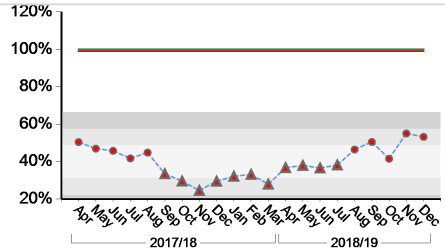
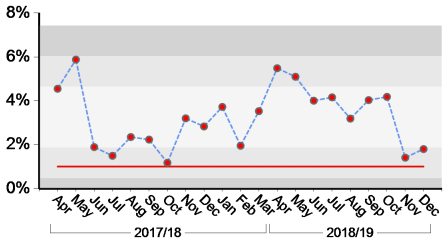
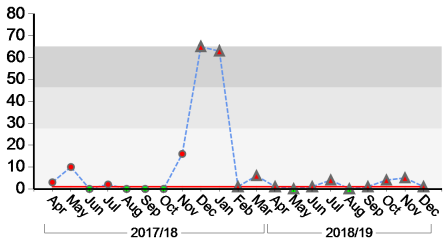
NHS Trust

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.	Performance remains stable in December at 89.48% which is significantly improved compared to performance in December 2017 (80.3%) - December saw an increase of 13.4% attendances (614 patients) with an overall increase of 650 majors patients compared to last year. 79.29% attendances were majors category in December 18 compared to 75.21% in December 17. Despite this rise, the conversion rate from ED attendance to admission dropped from 32.94% last year to 30.42% this year. Performance against the 4-hour standard on the Southport site on its own saw a 26% improvement compared to December 17. This is 920 less patients spending longer than 4-hours in A&E compared to last year. Due to improvements in flow, NWAS handover times also saw improvements enabling NWAS to respond to patients in the community quicker. Care provided on the corridor fluctuated in the month, but is significantly improved compared to last year. The new waiting room and additional 2 clinical assessment rooms opened just before Christmas providing additional space for patients. Difficulties continue in maintaining ED flow particularly during periods of surges, blockages in inpatient areas and the knock on effect of delays in creating assessment capacity in the assessment areas. ED continues to develop its workforce model with a further substantive consultant interview scheduled during Feb 19, and positive interest in the latest round of Physicians Associate recruitment. Difficulties remain in attracting Middle Grade Doctors and there are some gaps in the junior tier of the rota for the February 2019 rotation that have only been disclosed to the CBU in the last week. 53.15% of ambulances were handed over within 15 minutes this December compared to 29.4% in December 2017	
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.	Performance is slightly lower (53.16%) than the previous month (55%) but remains higher than previous months - For the second month running, over half of patients brought in by ambulance were handed over within 15 minutes of arrival. This was against a backdrop of an additional 614 attendances compared to December 2017. The ED estates works has provided additional clinical space to support reducing ambulance handover times. There are still difficulties experienced during periods of surges, and blockages in patient flow. ED continues to work with NWAS to drive further improvements, ensuring that recorded timestamps on NWAS data match EDs clinical records	
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 slightly reduced in the last month, from 1.41% in November, to 1.8% in December. This still represents a significant improvement compared to previous performance. - The breaches were: Cardiology - Echo - 3 patients - 1% - patient choice, Colonoscopy - 8 - 6.2% - patient choice, Computed Tomography - 2 - 0.7% - 1 x CT repair, 1 patient choice, Cystoscopy - 4 - 4.1% - patient choice, Cystoscopy (Gynaecology) - 6 - 6.2% - capacity, Flexi Sigmoidoscopy - 1 - 1.6% - patient choice, Gastroscopy - 1 - 0.7% - patient choice, MRI - 8 - 1.7% - 6 - difficulty contacting patients, 1 patient cancellation, 1 patient had MRI safety issue, Non-obs Ultrasound - 16 - 1.7% - 12 difficulty contacting patients, 2 patient choice, 2 were next available musculoskeletal apt, Urodynamics - 2 - 4.1% - 1 - long term staff sickness, 1 consultant sickness. Out of 2829 patients in total, 51 breached beyond the 6 week wait. A review of productivity and utilisation of endoscopy sessions is underway. 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.	
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 was 1 reportable 12-hour breach for the month of December. This was a 17 year old West Lancs patient who required a mental health admission to a CAMHS bed. - A mental health stakeholder group has been established to meet on a monthly basis, and will review incidents and trends to enable lessons to be learned. This is the first occasion of a patient requiring CAMHS intervention. The patient remained in A&E as the only suitable location within the Trust to support them until a bed was identified.	

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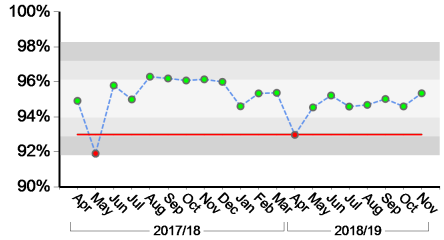
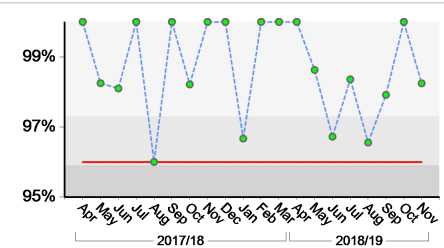
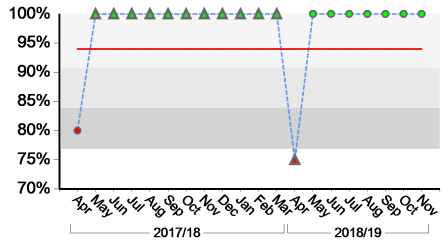
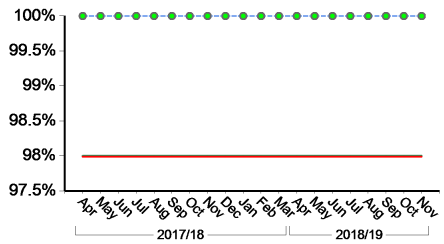
NHS Trust

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.	The Trust continues to meet the standard - Ongoing work within the Trust has resulted in an improved compliance against this standard. There is a review of all cancer pathways for the need to implement RAS into ERS. The move to first appointment at day 7 will mean more options are available if patients are unable to attend and reduce the number of breaches due to patient choice too.	
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.	The Trust remains compliant against standard at 98.25% - The Trust continues to meet this standard which measures how long patients wait for treatment after agreeing a treatment plan with their provider.	
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').	The Trust is compliant against standard at 100% -	
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').	Trust is compliant at 100% - The Trust continues to meet this target at 100%	

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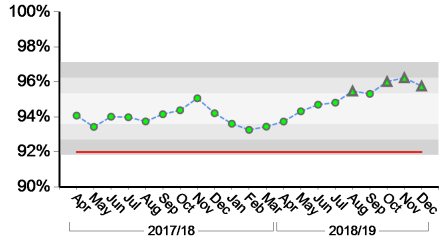
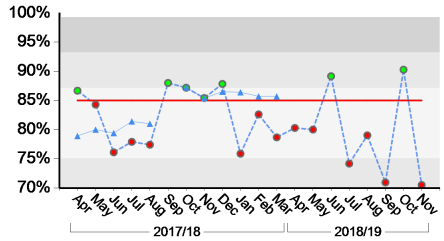
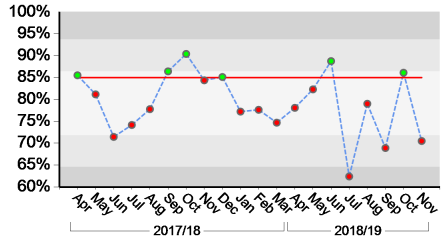
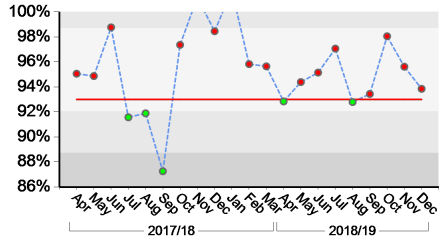
Responsive

Indicator Name	Description	Narrative	Month Trend
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher.	The Trust remained compliant at 95.76% - 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.	Although target was achieved in October at 91.28%, performance continues to decline and was 70.49% in November. This amounts to 9 patients. Average performance for the last 12 months is 79.85% which is an average of 8 patients per month. - Action planning is in place and improvement works underway. The cancer improvement group has developed an action plan to embed the new 7 day pathway which should lead to sustainable and compliant performance. This is a large Trust wide piece of work which will take some time to show results. There are some visible improvements in Diagnostics, Endocsopy and Radiology but risks remain because of capacity issues due to recruitment and sickness. A successful pilot of the pathway in gynaecology has proved to be very successful, with measureable improvements and this has been embedded into their practice and is being rolled out across other tumour sites. The next two areas are Colorectal and Urology. Colorectal is dependant on Endoscopy improvements.	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	The Trust was non compliant against the standard at 70.49% in November - Due to non compliance with the national 62 day standard the Trust is also non compliant following re-allocation. Given currently position against the proposed 7 day pathway it is anticipated this will be challenging to be recovered within this year. Cancer performances against the 62 day standard is currently off trajectory and it is anticipated it will take several months to sustain a recovery.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Occupancy continues to improve with the flow programme and reduced from 95.62% in November to 93.85% in December. - The red2green roll out continues, secondment into lead now in place to support; discharge facilitators all in post and training continued; weekly LoS reviews were on hold over 2 weeks following near year due to activity- restarted week of 14th Jan; data improvements are continuing	

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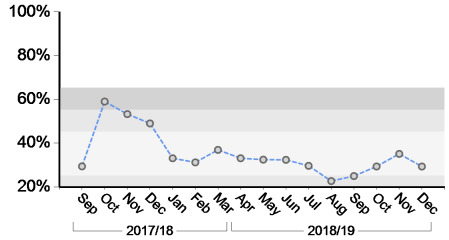
Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site. A lower percentage is good. Threshold is 93%.	There is a reduction in occupancy to 29.31% in December compared with the November figure of 35.1%. Numbers remain within the normal variation. - The Theatre Maintenance Programme resulted in loss of 25 theatre lists. 17 sessions were also lost due to maternity theatre issues. These figures include all beds on ODGH site. Please note: Specific calculations are required to adjust for day beds at Ormskirk , so this data is currently being validated and adjusted for future reports.	

