Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 09.30 – 12.45 on Wednesday, 6 March 2019
Ruffwood Suite, Ormskirk District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				**09:30**
TB044/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**09:30**
TB045/19 (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**		
TB046/19 (D)	**Minutes of the Meeting held on 6 February 2019** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB047/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB048/19 (D) **(V)** **(P)**	**Summary of Complaints & Compliments** **NEDs & Executive Visits/Walkabouts** **Patient/Staff Story: Winter Pressures – The Patient Experience** To **receive** the presentation and **note** lessons learnt	**DoN** **NEDs/EDs** **Michelle Kitson**	**25**	**09:40**
STRATEGIC CONTEXT				**10:05**
TB049/19 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO including sign posting the following: • Mortality Report, including External Mortality	**CEO**	**30**	**10:05**

	Review • Winter Plan • Quality Improvement Plan and CQC Progress • Safe Staffing • Financial Position – Forecast Outturn • Acute Sustainability To **receive** the report			
QUALITY & SAFETY				**10:35**
TB050/19 (D)	**Monthly Mortality Report** To **receive** the monthly report	**MD**	**10**	**10:35**
TB051/19 (D)	**Equality & Diversity Annual Report & Objectives** To **receive** the annual report	**DoHR**	**10**	**10:45**
PERFORMANCE & GOVERNANCE				**10:55**
TB052/19 (D)	**Alert, Advise and Assure (AAAs) Reports from:** • Finance, Performance & Investment Committee • Quality and Safety Committee • Workforce Committee **Executive Summaries from Executive Directors** **Integrated Performance Report – Introduction followed by presentations from:** • **Quality Indicators** • **Operational Indicators** • **Financial Indicators** • **Workforce Indicators** To **receive** the highlight reports from the assurance committees, the Executive performance summaries and assurance from the Executives and reports on performance indicators	**Committee Chairs** **Executives** **DoN/MD** **COO** **DoF** **DoHR**	**30**	**10:55**
TB053/19 (D)	**Financial Position at Month 10 including: Forecast Outturn 2018/19** To **receive** the report	**DoF**	**5**	**11:25**
TB054/19 (D)	**Segmental Reporting & Charitable Funds** To **approve** the method of reporting operating segments and the consolidation of charitable fund accounts	**DoF**	**5**	**11:30**

TB055/19 (D)	**Risk Management** **Risk Register** To **receive** the monthly report on the Corporate Risk Register	**DoN**	**10**	**11:35**
OTHER REPORTS FOR NOTING				**12:05**
TB056/19 (D)	**Quality Improvement Plan and CQC Progress Report** To **receive** the monthly report	**DoN**	**5**	**11:45**
TB057/19 (D)	**Monthly Safe Nursing & Midwifery Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**5**	**11:50**
APPROVAL & RATIFICATION				**11:55**
TB058/19 (D/V)	**Items for approval/ratification** • To **approve** the drawdown of Public Dividend Capital (PDC) • To **ratify** the decision taken under Emergency Powers Section 4.3 of the Standing Orders • To **ratify** the decision taken at the Quality & Safety Committee to approve the Seven Day Services (7DS) Self Assessment	**DoF**	**5**	**11:55**
CONCLUDING BUSINESS				**12:00**
TB059/19 (V)	**Questions from Members of the Public**	**Public**	**10**	**12:00**
TB060/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**5**	**12:10**
TB061/18 (V)	**Items for Forward Agenda - 3 April 2019** • Board Assurance Framework 2019/20 • Board Development Programme • Board Annual Business Cycle	**Chair**	**5**	**12:15**
TB062/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	**10**	**12:20**
TB063/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**		
TB064/19 (V)	**Date and time of next meeting** **Wednesday 3 April 2019, 10.00am** Ruffwood Suite, Ormskirk District General Hospital	**Chair**		**12:30** **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

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting
Wednesday, 6 February 2019
Clinical Education Centre, Southport, PR8 6PN
(Subject to the approval of the Board on 6 March 2019)