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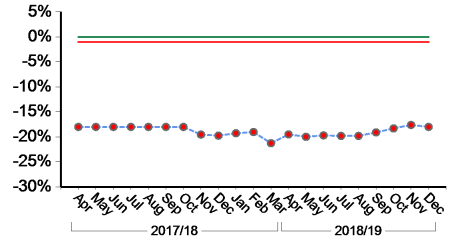
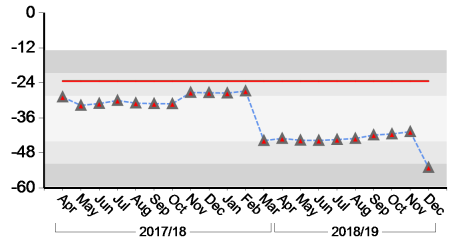
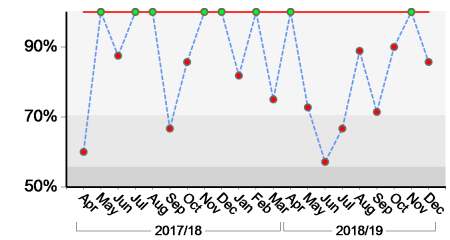
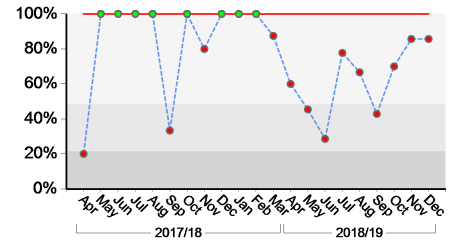
Well-Led

Indicator Name	Description	Narrative	Month Trend
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Please refer to the DoF Report for the detail -	
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	A step change with an adverse movement of over 12 days in month - In the month 9 interim accounts, the Department of Health has re-classified a number of loans as current liabilities (due within 12 months). This has resulted in a significant adverse step change to the metric.	
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	Performance was lower in December at 85.71% which equates to one patient out of 7 - This statutory duty was achieved by the Urgent Care CBU/ Women's Childrens CBU and Clinical Support Services, The Planned Care Business Unit did not achieve compliance. The incident involved a patient who was at the nearing the end of their life. Extra support / education will be provided to this CBU so compliance is reached. The CBU have a plan in place and are contacting the patient / relatives as a priority	
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.	Compliance remains the same as for November at 85.71% which equates to one patient - The Daily Duty of Candour Alerts continues with positive effect. The Urgent Care Business Unit (CBU) / Women's and Children's CBU/ Clinical Support Services CBU were compliant in December 2018. The Planned Care CBU is being supported with this statutory duty. Education and advice continues with clinicians. One breach occurred due to a patient being at the end of their life. The CBU have a plan in place and are contacting the patients / relatives as a priority	

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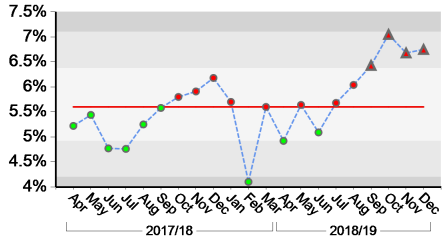
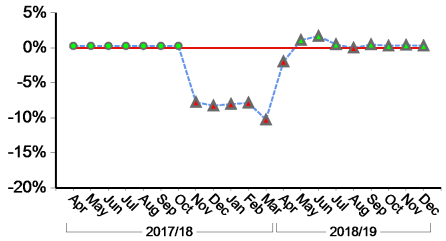
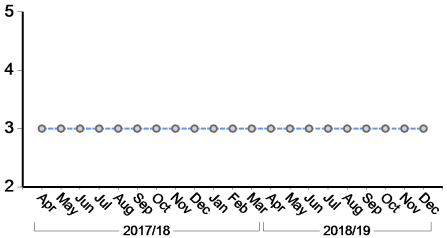
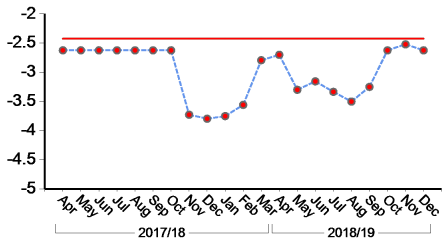
Indicator Name	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	Agency costs remain high and increased in December from 6.68% in November to 6.75% -	
Distance from Control Total	Distance from Control Total.	The Trust is 0.3% ahead of plan - The Trust has delivered a higher I&E margin (-18%) than plan (-18.3%). Although the actual deficit is £454k worse than plan this is over a higher turnover (plan £121.3m; actual £125.3m).	
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) - There are no changes to the individual elements that make up this metric and the unrounded rating remains at 3.2.	
Capital Service Capacity	The level of debt the Trust is required to service. This indicator is 1 of 5 used to derive the 'Use of Resources (Finance)' score.	Minor deterioration to last month's figure - The metric is now slightly away from the plan at the end of December (-2.58).	

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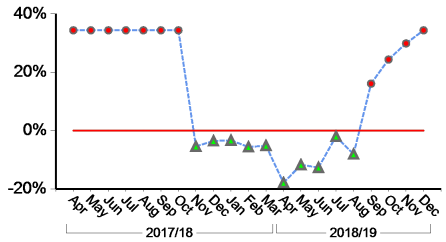
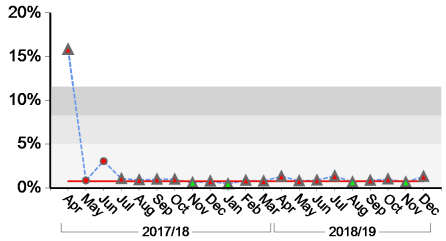
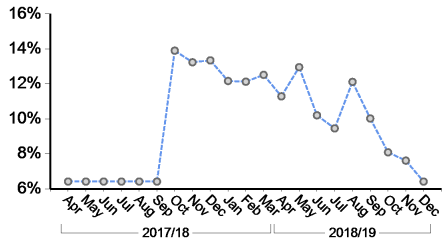
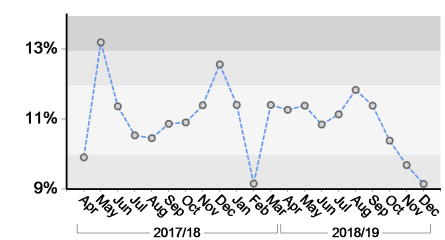
Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Please refer to the Director of Finance Report for the detail. - The cap cannot be achieved in 2018/19.	
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month.	Staff turnover increased in December from 0.65% to 1.3% which is the highest level of turnover since July. - YTD turnover is 8.79%, Rolling 12 months turnover is 11.6%. 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. The metric will change on the dashboard for future reports to a rolling annual figure	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The rate has continued to reduce over the last year and so is currently at the lowest rate of 6.42% -	
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Performance improving following local recruitment events - Registered nurse vacancy against overall establishment has remained static in month. Non – registered vacancy has reduced / improved in month by 6 wte	

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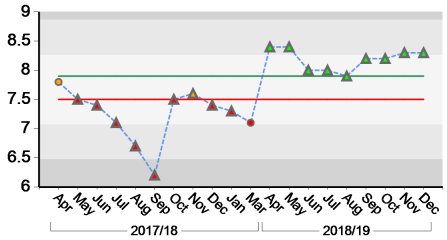
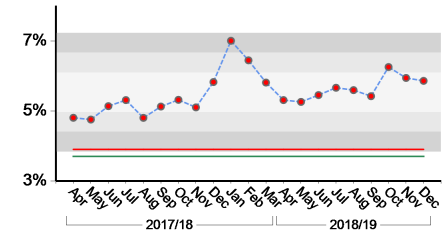
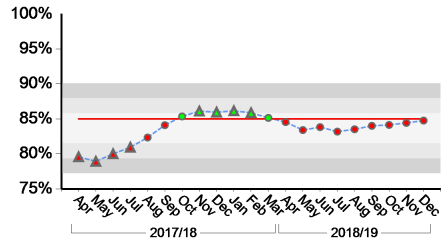
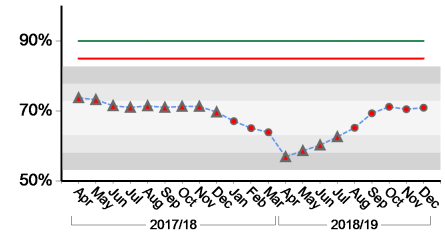
Well-Led

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.	The Trust remains compliant - Performance remains stable at 8.3% in December - slightly above the national average. Further scrutiny of this data is continuing.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence has decreased slightly again in month to 5.86% but remains high above target. - Sickness absence continues to be a concern for the Trust. The monthly trend was a month on month reduction in sickness absence with a significant increase in the month of October 2018. There has been a reduction in sickness absence in November and again in December which is promising. 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 and Trust and CBU staff survey action plans. All action plans performance will be monitored at Workforce Committee to ensure progress. The Trusts new Supporting Attendance Policy will be implemented on 28/01/19 along with revised support materials and training.	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Statutory & core mandatory training compliance has risen consistently since July 2018 in small increments but remains 0.24% below the Trust target of 85% at 84.76% - The Trust understand the key areas to focus to continually improve, both at business unit level and by specific courses to enable a targeted approach. The Infection Control Team has delivered hand hygiene training via the "bug bus", and a significant amount of people have been trained. There are sufficient episodes of training for Resuscitation Level 1 and Moving & Handling Level 2 - held over both sites each month. The data currently includes local fire safety and hand hygiene training which are Trust requirements but do not form statutory or Core Skills Framework training requirements.	
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance increased slightly in month from 70.48% to 70.91% - CBU Improvement trajectories have been reviewed and revised to ensure that they have a realistic plan to deliver the improvement by February 2019. The revised trajectories have been presented at Performance Review Board.	

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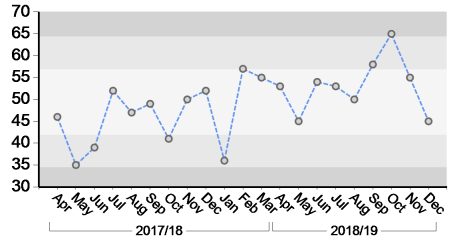
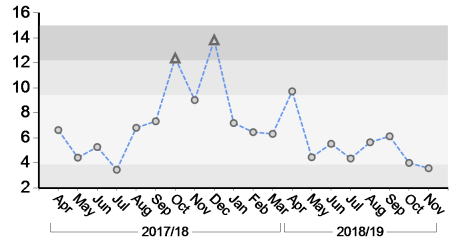
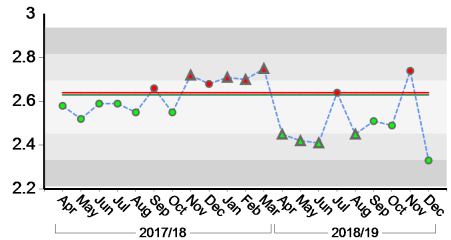
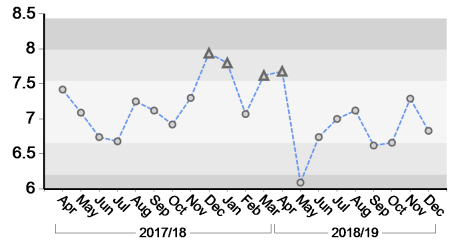
Efficiency

Indicator Name	Description	Narrative	Month Trend
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	Average Number of Daily Beds Lost In Month.Taken from A Daily Snapshot Of Patients Medically Fit For Discharge. Lower is better.	The metric for this KPI has been revised. The Trust is now reporting on the average daily bed days lost. The numbers lost in in December were on average 45 per day, the rolling yearly average is 52 - 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. following pressures in new year introduction of weekly MADE to support flow and whole system working	
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).	DTOcs continue to reduce. There were 3.57 days lost due to DTOCs in December which is in line with November's performance of 4 beds. - Over the last 12 months the Trust can demonstrate a trend of fewer days lost. In December 2017 DTOCs were 13.84 days and in January it was 7.19 beds. The introduction of community discharge to assess beds has improved our delays; continued weekly PDSA to support process; review of process for recording of DTOC	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	The Trust improved in December and returned to achieving the target - Performance was recorded at its lowest ratio in the last 12 months at 2.33%	
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.	Length of stay remains within normal variation and reduced in the last month from 7.29 to 6.83 days - There is a re-launch of LOS reviews with support from ECIST- ward based reviews of all patients 20+days with system partners. The appointment of a red2green lead on a 3month secondment supports the review and further rollout. Exec and operational support is identified for all inpatient areas.	

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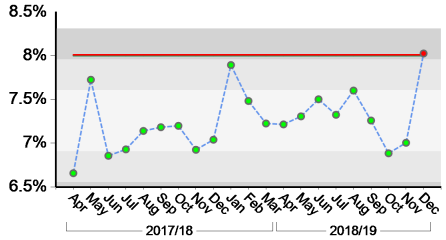
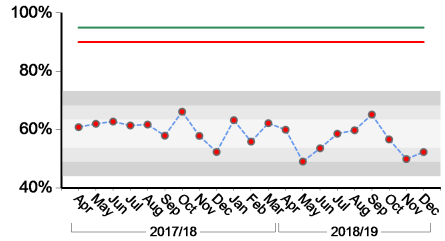
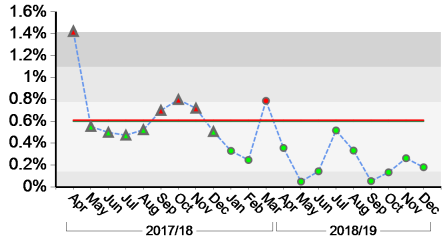
Efficiency

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 again in December to 8.03%. - Actions are in place that all ERS New patients would be telephoned in a bid to reduce New Patient DNA's and short notice cancellations as part of the Outpatient Improvement Programme. This piece of work has commenced and a reduction in the January position is anticipated.	
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 fall below the 90% target and was at 52.29% in December. This is a slight improvement on November which was 49.88% - Utilisation on the SDGH site is dependent on availability of beds. Utilisation data of both sites is under review for accuracy, and Ormskirk utilisation will be reported in future reports	
Cancelled Ops	Percentage of Operations Cancelled.	The Trust continues to achieve the target of 0.6% for the ninth month in succession - December performance was 0.26%which amounts to 6 patients	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	TB032/19	Report Title	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, one new risk has been escalated onto this risk register.

- **1942** - Eradicating the Trust's deficit by 2023/24. This risk replaces risk 1329 (Returning to financial balance by 2021). This risk reflects the Vision 2020 objective of reducing deficit to below £25M by 2020.

One risk has been removed from the risk register:

- **1329** – This risk has been closed and replaced by risk 1942 (as above).

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)
- **1942** - Eradicating the Trust's deficit by 2023/24

Risk **1367** (Failure to have a motivated and engaged workforce (culture)) was due to be re-written in January 2019. A new risk has been drafted however the decision was taken at Workforce Committee to delay the approval of this risk until the results of the staff survey have been received (expected early February 2019). This risk will come to Trust Board in March 2019.

Recommendation:

The Board is asked to:

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

Strategic Objective(s) and Principal Risks(s)

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

Strategic Objective	Principal Risk

✓ **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

JANUARY 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 29/01/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
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	Risk Closed - replaced with Risk 1942
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	12 ↓	=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	12 ↓	=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	15 ↑	=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	=16
1917	SO2 - Improve clinical outcomes and patient safety	Quality of Older Peoples Care	Director of Nursing & Quality			!16	=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 ↓	=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	16 ↑	=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	=16
1942	SO3 - Provide care within agreed financial limit	Eradicating the Trust's deficit by 2023/24	Director of Finance						!16

TRUST RISK PROFILE AS AT 29/01/2019

	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** **1942 – Eradicating the Trust's deficit by 2023/24** **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)					

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services			Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**		
13/11/2017	1688	Chief Operating Officer	Mandy Marsh	Inadequate Staffing Levels in Anaesthetic Department		
Description	Staffing Levels of anaesthetic department affecting capacity and safety of emergency/ICU/Maternity cover. Lack of emergency cover for on call / ICU / maternity both sites. This would result in the closure of high risk patients presenting to A&E for both adult and children and the inability to staff ITU. Update - High level meetings with COO and the anaesthetic team to seek solution.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 6 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	16/01/2019	18/02/2019

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. Update 29.01.19 - Business case currently with finance following workforce review. Implement new ways of working using support staff to maintain safe staffing levels and robust succession plan in view of extreme recruitment and retention issues.	**Action Plan Due Date**	18/12/2017 01/03/2019	**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 Well-led work ongoing with AQUA						**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	22/01/2019	18/02/2019	
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 Internal assurance panels						**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**	31/03/2019 31/03/2019 31/03/2019	**Action Plan Rating**	Moderate Progress Made Moderate 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 - planned completion 11/03/2019 Work Currently underway to review falls documentation Inability to consistently staff additional care bay Training for staff re: older people risks not currently provided - New Training Programme drafted and out for comments Environment not conducive to reabling patients and maintaining function, social interaction or orientation Environment not wholly adapted for additional/enhanced care needs eg dementia Lack of understanding of the impact of patients remaining in bed, in pads, with cot sides, not eating/drinking - New Training Programme Drafted and out for comments Lack of pathway/service availability to support patients with enhanced needs returning home- i.e lack of 24hour care in community to step down - Work underway with CCG, Community and LA colleagues to redesign pathway, Homefirst and Delirium/Dementia		
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	21/01/2019	28/02/2019
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 and work up discharge pathways group to rid of unnecessary delays which cause harm to						**Action Plan Due**	12/02/2019	**Action Plan**	Moderate

	patients who remain in the acute setting. 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 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. Continue to roll out Red2Green and education across all wards	**Date**	12/02/2019 12/02/2019 15/02/2019 12/02/2019 29/03/2019	**Rating**	Progress Made Moderate Progress Made Moderate Progress Made Moderate Progress Made Little or No 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 liasion 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	21/01/2019	28/02/2019
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 Merseycare 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						**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

	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				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	17/01/2019	12/02/2019
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 Completed Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team						Link to BAF	BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).					
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, high turnover.								
Controls	Leadership Master Classes Annual Shine Awards Workforce Strategy and OD Plan Junior Doctors Survey Friends and Family Test Valuing our People Working Group New post created for support of records system, recruitment process is ongoing. Staff Survey Action Plan						**Gaps in Controls**	lack of OD resource within organisation	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	19/12/2018	28/02/2019
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	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**						
15/01/2019	1942	Director of Finance	Steve Shanahan	Eradicating the Trust's deficit by 2023/24						
Description	If the Trust does not reconfigure services alongside capital investment in its infrastructure then it will not make significant financial improvements against the current deficit. Therefore, it won't comply with NHS Operational Planning and Contracting Guidance 2019/20 which states that all Trust deficits should be eradicated by 2023/24.									
Controls	Turnaround Director review of financial governance PMO in place to assisst the drive for internal efficiencies identified through Model Hospital GIRFT programme commenced with future roll out to other specialties proposed						**Gaps in Controls**	West Lancs CCG member of Healthier Lancashire and S Cumbria STP Uncertainty around future funding of CCG's and proposed restructure of tariff could lead to unrealistic financial assumptions Future clinical model not yet finalised Stress testing of high level financial assumptions not yet been undertaken Accuracy of PLICS and Model Hospital data		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	15/01/2019	18/02/2019	
Assurance	Acute Sustainability Programme Board-currently fortnightly FPI committee and Trust Board-monthly Hospital Management Board-monthly Performance Review Board-monthly						**Gaps in Assurance**			
Action Plan	Finance team to model the impact of the proposed change to the finance architecture to assess the improvement to the Trust's underlying financial deficit. Trust and CCG to work together to establish a financial model for the revised Frailty pathway; this could then be used to roll out for other services that have an element of service provision outside the Trust. Review of Model Hospital data to ensure its accuracy and relevance in driving Trust efficiency improvements						**Action Plan Due Date**	31/01/2019 20/03/2019 01/03/2019	**Action Plan Rating**	Actions Almost Completed Little or No Progress Made Little or No Progress Made

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	TB033/19	Report Title	Financial Position at Month 9
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. The Trust was £197,000 short of the plan for December, increasing the year to date deficit to £22.612 million which overall is £479,000 worse than plan.

Income and activity continues to over perform 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. Expenditure run rate remains consistent with previous two months.

The cumulative pay budgets overspend increased by £217,000 to £1.346 million (month 9 YTD). Agency spend this month is similar to November (£730,000 in month; YTD £5.9 million); the NHSI cap of £5.6 million has now been exceeded. Non-pay expenditure in December is marginally lower than November but the cumulative budget overspend has increased by £122,000 to £1.03 million. CIP underperformance on expenditure schemes contributes significantly to this.

The Forecast Outturn for 2018/19 remains unchanged at £28.8m deficit but there are a number of risks that need to be managed:

- Contract challenge by Commissioners for non-elective activity and income.
- Contract sanctions; Trust reduced month 9 YTD income by £1.1 million for sanctions due to date with breaches of the A&E 4 hour performance target being based on the local trajectory agreed with NHSI.
- CIP programme is forecast to be £600,000 lower than the £7.5 million plan although the Trust continues to work on additional schemes to mitigate this risk.
- Cost of resourcing additional beds which were introduced in significant reliance on off-framework agency to fill nursing shifts as the Trust has had to open additional beds in January following significant winter pressures.

Capital expenditure; the Trust is forecasting to spend its Capital Resource Limit (CRL) with mitigating plans agreed at Capital Investment Group. The Trust continues to require revenue support loans with monthly rolling 13 week cash forecasts being provided to NHSI.

The Trust has received earlier this month it's 2019/20 Control Total which is a deficit of £26.567 million before Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) allocation. If we agree, the Trust would benefit from non-recurrent funding of £18.271 million.

Recommendation:

The Board is asked to **receive** the Financial Position at Month 9.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

Previously Presented at:

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

Director of Finance Report

1. Purpose

1.1. This report provides the Board with the financial position of the Trust at Month 9, and the risks to delivering the forecast outturn of £28.8 million. The report also advises the board of the Trust's 2019/20 Control Total.

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 £197,000 short of the plan for December, increasing the year to date deficit to £22.612 million which overall is £479,000 worse than plan.

2.3. Income and activity continues to over perform for A&E attendances and non- elective admissions. This includes income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity.

2.4. Elective activity underperformance against plan has continued.

2.5. Expenditure run rate remains consistent with previous two months.

2.6. The cumulative pay budgets overspend increased by £217,000 to £1.346 million (month 9 YTD).

2.7. Agency spend this month is similar to November (£730,000 in month; YTD £5.9 million); the NHSI cap of £5.6 million has now been exceeded.

2.8. Non-pay expenditure in December is marginally lower than November but the cumulative budget overspend has increased by £122,000 to £1.03m. CIP underperformance on expenditure schemes contributes significantly to this.