Members Present

Neil Masom, Chair
Jim Birrell, Non-Executive Director
Juliette Cosgrove, Executive Director of Nursing & Midwifery
Terry Hankin, Executive Medical Director`
Julie Gorry, Non-Executive Director
Silas Nicholls, Chief Executive
Therese Patten, Deputy Chief Executive/ Executive Director of Strategy
Steve Shanahan, Executive Director of Finance
Gurpreet Singh, Non-Executive Director

In Attendance

Steve Christian, Chief Operating Officer
Pauline Gibson, Non-Executive Director Designate
Jane Royds, Director of Human Resources & Organisational Development
Audley Charles, Company Secretary
Samantha Scholes, Interim PA to the Company Secretary

Apologies:

David Bricknell, Non-Executive Director
Ged Clarke, Non-Executive Director

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB021/19	**Chair's Welcome and Note of Apologies**	
	Mr Masom, as Chair, opened the meeting by welcoming the Board members and attendees. He welcomed members of the public and informed them that there would be an opportunity for questions to be raised at the end of the meeting. He also welcomed Mrs Michelle Kitson, Patient Experience Matron and Mrs Mel Pinnington, Clinical Educator, Critical Care, who were attending to present the Patient and Staff Story. Apologies were received from Dr Bricknell and Mr Clarke, Non-Executive Directors (NED).	
TB022/19	**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. No interests were declared and no further additions were made to the Register.	
TB023/19	**Minutes of the Meeting Held On 6 February 2019**	
	The Chair asked the Board to approve the Minutes of the Meeting of 6 February 2019. Amendments made included: **Attendance** *Mrs Gibson to be included in the list of attendees for January.* **TB010/19 Guardian of Safe Working Report** *Remove reference to the naming of the Doctors' Mess.* **TB013/19 Risk Management** Fifth paragraph to e*nd the sentence at 'lost'.* **TB014/19 The 2017/18 Charitable Funds Accounts** Second paragraph to read: *Consolidation of Trust's account statement revision?* Third paragraph to read '...*the Trust was not maximising the attraction of Charitable Funds…'* *The Chair requested that at the next Charitable Funds Committee meeting the role of volunteers and maximising the community's involvement should be discussed* **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendments.	**DoF**
TB024/19	**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 by 1st April 2019 **TB005/19: Patient/Staff Story: Waiting Times – In/Out Patient Areas** *Mr Christian was scheduled to meet with a Co-ordinator in A&E w/c 11 February to discuss practical steps on communicating with patients in waiting areas. Update to be brought to the March Board* **TB010/19: Guardian of Safe Working** *Remove action* **TB011/19: Integrated Performance Report** None of the 35 complaints received related to winter pressures. Monitoring of complaints would continue Ward 1 was the subject of a discussion regarding its use as an escalation area and had received good patient feedback. Mr Nicholls commented that Pharmacy had provided a Ward Pharmacy Technician on the ward to ensure that all pharmacy requirements were met thus aiding discharge	**COO**

	TB011/19: Integrated Performance Report *Theatre Utilisation data had included patients Medically Optimised for Discharge which was not inaccurate and would be corrected.*	
TB025/19	**Patient/Staff Story: Health and Wellbeing on Critical Care: Patients and Staff**	
	Mrs Mel Pinnington, Clinical Educator, Critical Care gave the presentation. Patients in the Critical Care Unit were very poorly and due to the nature of their needs might not be active, which might negatively impact on them physically and mentally. Staff members caring for these poorly ill patients might experience stressful situations. It was better for patients to have as short a stay as possible on the Unit and cared for by staff members who were confident and positive and ideally not stressed. The programme included helping staff to feel engaged within a challenging working environment. As part of their role, staff participated in a competency framework in addition to mandatory training. **Global Challenge** An initiative was developed within the Unit for all staff to gain points by engaging in a '*round-the-globe'* experience. Staff members from diverse backgrounds were asked to share their knowledge and experience of their country. That was shared using a blog and the Trust's Facebook page. Staff received extra points for participating in physical activities such as walking along Southport Pier with a group of colleagues after work, or having a coffee with someone with whom they would not normally interact. The NHS at 70 celebrations in 2018 had provided a great opportunity to fundraise. Staff achievements, a well-being wall and noticeboards with inspirational messages all contributed to its success. A lot of the activities involving patients and staff were captured in photographs which were shared. The Chair thanked Mrs Pinnington for her inspirational presentation, which was good news for both patients and staff. Mrs Gorry commented that the presentation had been uplifting and asked how patients moving from Critical Care to wards were supported. Mrs Pinnington replied that a Critical Care Outreach Team monitored feedback from wards on the progress of each patient and that *Red2Green* and Ending Pyjama Paralysis were important in supporting that. Ms Cosgrove added that patients from a Critical Care Unit going onto wards could have a significant impact on the function of the ward, due to their support requirements resulting from their time spent in the Unit. Mrs Pinnington added that five students who had spent some time on the Unit had all applied for roles, which was satisfying.	