2.9. The table below is the I&E statement for December:

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	111,557	113,368	1,811	11,884	11,985	101
PP, Overseas & RTA	1,387	1,040	801	(239)	120	71	(49)
Other Income	14,500	10,846	11,286	440	1,297	1,395	98
Total Income	**164,809**	**123,443**	**125,455**	**2,012**	**13,301**	**13,451**	**150**
Operating Expenditure							
Pay	(129,291)	(97,209)	(98,555)	(1,346)	(10,604)	(10,820)	(216)
Non-Pay	(53,152)	(40,003)	(41,033)	(1,030)	(4,463)	(4,584)	(121)
Total Expenditure	**(182,443)**	**(137,212)**	**(139,588)**	**(2,376)**	**(15,067)**	**(15,404)**	**(337)**
EBITDA	**(17,634)**	**(13,769)**	**(14,133)**	**(364)**	**(1,766)**	**(1,953)**	**(187)**
Non-Operating Expenditure	(11,217)	(8,412)	(8,420)	(8)	(935)	(937)	(3)
Retained Surplus/(Deficit)	**(28,851)**	**(22,181)**	**(22,552)**	**(372)**	**(2,700)**	**(2,890)**	**(190)**
Technical Adjustments	63	47	(60)	(107)	6	(1)	(7)
Break Even Surplus/(Deficit)	**(28,788)**	**(22,134)**	**(22,612)**	**(479)**	**(2,694)**	**(2,891)**	**(197)**

2.10. The Forecast Outturn for 2018/19 remains unchanged at £28.8m deficit but there remains a number of risks that need to be managed

2.10.1. Contract challenge by Commissioners for non-elective activity and income.

2.10.2. Contract sanctions; Trust reduced month 9 YTD income by £1.1 million for sanctions due to date with breaches of the A&E 4 hour performance target being based on the local trajectory agreed with NHSI.

2.10.3. CIP programme is forecast to be £600,000 lower than the £7.5 million plan although the Trust continues to work on additional schemes to mitigate this risk.

2.10.4. Cost of resourcing additional beds which were introduced in significant reliance on off-framework agency to fill nursing shifts as the Trust has had to open additional beds in January following significant winter pressures.

2.11. Capital expenditure; the Trust is forecasting to spend its Capital Resource Limit (CRL) with mitigating plans agreed at Capital Investment Group.

2.12. The Trust continues to require revenue support loans with monthly rolling 13 week cash forecasts being provided to NHSI.

2.13. The Trust has received earlier this month it's 2019/20 Control Total which is a deficit of £26.567 million before Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) allocation. If we agree, the Trust would benefit from non-recurrent funding of £18.271 million.

3. Income Performance

Elective

3.1. Elective activity is down by 11.68%; which is worth £1.091 million in income further impacted by theatre maintenance during the first two weeks of December and bed pressures on the Southport site.

3.2. The Trust's original forecast outturn assumed that the elective shortfall is brought back to plan although this is now unlikely it can be mitigated by additional non elective over-performance.

3.3. Outpatient performance has improved again in month despite activity YTD being 1.23% below plan. The activity case mix continues to generate a favourable variance (£312,000 YTD).

A&E

3.4. As reported in previous months, A&E attendances continue to over perform with activity up 5.2% year to date.

3.5. A & E attendances exceeded plan again this month and now contribute a favourable variance of £414,000 YTD.

Non Elective

3.6. 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 £1.296 million.

3.7. 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.

3.8. A joint letter was received from NHSI/NHSE on 10 January which stipulated that the

commissioners should pay for the CDU tariff as recommended in the MIAA report.

3.9. Overall non elective activity (including ACU and CDU activity) is generating £4.386 million more than plan after accounting for MRET.

Commissioning for Quality and Innovation payments (CQUINS)

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

3.11. 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.

3.12. No further income deductions for CQUIN have been made as performance had improved However, since month 9 closedown an assessment of the likely quarter 3 position has been made and it is now anticipated that total deductions will be £439,000 for the full year. Discussions with commissioners are ongoing to minimise this.

Sanctions

3.13. The Trust has been informed CCGs will impose sanctions in 2018/19 for non-compliance with operational and national performance standards.

3.14. The Trust has assumed that A&E breaches will be based on the Trust's NHSI planned trajectory and not on achieving 95%.

3.15. Based on performance in the first nine months sanctions of £1.06 million have been provided for which are forecast to be £1.6 million in a full year.

4. Expenditure

4.1. Underlying expenditure levels for pay have remained consistent in December; non-pay has reduced in comparison to November.

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. Non-consultant medical staff overspend is in medicine, surgery and paediatrics

4.4. The key areas for nurse overspend are the medical and surgical wards, A&E and theatres.

4.5. Non pay spend has reduced slightly in comparison to November, although cumulative overspend remains at 2.6% (before reserves and CIP).

5. Agency spend

5.1. The Trust has spent £730,000 on agency staff in December (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.

5.2. This takes the spend YTD to £5.9 million, £300,000 above the NHSI agency cap with another 3 months still left in the year.

5.3. As reported previously high levels of nurse agency continue in A&E, general medicine, general surgery and theatres.

5.4. There was a concerted effort by the nursing team to reduce the use of Thornbury agency which was successful until Christmas week when it increased considerably from an average of 14 shifts a week prior to 24th December rising to 33 shifts week commencing thereafter. This

resulted in spend being down £32,000 on the previous month to £262,000.

5.5. With 131 Thornbury shifts booked between New Year's Eve and 13th January to cover the escalation beds open with patients boarded on wards and 15 beds opened as ward 1, significant increase in cost is expected in January.

5.6. Overall nurse vacancy levels have reduced by 0.5% to 8.9% however, the reduction is in unregistered nurses only.

5.7. Bank fill has reduced in month; the focus continues to be recruiting to substantive posts.

5.8. The cost of providing cover for nurse sickness in December was £123,000 (bank £89,000; agency £34,000) based on the information provided by NHSP. Thornbury is excluded from this as there is no reason recorded for agency use with this provider.

5.9. As reported previously, a revised escalation procedure is in place for medical staff required on short notice (less than 7 days).

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

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

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

5.13. The cost of providing cover for medical sickness in December was £6,000 (based on the information provided by TempRE).

6. Cost Improvement Plan (CIP)

6.1. The Trust's I&E plan assumed a £7.0 million CIP was delivered in 2018/19 from both increased income and reduced expenditure.

6.2. 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.

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

	Annual	YTD			In Month			
	Plan £000	Plan £000	Actual £000	Var £000	Plan £000	Actual £000	Var £000	FOT £000
18/19 Plan	7,006	4,797	3,173	(1,624)	731	482	(249)	6,385
17/18/ balance to FYE	535	401	401	0	44	44	0	535
Total	7,541	5,198	3,574	(1,624)	775	526	(249)	6,920

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

6.5. This is expected to improve significantly when the CDU income is transacted although this has not yet been finalised as explained above.

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

7. Forecast Outturn 2018/19

7.1. The Trust's forecast outturn with NHSI remains at £28.8 million deficit.

8. Risks

8.1. Contract challenge by Commissioners for non-elective activity and income.

8.2. Contract sanctions; Trust reduced month 9 YTD income by £1.1 million for sanctions due to date with breaches of the A&E 4 hour performance target being based on the local trajectory agreed with NHSI. Forecast £1.3 million in full year.

8.3. CIP programme is forecast to be £600,000 lower than the £7.5 million plan although the Trust continues to work on additional schemes to mitigate this risk.

8.4. Cost of resourcing additional beds which were introduced in significant reliance on off-framework agency to fill nursing shifts as the Trust has had to open additional beds in January following significant winter pressures.

9. Cash

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

9.2. 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 (December's cash flow requirement was sent on 14th November 2018).

9.3. The Trust borrowed £2.09 million in December 2018.

9.4. As the Trust did not agree its control total, there is a punitive interest rate charge of 3.5% (normally 1.5%) on the Trusts revenue support loans.

9.5. Performance against the cash target in December was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,219	Brought forward balance.
Cash inflows	16,531	16,600	Forecast was accurate no material variance
Cash outflows	-16,531	-16,698	Forecast was accurate no material variance
Closing balance	**1,000**	**1,121**	

9.6. 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 £1.0 million bank balance at the end of the month.

9.7. The loan for January 2019 was £2.44 million and the request for February 2019 is £2.64 million.

9.8. The Board is asked to note that there remains a potential cash risk if the CCGs do not pay for the non-elective over-performance despite joint note from NHSE and NHSI requiring them to do so to avoid further review support loans at a punitive interest rate.

10. Capital

10.1. In month capital spend was £894,000 with the largest elements relating to the A&E Redesign Project (£262,000), Datacentre (£179,000) and the Patient Service Signposting System (£149,000).

10.2. Year to date spend is £4.056 million.

10.3. Commitments now stand at £1.038 million with the largest areas including £366,000 of IT approved orders (not yet received), £167,000 of medical equipment, and £72,000 on A&E phase 3, £99,000 on the Ormskirk Theatre UPS and £193,000 for sexual health accommodation.

10.4. Additional funding of £456,000 was received in December for the Strata Patient Service Signposting System and the capital budget has been increased by this amount.

10.5. A demonstration day, showcasing anaesthetic machines took place in December with the view to place an order with the preferred supplier to replace all the Trust's machines prior to the end of March.

10.6. Capital Investment Group is fully sighted on being able to spend in full the capital allocation.

11. 2019/20 Control Total

11.1. The 2019/20 control total before Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) allocation is a deficit of £26.567 million.

11.2. If we agree, the Trust would benefit from non-recurrent funding of £18.271 million (PSF £3.464 million; FRF £14.807 million) which would give a final control total deficit of £8.296 million.

	£000
Control Total before PSF and FRF allocations	**-26.567 Deficit**
Non recurring PSF allocation	**3.464**
Non recurring FRF allocation	**14.807**
2019/20 control total (including PSF and FRF funding)	**-8.296 Deficit**

11.3. FRF is a new fund that will be targeted at trusts that agree control totals, deliver efficiencies, but still record a deficit.

11.4. Trusts and systems will be expected to produce recovery plans during 2019/20 and beyond and further guidance is expected.

11.5. There is no performance, or any other requirements linked to the receipt of FRF funding.

11.6. The new financial regime will phase out the control total and PSF in 2020/21.

11.7. There are no national financial reserves in place for 2019/20, and the control total letter makes the identification and management of risk a key component of organisation and system planning and will test the internally consistency between activity, workforce and finance.

11.8. NHSI and the DHSC are also reviewing the cash and capital regimes for providers and more detail is expected in the comprehensive spending review in the autumn.

12. Recommendation

12.1. The Board is asked to **receive t**he Financial Position at Month 9 report.

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/12/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	126,075	(715)	372
Other assets	1,382	1,167	(215)	(19)
TOTAL NON CURRENT ASSETS	**128,172**	**127,242**	**(930)**	**353**
CURRENT ASSETS				
Inventories	2,454	2,451	(3)	60
Trade and other receivables	9,591	13,603	4,012	(77)
Cash and cash equivalents	1,079	1,120	41	(99)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**17,174**	**4,050**	**(116)**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(26,102)	(871)	(654)
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)	(164)	307	2
TOTAL CURRENT LIABILITIES	**(32,199)**	**(32,794)**	**(595)**	**(652)**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(15,620)	3,455	**(768)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**111,622**	**2,525**	**(415)**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(91,348)	(24,733)	(2,090)
PFI/Finance lease liabilities	(13,807)	(13,699)	108	71
DH Capital loan	(1,400)	(1,000)	400	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(106,313)**	**(24,213)**	(2,019)
TOTAL ASSETS EMPLOYED	**26,997**	**5,309**	**(21,688)**	**(2,434)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	98,104	863	456
Retained earnings	(83,484)	(106,035)	(22,551)	(2,890)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**5,309**	**(21,688)**	**(2,434)**

In month material movements are as follows:

Spend on capital projects in the month increased the net value of non-current assets by £372k (additions exceeded depreciation).

PDC of £456k was received for the Strata e-Referral System, which will be implemented over 2 years.

Trade and other payables increased by £654k. This is a combination of an increase in accruals and a decrease in the value of invoices owed to suppliers.

DH Revenue loans increased by £2.1m in the month

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	Actual 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)	(2,471)	(1,509)	(2,085)	(1,428)	(23,850)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)	(20)	0	(6)	(12)			(17)	(180)
Depreciation and Amortisation	523	524	523	524	523	524	518	522	522	505	505	506	6,219
Impairments and Reversals	0	0	0	0	0	0	0	0	0				0
(Increase) in Inventories	(50)	59	(83)	0	(39)	19	95	62	(60)	(3)			0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818	(805)	(540)	(4,585)	100	650	1,200	1,943	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	(144)	492	472	1,324	(890)	(306)	(1,016)	(1,416)
Increase in Provisions	(3)	(3)	(61)	82	0	(3)	7	0	(7)	(30)		(22)	(40)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(1,465)	(2,221)	(1,097)	(5,042)	(604)	(1,277)	(686)	(34)	(19,267)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	5	4	4	5	2	2	1	35
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(8)	0	(2)	(35)	(150)	(298)	(300)	(1,002)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(214)	(114)	(114)	(1,515)	(738)	(738)	(737)	(5,889)
Receipts from disposal of fixed assets	0	0	1	2	0	0	37	31	1				72
Receipt of cash donations to purchase capital assets	5	52	30	18	20	20	0	6	12			17	180
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(197)	(73)	(75)	(1,532)	(886)	(1,034)	(1,019)	(6,604)
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				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	0				(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(554)	(122)	13	(8)	(264)	(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)	(165)	(172)	(199)	(1,052)	(2,957)
Interest element of finance lease	0	0	0	0	0	0	(262)	(5)	0		(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	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	2,038	2,163	1,600	1,053	25,792
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**(1,076)**	**194**	**(9)**	**(98)**	**0**	**(120)**	**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	1,120	1,120	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**	**1,120**	**1,120**	**1,000**	**1,000**	**1,000**

NHS Southport and Ormskirk Hospital NHS Trust

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2018/19 £'000	YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Original Plan	Plan	Actual	Variance	Actual	Actual	Plan (Rev)	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0072	870	635	349	286	70	97	735	516	219
	Beds / Trolleys	G0060	50	50	51	(1)	0		50	51	(1)
	Sub total MEDICAL DEVICES		**920**	**685**	**400**	**285**	**70**	**97**	**785**	**567**	**218**
IM&T	Electronic Patient Record	F6409	190	170	64	106	60		190	124	66
	Patient Service Signposting	G0081	0	455	149	10	0	306	455	455	0
	Vitalpac	G0007	30	24	14	10	0		30	14	16
	eDMS	F6447	160	120	15	105	0		160	15	145
	Wireless network upgrade	G0073	150	302	195	107	0		302	195	107
	Server warehouse infrastructure incl. storage	G0078	75	75	36	39	0		75	36	39
	Telephony system replacement	G0059	120	95	0	95	0		95	0	95
	Cyber security	G0071	50	38	12	26	0		50	12	38
	Fixed network infrastructure	F6498	100	76	21	55	0		100	21	79
	Datacentre	G0075	50	50	184	(134)	0		50	184	(134)
	Virtual desktop infrastructure	G0076	25	20	2	18	0		25	2	23
	Equipment refresh	G0077	50	38	5	33	0		50	5	45
	Sub total IM&T		**1,000**	**1,463**	**698**	**459**	**60**	**306**	**1,582**	**1,064**	**518**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	400	(50)	226	(276)	7		200	233	(33)
	Southport A&E Redesign	G0068	350	753	730	23	0	72	753	802	(49)
	Ward reconfigurations	G0064	140	140	134	6	0		140	134	6
	Medical gasses	G0067	30	30	43	(13)	0		30	43	(13)
	UPS Theatre	G0053	50	140	35	105	0	99	140	134	6
	Waste management storage facilities	G0080	100	100	6	94	0		100	6	94
	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	133	1	0		134	133	1
	Spinal isolation works		200	200	(9)	209	0		200	(9)	209
	Additional Car Parking		0	50	3	47	0		50	3	47
	Sexual Health Accomodation	G0079	0	260	2	258	30	193	260	225	35
	Doctor's Mess Facilities	G0082	0	0	25	(25)	19		0	44	(44)
	Capital team	F6305	155	74	137	(63)	0	36	155	173	(18)
	Aseptic isolator		30	75	0	75	0		30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**1,845**	**2,035**	**1,484**	**551**	**56**	**400**	**2,321**	**1,940**	**381**
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**	**155**	**184**	**114**	**70**	**7**		**258**	**121**	**137**
	Capital plan excluding donations and IFRIC 12		**4,020**	**4,467**	**2,720**	**1,441**	**192**	**803**	**5,046**	**3,715**	**1,331**
OTHER	Donated assets	000000	120	90	163	(73)			120	163	(43)
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	2,168	808	1,173	(365)		235	1,488	1,408	80
	Sub total Donations and IFRIC 12		**2,288**	**898**	**1,336**	**(438)**	**0**	**235**	**1,608**	**1,571**	**37**
	TOTAL CAPITAL SPEND		**6,308**	**5,365**	**4,056**	**1,003**	**192**	**1,038**	**6,654**	**5,286**	**1,368**

Capital Actual spend is £4,056k with a further £1,230k committed.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	**TB034/19**	**Report Title**	**Guardian of Safe Working - Quarterly Report**
Executive Lead	Terry Hankin, Executive Medical Director		
Lead Officer	Dr Ruth Chapman, Guardian of Safe Working until 31st January 2019		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The report highlights the following:

- Southport Doctor's Mess enlargement is finished, still awaiting new furniture
- Exception Reports are reduced by 80% compared with the same period last year – this is attributed to the additional staffing provision in Medicine
- Amendment required to Surgical Acting Down Policy
- An Interim GOSW has been appointed

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

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

Southport and Ormskirk Hospital NHS Trust

THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT 1st November 2018 – 24th January 2019

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)

	PERIOD: 01/11/18-24/01/19	PERIOD: 20/10-23/01/18
Exception Reports ERs	14	95
Completed ERs	9/14*	22/72
Trainees	8*	15
Episodes	16*	103
Review Interview Held	13/16*	56/103
A&E	0	0
Medicine	9*	88
Surgery	3*	3
T & O	0	2
Anaesthetics	0	0
Ophthalmology	0	0
Paediatrics	2	2
Obs & Gynae	0	0
GP	0	0

*5 not yet overdue

AREAS	First Quarter: 01/08-31/10/18	Second Quarter: 01/11/18-24/01/19
Exception Reports ERs	13	13
Completed ERs	11/13	9/14*
Trainees	7	7*
Episodes	18	15*
Review Interview Held	11/13	13/16*
A&E	0	0
Medicine	8	9*
Surgery	0	3*
T & O	5	0
Anaesthetics	0	0
Ophthalmology	0	0
Paediatrics	0	2
Obs & Gynae	0	0
GP	0	0

*5 not yet overdue

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

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

2. MEDICINE

Eight Clinical Fellows have been appointed and are awaiting visas. They 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. Although Medicine has again been under intense pressure the number of Exception Reports has reduced by 80% compared with the same period last year. Trainees at January Trainee Doctor Forum explained having additional F1s shifts in the evening and at weekends have made a significant difference to the workload.

Four SAS doctors are in post.

Whiston has agreed additional staff are necessary to cover the shortfall in Phlebotomy capacity. The Business case will be submitted to BDISC for approval on 12th February.

3. PAYMENT AND FINES

Payment for additional hours generated from Exception Reports from 1st November 2018 to 24th January 2019 was £110.13.

In Medicine it has been necessary to compensate additional hours by payment rather than TOIL in the last Quarter. Some payments will be made in February and reported in the May Quarterly GOSW Report.

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

4. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

All Trust Rotas are 2016 compliant.

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 0 episodes of Double Bleep carrying reported.

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. TRAINEE CONCERNS

The Trainee Doctor Forum (TDF) continues to meet monthly. Trainee attendance remains low. Trainees continue to contact GOSW with concerns outside of the Forum.

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

8.1 Surgery

The EMD has given assurance if the shifts remain unfilled, this should not result in Double Bleep carrying. However the Surgical Acting Down policy will need updating to reflect this.

ACTION: *GOSW and EMD will continue to monitor Surgery and T & O closely.*
ACTION: *EMD will ensure acting down occurs and the Surgical Acting Down Policy is revised.*

8.2 Facilities

Trainees have been able to use the enlarged Doctors' Mess from 21st December. The Mess is now a much more welcoming environment. However there was a problem with the furniture order, so it only has minimal furniture at present.

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 refurnishing*
ACTION: *GOSW to monitor initial improvements in Ormskirk Mess*

9. GOSW's ROLE

Core GOSW work load has improved. Excellent administration support of 4 hours/week has been in place. However the member of Medical HR who has been providing GOSW support is moving to a new role and therefore more training will be needed. The GOSW role needs to be taken forward, as intended in the 2016 Junior Doctors' Contract, as a disseminator of information, with others providing the solutions.

Appointment of both a permanent Executive Medical Director and a new Director of Medical Education has already resulted in increased engagement at Trainee Doctor Forum.

My tenure as GOSW ends on the 31st January 2019 and recruitment process for my successor is underway, with Dr Sharryn Gardner being appointed as Interim GOSW prior to interview.