	Mr Birrell congratulated Mrs Pinnington and her team for their hard work, commitment and results. He suggested that they participated in a national competition for recognition of both the Unit and the Trust and asked how the organisation could roll out a similar initiative across the Trust. Mr Nicholls echoed the thanks given for the exciting initiative and agreed that consideration should be given as to how it could be shared locally and nationally. Mrs Pinnington stated that it had been shared with the Critical Care Cheshire & Merseyside Network and would also be presented at the Intensive Care Society Conference in May 2019. Mr Nicholls stated that it was important to share great practice both internally and externally and certainly with the CQC. The reason the initiative worked was because the concept came from staff, who all worked together, so it would be good to encourage other staff to do likewise. **RESOLVED:** The Board **received** the presentation and **noted** the lessons learned.	
STRATEGIC CONTEXT		
TB026/19	**Chief Executive's Report**	
	Mr Nicholls presented the report and sign posted the following reports which would follow: **Winter Plan** Activity within the Trust remained on an upward trajectory and was performing well. Difficult choices sometimes had to be made between patient experience and safety, with safety being of paramount importance. **Mortality Report, including External Mortality Review** The Medical Director had identified themes in terms of observations and documentation. Escalation of key pathways and pneumonia would be the focus of the Reducing Avoidable Mortality Group for the coming year. **Quality Improvement Plan and CQC Progress** The Trust celebrated a 'So Proud' week in the final week of January 2019 which shared initiatives of what made great care for patients and staff. The week concluded with a Quality Summit involving partners from across the local NHS and health economy where the Trust reflected and fed back on the lessons learned from the week. The Trust was also focused on the Quality Improvement Plan, Quality Priorities and feedback from the Core Services Review in December 2018. The Trust had faced challenges this winter with patients presenting with norovirus (the so-called winter vomiting bug) and seasonal flu. More than 80% of frontline staff – and many non-clinical staff – had the free NHS flu vaccine which was helping to keep both patients and staff protected from infection. The Deputy Director of Infection Prevention and Control was leading on changes that included flexible signage on ward side rooms where patients were an infection risk; introducing disposable patient wash bowls; and trialling disposable	

bed curtains.

Financial Position – Forecast Outturn
The forecast outturn for 2018/19 remained unchanged at £28.8m deficit and there were a number of risks which needed to be managed in order to achieve that. They were:

- Contract challenge to 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 Cost Improvement Programme (CIP) gap given the winter pressures in December 2018 and January 2019

The run rate schemes related to agency reduction continued to deliver however; they were 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.

Car Parking

Mr Nicholls acknowledged that there had been complaints from staff and patients about the lack of parking spaces available at the Southport site. The re-lining of the car parks, which had provided more spaces, had been delayed due to the cold weather.
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The Quality Improvement Plan and Quality Priorities should have been reviewed by the Quality & Safety Committee along with the Board prior to their exposure at the end of the Quality Summit week.