Dr Ruth Chapman
Guardian of Safe Working
24th January 2019

Appendix 1
EXCEPTION REPORT OVERVIEW (31st October 2018-24th January 2019)

Exception Reports 13 by 7 trainees
8* Medicine
2 Paediatrics
3* Surgery
9/13* Completed on system
15* Episodes

Exception Episodes

Medicine

- 10* Episodes
- 8* Extra Hours Episodes
- 2* Extra hours and Service Support Episodes
- 1 Education

Extra Hours

- 8/10 Episodes Completed
- 10/10 Episode interviews have taken place
- 6/10 Episode Interviews within 14 days*
- 2/10 Awaiting trainee sign off
- 12.50 Extra hours worked, 0.00 hours TOIL agreed
- 12.50 hours. Overtime pay agreed
- 0 Episodes overdue review
- 0 days overdue

Extra hours and Service Support

- 2/2 Episodes Completed
- 2/2 Episode interviews have taken place
- 0/2 Episode Interviews within 14 days, 5.00 Extra hours worked, 0.00 hours TOIL agreed
- 5.00 hours Overtime pay agreed
- 0/2 Awaiting trainee sign off
- 0 Episodes overdue

Paediatrics

- 2 Episodes
- 2 Extra Hours Episodes

Extra Hours

- 2/2 Episodes Completed
- 2/2 Episode interviews have taken place

- 2/2 Episode Interviews within 14 days
- 0/2 Awaiting trainee sign off, 1.00 Extra hours worked 1.00 hours TOIL agreed, 0.00 hours Overtime pay agreed
- 0 Episodes overdue review
- 0 days overdue

Surgery

Extra Hours

- 3* Episodes
- 3* Extra Hours Episodes
- 1/3* Episodes Completed
- 1/3* Episode interviews have taken place
- 1/1* Episode Interviews within 14 days
- 0/1 Awaiting trainee sign off, 2.00 Extra hours worked, 2.00 hours TOIL agreed, 0.00 hours Overtime pay agreed
- 0 Episodes overdue review
- 0 days overdue

* not yet overdue

Appendix 2

VACANCIES AS OF 1 FEBRUARY 2019

AED Adult and Paediatric

Consultant	6 vacancies in 12 posts (3 longterm locums) (1 SAS acting up)
SAS	2.5 vacancies in 8 posts (but 1acting up)
ST3	1 vacancies in 2 posts
FY2 – ST2	2.4 vacancies in 8 posts
Clinical fellow	1.5 vacancies in 4.5 posts
FY1	0 vacancy in 2 posts

Anaesthetics

Consultant	6 vacancies in 20 posts (1 locum in post)
SAS	3 vacancy in 16 posts (1 awaiting start date)
ST3	1 vacancies in 3 posts
FY2 – ST2	0 vacancy in 8 posts (3 not be on call until May19)

Dermatology

Consultant	0 vacancies in 2 posts
SAS	2 vacancies in 6 posts
ST3	2 vacancies in 3 posts

GP Practice

FY2 – ST2	1 vacancy in 9 posts

Haematology

SAS	0 vacancies in 1 post

MFU Medical Staff

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

Medicine

Consultant	5 vacancies in 20 posts (4 locums in post) 2 vacancies in 11 person rota (2 locums in post)
SAS	2 vacancy in 5 posts (1 locum in post)
ST3 and above	1 vacancy in 10 posts (1 parental leave)
FY2 – ST2	1 vacancy in 16 posts (1 locum in post) .6 due to PTW
FY1	0 vacancies in 16 posts

Obstetrics and Gynaecology

Consultant	2.5 vacancies in 13 posts (1 locums in post)
SAS	2 vacancies in 3 posts
ST3	2 vacancy in 5 posts (1 parental leave)
FY2 – ST2	1 vacancies in 8 posts

Ophthalmology

Consultant	2 vacancies in 3 posts (1 appointed with March 19 start date)
SAS	0 vacancies in 5.7 posts
ST1-7	0 vacancies in 1 posts

Orthopaedics

Consultant	1 vacancies in 10 posts
SAS	2 vacancy in 8 posts
ST3	2 vacancy in 2 posts
FY2 – ST2	0 vacancies in 8 (10 in post)
FY1	0 vacancies in 3 posts

Paediatrics

Consultant	0 vacancies in 6 posts
SAS	0 vacancies in 5 posts
ST3	0 vacancies in 4 posts
FY2 – ST2	0 vacancies in 9 posts 0 in 8 person rota
FY1	0 vacancies in 1 post

Psychiatry

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

Sexual Health

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

Spinal Injuries

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

General Surgery

Consultant	0 vacancies in 7 posts
SAS	2 vacancies in 5 posts (2 locums in post)
ST3	2 vacancies in 3 posts
FY2 – ST2	3 vacancies in 9 posts (1 locum in post)
FY1*	0 vacancies in 8 posts

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

Urology

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

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

Southport and Ormskirk Hospital NHS Trust

GOSW Feb 19 Trust Board Report Action Log
Matters Arising Action Log
Feb-19

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 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	**Completion rate significantly improved. 3 trainees have received Payment via the new system**	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	**No episodes of Double Bleep carrying reported to GOSW in the last Quarter.**	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 - 5 Exception report given as Payment, most due to Winter pressures**	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, completed on 21st December 2018. Still awaiting new furniture. There has been an issue with procurement**	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/GOSW	Aug-18	Aug-18	**4 SAS doctors employed and in post. 8 Clinical Fellows appointed and awaiting visas. Additional F1 shifts have supported Clinical Care over the last 4 weeks**	GREEN
GOSW May Trust Board Report	May-18	**MIAA identified Terms of Reference for TDF required**	GOSW to write Terms of Reference for Trainee Doctors Forum by June 2018	GOSW	Jun-18	Jun-18	**ToR written and agreed by Medical Education Committee**	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**	RED
GOSW Nov Trust Board Report	Jan-19	**Surgery Acting Down Policy**	RC to discuss with EMD completion of an Acting Down Policy in Surgery that does not include Double Bleep Carrying	EMD	Feb-19	Feb-19	**RC discussed with EMD, EMD to ensure appropriate policy in place**	AMBER

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

6 February 2019

Agenda Item	**TB035/18**	**Report Title**	**Monthly Safe Nurse & Midwifery Staffing Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery Therapies		
Lead Officer	Fiona Barnes Deputy Director of Nursing Carol Fowler Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

This report presents the safer staffing position for the month of December 2018.

For the month of December 2018 the Trust reports safe staffing against the national average (90%) at 93.61%.

Within the report there is a summary improvement plan to address the gap analysis of the Trust compliance with National Quality Board '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)'.

The committee is advised that the current nurse staffing risk reports as extreme (Major - 4 x Likely – 4 RR =16) via the risk register (ID 1862). A risk assessment has also been undertaken in regards to the use of a non-framework nurse agency.

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)*

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

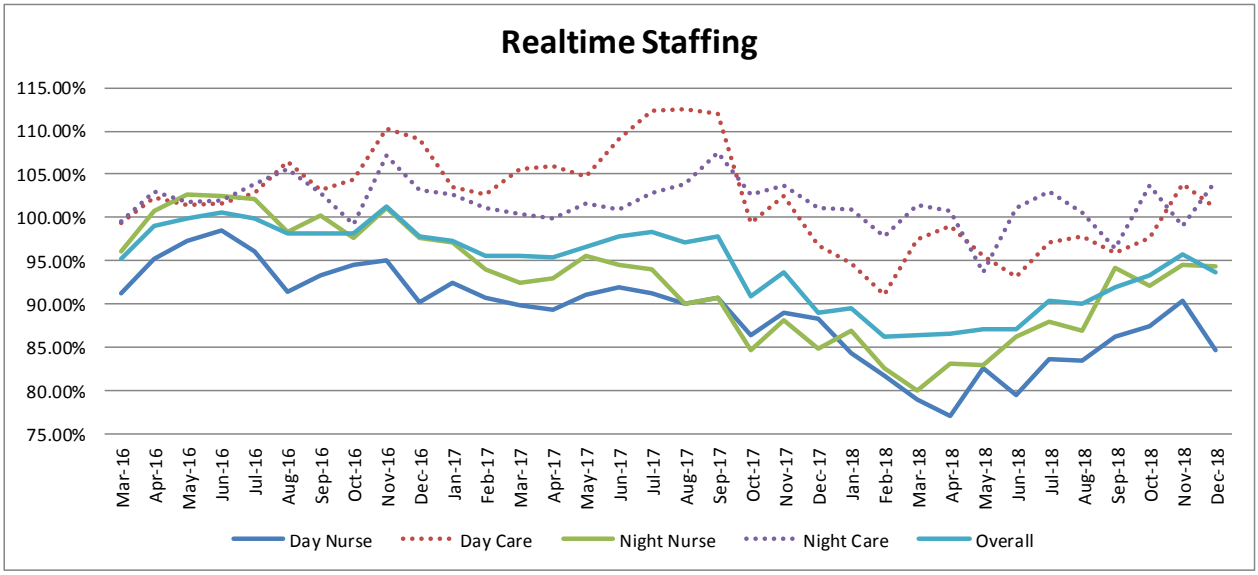
1. Introduction

This report provides an overview of the staffing levels in December 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 December 2018 was 93.61% compared to November 2018 that was 95.76% and 93.25% in October 2018 (Appendix 1).

- 84.59% Registered Nurses on days
- 94.36% Registered Nurses on nights
- 101.13% Care staff on days
- 104.12% Care staff on nights

There has been a slight decrease in our overall fill rate due to sickness and the underlying vacancy position.



The overall CHPpD for the Trust remains 8.3hr (Appendix 1) and slightly above the national average, there are a number of wards that have a low CHpPD, for example Frail & Elderly continue to show 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.

2. December Safe Staffing

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

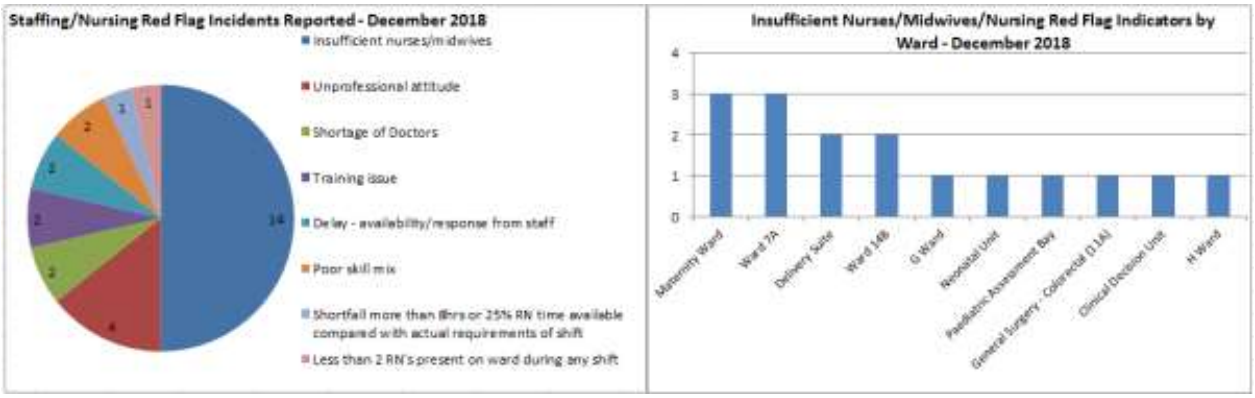
	Funded WTE	Contracted WTE	Dec Total Vacancy
Registered	864.63	774.56	90.07
Non-registered	377.98	357.46	20.52
Total	1242.61	1132.02	110.59

Registered nurse vacancy against overall establishment has remained static in month.
Non – registered vacancy has reduced / improved in month by 6 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 ratified through the Nursing and Midwifery Group in January 2019.

Further to this the Trust remains engaged with local recruitment opportunities hosting its next Registered Nurse recruitment event Saturday February 2nd 2019 in the Clinical Education Centre SDGH site 11- 3pm.

Further scrutiny of roster performance continues to be 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 December 2018



28 staffing incidents reported in December with 2 of these through Datix against the nursing red flag criteria. Overall reported incidents have increased by 4 against the previous month. 16 of these incidents highlight insufficient nurses/midwives or nurse shortfalls,double those reported in the previous month. The highest reported numbers were on Maternity, with a total of 5 reported.

4. Trust compliance with relevant & recent NICE & NQB guidance

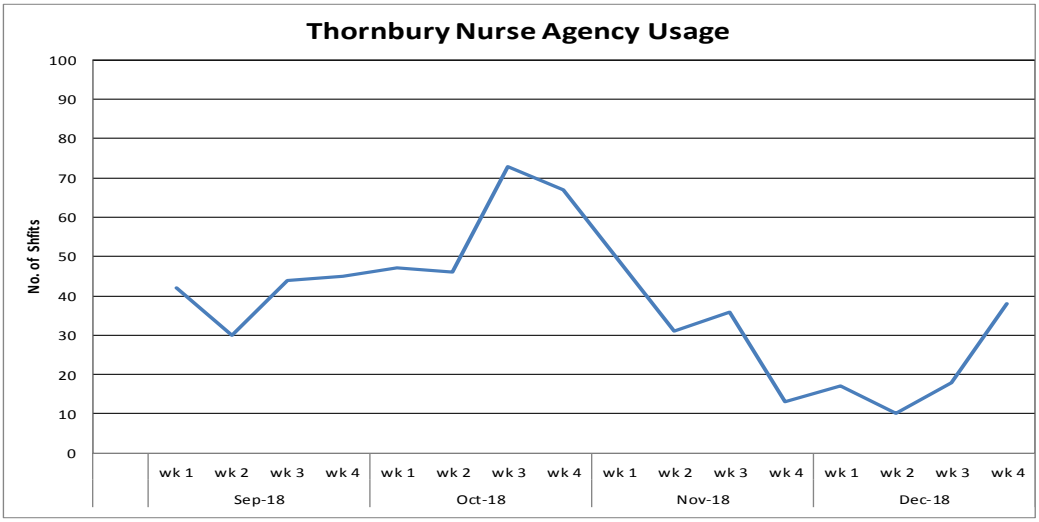
A gap analysis of recommendations from the following national guidance has been completed and was shared with Trust Board in early January 2019.

- 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)
- 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)

A combined improvement plan has been developed and is progressing against planned timeframes, see appendix 2. This month the Recruitment & Retention ToR to be ratified by NM Group in January 2019 and the Escalation Process & Establishment Review SOP are in draft format to finalise next month.

5. Non Framework Nurse Agency Usage

Over the past month there has been an increase in the number of non framework nurse agency shifts used to maintain patient safety. This is due to an increase in short term sickness and, at the end of December, the increase in escalation capacity.



With the increased use of a non-framework nurse agency a risk assessment has now been undertaken and is on the trust risk register. The rating is currently 9, high risk (ID1941). The Head of Resource and Assistant Director of Workforce will continue to monitor the risk on a monthly basis.

6. Recommendations

The Trust Board is asked to note the content presented in this paper and support the on-going plans to achieve and sustain compliance against national guidance.

Fiona Barnes
Deputy Director of Nursing

Carol Fowler
Assistant Director of Nursing – Workforce

Appendix 1: Care Hours per Patient Day (CHPPD – December 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	1,351.75	1,155.08	918.00	1,483.75	1,091.75	1,031.75	727.50	625.00	828	85.5%	161.6%	94.5%	85.9%	2.6	2.5	5.2		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	774.50	648.50	361.00	516.50	728.00	680.00	369.50	338.50	265	83.7%	143.1%	93.4%	91.6%	5.0	3.2	8.2		
E A U	300 - GENERAL MEDICINE	1,689.75	1,527.25	1,058.00	1,131.00	1,088.50	1,027.50	733.50	685.00	519	90.4%	106.9%	94.4%	93.4%	4.9	3.5	8.4		
FESS Ward	300 - GENERAL MEDICINE	1,557.58	1,074.83	1,365.50	1,312.25	1,104.50	1,040.00	738.50	730.00	832	69.0%	96.1%	94.2%	98.8%	2.5	2.5	5.0		Risk assessed by ward manager and matron - no patient harm caused.
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,314.00	1,070.83	1,121.50	1,445.58	1,111.00	774.00	731.00	993.50	794	81.5%	128.9%	69.7%	135.9%	2.3	3.1	5.4		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,603.50	1,516.25	1,356.00	1,405.98	1,106.25	1,094.25	737.50	774.00	900	94.6%	103.7%	98.9%	104.9%	2.9	2.4	5.3	Y	Registered nurse requirement for the CBU risk assessed to ensure all clincal areas safe - Staff redeployed to other area for part of the shift to assure pateint safety. No patient harm occurred directly relating to staffing in this area.
Short Stay Unit	300 - GENERAL MEDICINE	1,494.25	1,130.00	1,088.00	1,747.25	737.00	1,086.50	732.50	898.50	847	75.6%	160.6%	147.4%	122.7%	2.6	3.1	5.7		Risk assessed by ward manager and matron - no patient harm caused.
Ward 15a General Med	300 - GENERAL MEDICINE	1,116.75	989.61	914.25	1,635.00	1,096.50	1,038.25	740.00	1,444.25	714	88.6%	178.8%	94.7%	195.2%	2.8	4.3	7.2		
Stroke Ward	300 - GENERAL MEDICINE	1,391.53	1,218.65	948.50	1,070.25	1,094.50	1,059.00	729.00	669.00	555	87.6%	112.8%	96.8%	91.8%	4.1	3.1	7.2		
Rehab & Discharge Lounge	314 - REHABILITATION	1,171.75	1,096.25	1,053.25	1,536.83	737.00	713.50	720.00	857.00	710	93.6%	145.9%	96.8%	119.0%	2.5	3.4	5.9		
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,332.00	1,311.25	1,622.25	1,585.65	729.00	1,027.25	741.50	1,321.00	840	98.4%	97.7%	140.9%	178.2%	2.8	3.5	6.2		
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,787.25	1,027.50	1,709.00	1,185.50	727.00	741.50	371.00	478.00	485	57.5%	69.4%	102.0%	128.8%	3.6	3.4	7.1		Attributed to Short term sickness of trained. All levels of staff supported with additional shifts or longer shifts to mitigate the risk of non fill. Additional HCA was requested nightly due to high acuity and specialing X3 patients.
Ward H	110 - TRAUMA & ORTHOPAEDICS	743.00	402.00	744.00	309.00	740.00	428.00	371.00	71.00	59	54.1%	41.5%	57.8%	19.1%	14.1	6.4	20.5	Y	Risk assessed for the site requirements stafing versus activity
Surgical Ward	100 - GENERAL SURGERY	1,327.50	1,044.50	1,108.75	887.00	742.50	717.00	743.00	347.00	522	78.7%	80.0%	96.6%	46.7%	3.4	2.4	5.7		Attributed to trained staff being transferred to support another area plus short term sickness. Risk assessed and area supported to ensure patient safety .
Spinal Injuries Unit	400 - NEUROLOGY	3,869.25	3,459.08	3,610.50	3,212.58	2,862.75	2,662.50	1,491.00	1,380.00	1,190	89.4%	89.0%	93.0%	92.6%	5.1	3.9	9.0		
Ward G	101 - UROLOGY	1,115.00	801.00	728.50	539.00	738.00	678.00	366.50	306.50	184	71.8%	74.0%	91.9%	83.6%	8.0	4.6	12.6		Risk assessed for the site requirements stafing versus activity
TOTAL		**23,639.37**	**19,472.58**	**19,707.00**	**21,003.12**	**16,434.25**	**15,799.00**	**11,043.00**	**11,918.25**	**10244**	**82.37%**	**106.58%**	**96.13%**	**107.93%**	**3.44**	**3.21**	**6.66**		

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		4,066.17	3,377.09	1,937.75	1,413.75	3,415.50	3,154.25	740.00	847.50	N/A	87.58%	112.84%	96.76%	91.77%	N/A	N/A	N/A		
Ambulatory Care Unit		384.00	290.00	541.33	339.83	156.02	13.52	161.00	116.00	30	75.52%	62.78%	8.66%	72.05%	N/A	N/A	N/A		Short term sickness on unit with establishment not reflective of 24/7 requirements currently. Risk assessed and supported across the EAU.
TOTAL		**4,450.17**	**3,667.09**	**2,479.08**	**1,753.58**	**3,571.52**	**3,167.77**	**901.00**	**963.50**	**30**	**82.40%**	**67.60%**	**70.74%**	**106.94%**	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	4,817.50	3,975.23	1,133.75	1,002.75	4,077.50	3,527.52	1,116.00	892.00	352	82.52%	88.45%	86.51%	79.93%	21.3	5.4	26.7		

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	1,580.50	1,637.17	371.00	347.50	1,484.50	1,483.83	371.50	348.00	67	103.59%	93.67%	99.96%	93.67%	46.6	10.4	57.0		
Maternity Ward	501 - OBSTETRICS	1,092.73	1,123.73	729.08	669.08	741.75	798.50	370.50	480.25	303	102.84%	91.77%	107.65%	129.62%	6.3	3.8	10.1		
MAU	501 - OBSTETRICS	1,169.50	1,011.17	349.50	349.50	740.50	716.50	368.00	368.50	81	86.46%	100.00%	96.76%	100.14%	21.3	8.9	30.2		
TOTAL		**3,842.73**	**3,772.07**	**1,449.58**	**1,366.08**	**2,966.75**	**2,998.83**	**1,110.00**	**1,196.75**	**451**	**98.16%**	**94.24%**	**101.08%**	**107.82%**	**15.01**	**5.68**	**20.70**		

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	1,110.25	1,077.50	363.58	264.58	1,115.50	1,122.25	144.00	12.00	226	97.05%	72.77%	100.61%	8.33%	9.7	1.2	11.0		
Paediatric Unit	420 - PAEDIATRICS	4,109.73	3,539.48	1,097.00	1,137.25	2,226.50	2,063.75	741.00	693.00	347	86.12%	103.67%	92.69%	93.52%	16.1	5.3	21.4		
TOTAL		**5,219.98**	**4,616.98**	**1,460.58**	**1,401.83**	**3,342.00**	**3,186.00**	**885.00**	**705.00**	**573.00**	**88.45%**	**95.98%**	**95.33%**	**79.66%**	**13.62**	**3.68**	**17.29**		
PLANNED		14,991.50	12,020.56	10,656.75	8,721.48	10,616.75	9,781.77	5,200.00	4,795.50	**3,632**	80.18%	81.84%	92.14%	92.22%	5.4	3.4	9.7		
URGENT		17,915.53	15,094.34	12,663.08	15,037.97	13,466.52	12,712.52	7,860.00	8,978.25	**6,994**	84.25%	118.75%	94.40%	114.23%	6.9	3.7	5.9		
W&C		9,062.72	8,389.05	2,910.17	2,767.92	6,308.75	6,184.83	1,995.00	1,901.75	**1,024**	92.57%	95.11%	98.04%	95.33%	6	3.9	18.8		
TRUST TOTALS		**41,969.75**	**35,503.95**	**26,230.00**	**26,527.37**	**30,392.02**	**28,679.12**	**15,055.00**	**15,675.50**	**11,650**	**98.16%**	**94.24%**	**101.08%**	**107.82%**	**4.9**	**3.4**	**8.3**		

Southport and Ormskirk Hospital NHS Trust

Safe Staffing Improvement Plan

Recommendations from Safe Staffing for Adult Wards, NQB July 2016

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
Development of an Establishment Review – Standard Operating Procedure (SOP)	Ratified SOP through Nursing, Midwifery (NM Group)	DDoN	January 2019	Currently in draft format awaiting outcome of 'Developing workforce safeguards' NHs Improvement October 2018	A
Implementation of the 'Red Flag' system on Data	Red flag summary as part of monthly safer staffing report	DDoN	December 2018	Shared with Matrons & Ward Managers. Datix format to facilitate Red Flag	G
Review & update of the Health roster Policy	Ratified health roster policy available on trust intranet	Assistant director of workforce	January 2019	Draft format	A
Development of the Enhanced Levels of Care guidelines	Ratified SOP through Nursing, Midwifery (NM Group)	Head of safeguarding	February 2019	Meeting to review scope of project continue	A
Development of the Clinical Metrics	Clinical metrix dashboard	DDoN/quality matron	February 2019	Draft clinical metrics formatted however, limited capacity within the BI team	A
Consider ward co-ordinator SOP training	Discussion with HoN & Matrons regarding this requirement	DDoN	February 2019	Planned for January Matrons meeting	A
Professional Learning Communities for Ward Managers– to include training opportunities in regard to budget setting & workforce planning	PLC to be set up in the new year	DDoN	February 2019	Not due to commence until New Year	A
Update SafeCare module 'criteria' in line with SNCT	SafeCare criteria reflects SNCT	DDoN/ Assistant Director of workforce	April 2019	To commence when Nurse Staffing review completed	A
Review needs of students and any other 'trainee' posts within the clinical setting	Safe staffing report that reflects the outcome of the establishment review will incorporate dedicated support for students	DDoN	March 2019	This will form part of the Staffing Review and will not commence until December 2018	A
To convert the Task & Finish group to a permanent meeting to address Recruitment & Retention. ToR to be ratified by NMG / Workforce Committee.	R&R meeting set up with ToR	DDoN	February 2019	Current T&F group in agreement. ToR to be drafted and shared. Due to commence in February 2019	A

Recommendations for 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

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
Compare staffing with peers: Organisation compares local staffing with peers taking into account local differences	S&O Model Hospital data to be accurate and understood by key staff	DDoN/ADF	May 2019	Trust wide Model Hospital Data Group set up to commence in February 2019	**A**
Mandatory training, development and education: Frontline staff clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing	To consider a workshop for ward co-ordinators to enhance the understanding of staffing escalation process	DDoN	May 2019	Due to commence in the Spring	
The organisation develops its staff skills, underpinned by knowledge and understanding of public health and health, wellbeing & prevention	To be part of future training opportunities for HCA & registered staff	Clinical T&D	July 2019	Awaiting confirmation from local college regarding opportunities for training programmes	**A**
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	Scope of competencies currently in place	**A**
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	DDoN	July 2019	On-going	**A**
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 therefore need to consider implementation	To be confirmed			
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	DDoN	May 2019	Scoping exercise to understand current trust-wide position	**A**
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	Draft SOP in progress	**A**
The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement	On-going work to reduce non framework nurse agency and consider other alternative	ADN WF	On-going	Due to vacancies, sickness & opening of Escalation areas this work has been	**A/R**

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
nurse agency rules, supplementary guidance and timescales	companies			delayed	
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	Part of the Establishment Review	A

RED	Little or No Progress Made/Delay
AMBER	Moderate Progress Made/On track
GREEN	Actions Almost Completed
BLUE	Completed / Not due to commence

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

6 February 2019

Agenda Item	**TB036/19**	**Report Title**	**Freedom To Speak Up Quarterly Report**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Martin Abrams, Freedom To Speak Up Guardian (FTSU)		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		✓ To Note ☐ To Receive

Executive Summary

This report provides an update of the concerns raised to the FTSU during Quarter 3- 2018/19 and has be uploaded to National Guardian Office (NGO) database.

There were 26 issues in total, all managed appropriately.

There were no themes to note.

The NGO action plan summary identifies 1 action currently off plan, (an improvement from 7) which relates to the sharing of the cultural review report. Advice is being sought now that the HR investigation has been completed. Positive progress has been made with 37 actions now delivered and sustained (an improvement of 36)

Following completion by the board of the Freedom to Speak Up self-review tool for NHS trusts and foundation trusts, which was submitted to NHSI in August and shared with them at the September improvement board, there has been positive improvement with an additional 10 recommendations moving to 'fully met'.

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)*

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

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

Freedom to Speak Up Guardian

Quarter 3 Update

1 Report on Submission to National Guardians Office

Quarter 3 — 1st October – 31st December 2018

Date Submitted to NGO: 8-1-19

Date National Data to be published: **TBC**

Number of concerns raised: 26

1.1 During quarter 3, 26 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG). This is in addition to the 21 concerns which were raised through the Speak Straight to Silas initiative.

For reasons of confidentiality only general themes are recorded within this report, a summary of which can be found in table 1.

Table 1: Concerns raised during Quarter 3

Month	No raised	Raised Anonymously*	Issues / Themes / Outcomes & Status)	Other Notes	Staff Group Raising Concern
Oct	6	0	Patient safety on ward (closed, significant issues raised and ongoing improvements practice made) Patient experience (closed after investigation which showed concerns not fully accurate, person raising concerns reassured after feedback) Inappropriate discharge of patient who later died. Concern raised by staff member who knew patient. (Closed as a concern, but may be raised as a complaint by family. Staff member satisfied with response from the trust) Working practices within a department (open - ongoing		AHCP 1, porter / ancillary 1, physio 1, nursing 2, ward clerk 1

			investigation) Pay / staff banding (ongoing process, person raising concern frustrated by length of process) Bank worker not being given proper opportunity to progress (closed after significant support / investigation. Person raising concern pleased with outcome)		
Nov	14	3	Verbal abuse by staff member (Ongoing HR investigation) Operational issue within facilities (Ongoing, issues yet to be resolved) Inappropriate deployment of nurses (2 concerns raised, now being pursued by union) Bullying (historic) 3, bullying (current) 6 – see notes Lack of dignity in workplace (ongoing support being given, due process being followed) Working in an oppressive culture (Closed, person requested conversation with me before leaving. Concerns passed on to exec lead and now part of wider cultural issue) Request for support within a department (Closed, department lead asked for support within department where some tensions have arisen. Advice and support given, mediation suggested, issues resolved through peer conversation)	Following staff stories of bullying in the local press concerns about current and historic bullying at work have been raised both formally and informally. The trust is investing resources and using experts to help the organisation progress to a better working culture. This has been set as an organisation priority. Each person raising a concern has been thanked, supported offered and investigations undertaken.	Manager 1, porter / ancillary 2, nursing 7, pharmacy 1, OT 1, medical secretary 1,
Dec	6	0	Concerns about relationships with a service, both may have low level impact on patient safety. (2 concerns raised about separate services, ongoing while those raising concerns reflect on best way forward for them) Parking Scheme (Closed, parking withdrawn following	Informally a number of concerns were raised about the review of the car parking scheme, with two becoming formal. The issue were resolved quickly following exec	Ward clerk 1, AHCP 1, pharmacy 1, leader of peer review / inspection 1, porter / ancillary 1, nursing 1.

			re-application, quickly re-instated following exec decision. See notes) Parking Scheme (Closed, new starter, essential car user, working for trust 3 months not given parking access. Resolved quickly by exec intervention. See notes) Issues around historic and current bullying 2, see November notes. One of these concerns was raised by the leader of the peer review / inspection following significant issues picked up. These concerns were also shared with CEO & exec leads.	intervention. However, a new starter raised the issue that if people are unlikely to be accepted for the parking scheme (especially people who need to use their vehicle as part of their role) this should be made clear during the recruitment process so this could be taken into early consideration by applicants.	

**Please note other people were happy for the FTSUG to know their name, but did not want it shared.*

Situations where detriment was expressed because of speaking up: None after speaking up, but some expressed concern before speaking up

1.2 Feedback

The National Guardians Office also requires the FTSUG to invite those who have raised concerns, and their concerns have been closed, to offer feedback. Specifically would they use the FTSUG again to raise a concern and they are invited to offer further comments.

During quarter 3 feedback was received from ten people.

Given your experience, would you speak up again?

All answered yes

Any other comments you would like to make or suggestions for improving the service offered?

No suggestions received

Some examples:

Thank you so much for your kind support, I really appreciate it! Yes, I would speak up again if I felt that I was in any way being bullied again and it would be you that I would contact.

Thank you once again for your continuing support, just seeing you around really does give me great comfort.

In answer to your two questions,

1. *I feel if I had another issue or problem I would be very happy to speak up.*
2. *The service is a great support. I feel we are very lucky to have Martin with his very caring, warm and helpful nature. In the two issues I have raised with Martin, I felt they were taken seriously and dealt with in a very prompt way. I think it's good to use the Trust News to highlight who the local Trust Guardians are.*

I would certainly both use the service again should it be required, and would undoubtedly recommend it to others who have concerns of their own.

I cannot fault the service provided. As you were on a course that day, I passed my number to another chaplain at the trust whom I knew my details would be safe with and additionally passed on to yourself. I received a phone call from you that same day and a meeting was promptly arranged.

You welcomed me and put me immediately at ease. Which I was extremely grateful for as I was experiencing anxiety surrounding my actions of coming forward. I found it very easy to speak candidly with you and felt you listened intently to what I had to say. Things quickly progressed and I was able to speak to those who could instil change. You relayed many times that I had done the right thing, which I definitely needed to hear, so thank you. I have also been updated on the actions that have been taken in response to my concerns. I am so happy to hear I was acknowledged. It has confirmed for me that my actions were the right ones and I can now rest easy knowing this.

*Yes I would speak up **and** it was answered very well*

Table 2: Concerns raised since July 1st 2017

Period	Number
1st October – 31st December 2018	26
1st July – 30th September 2018	11
1st April – 30th June 2018	9
1st January – 31st March 2018	5
1st October – 31st December 2017	4
1st July – 30th September 2017	4

The increase in concerns raised is positive and gives assurance that staff are confident in accessing the FTSU guardian.

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

The organisational wide action plan has been reviewed and updated by non-executive lead, Director of HR and FTSU guardian on 7th January 2019.

Some positive highlights during quarter 3 are:

- MIAA completed an audit of the FTSU policy – significant assurance
- Trust board members attended FTSU training
- FTSU video launched and is on the FTSU intranet site
- Personal letter from the CEO sent to all staff (with payslips) reiterating his personal and the boards commitment to FTSU, eradicating bullying across the organisation and positively supporting staff who raise concerns.

Progress has been positive during quarter 3, with 36 actions moving to Blue, reduction of 25 Amber and reduction of 6 rated red. Detail described in table 3.

Table 3 : NGO action plan - Progress to Date

Rating	Number	Comment
Delivered and Sustained	37	
Action Completed	25	
On track to deliver	8	
No progress / Not progressing to Plan	1	1 – Sharing of cultural review report delayed due to ongoing HR issue

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

Following completion of the tool and incorporating actions into the NGO action plan, the position in August 2018 was presented to NHSI, CQC and CCGs through the Southport and Ormskirk Improvement Board (SOIB) in September. The SOIB were supportive of progress in implementing National FTSU recommendations, NGO recommendations and completion of NHSI FTSU self-assessment tool.

Progress continues to complete actions identified with movement of 10 recommendations to fully met since reporting in November 18.

Current position is detailed below

Table 4 : self-assessment tool current position

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

The committee are asked to support progress being made.