He also questioned how the Trust, being a 'Centre of Excellence for Older People' would be defined, to which Mr Nicholls replied that that would be by benchmarking against similar organisations with similar populations with the intention of being in the upper quartile. In addition, the Trust was focused on being academically attractive and retaining staff by doing things innovatively.

The Chair added that the Trust must focus on the whole population, not just the elderly, to which Ms Cosgrove commented that when she started in post, it was evident that older people were not being focused upon. Whilst not disagreeing with the Chair's comment, that group of patients was the core business of the Trust.

Mr Nicholls added that the patients the Trust was currently looking after were those that the general population would need to care for in years to come and it was a fantastic opportunity to demonstrate how being a Centre of Excellence for Older People could be achieved.

Mr Singh suggested that the Board engaged with Health Education England's North West Trust in 2019 to establish robust academic links. — MD

RESOLVED:
The Board **received** the report

QUALITY & SAFETY

TB027/19	Quality Improvement Plan and CQC Progress Report	
	Ms Cosgrove presented the report. The Quality Improvement Plan (QIP) had been developed and was being populated. It would incorporate priorities *Must and Should DOs* recommendations arising from the Care Quality Commission (CQC) inspection. It had been established that CQC focus was shifting from Key Lines of Enquiry (KLOEs) to regulatory requirements. The Trust was in the process of mapping regulations against the improvement framework with the assistance of NHS Improvement (NHSI). A core services review had taken place in December 2018 and following reflection of that and other data, the Trust's key quality priorities were identified as: • Care of the Deteriorating Patient • Care of Older People • Infection Prevention and Control • Medicines Management The CQC had also recently queried the Trust's compliance in relation to *Regulation 20 'Duty of Candour'*. As a result the CQC had reviewed the evidence recently submitted and the Trust's regulatory history. The CQC had stated that they had decided in that case that although the organisation had breached the regulation, they felt a fair and proportionate response would be by carrying out enhanced monitoring at the monthly relationship meeting. Following a CQC Review of health services for *Looked After Children* and Safeguarding in Sefton, the Clinical Commissioning Groups (CCG) set up a CQC Task & Finish Group of stakeholders. That group developed an action plan which was provided to the CQC. The CQC positively noted that the action plan clearly demonstrated shared activity planned over the coming months to drive improvement, and they also positively noted areas which had already been strengthened since the review. Within the plan many of the actions were on track to be met within the target timescales. The CQC also highlighted that not all recommendations had a specific or child focused outcomes statement. The action plan will be overseen at future Task & Finish Groups. Mrs Gorry asked what lessons had been learned from the Well Led Review discussion with Bolton Hospital NHS Trust and Ms Cosgrove replied that there had been two key learning points: 1. The focus had centred on what the Trust was good at and considered that it was a hub for demonstrable improvement 2. Clear Executive portfolios should include responsibility for data sets and actions and would be reported weekly at the Thursday Executive Team Meeting (ETM) to provide a grip on improvement Mrs Gorry further asked if the emerging priorities would be agreed on that date, to which Mr Nicholls responded by saying that it would be discussed in the afternoon session of the Board. Ms Patten added that that was examined in the previous month's afternoon session and concurred that further conversations would take place in the	

	afternoon. Mr Birrell asked if any quick wins had been identified from the review and Ms Cosgrove responded that there were some. Mr Nicholls added that some issues, like the Uniform Policy and sorting of clutter could be swiftly addressed and Ms Patten concurred, stating that that was work in progress. *Mr Birrell requested that an update be brought to the next Quality & Safety Committee (QSC) for review.* *The Chair* commented that the actions appeared to be on track and *suggested that timelines be mapped by the Trust to provide assurance on how close the Trust was to achieving the outcomes required.* He added that the February QSC would also be considering the Acute Sustainability Review. Ms Cosgrove stated that progress would be evidenced at the weekly ETM and that monthly reports were reviewed at QSC on Medicines Management, Infection Control and Mortality. Mr Birrell commented that a balance between operational and assurance processes was required to deliver assurance to which the Chair concurred, adding that the key to understanding was having SMART objectives within the report, in particular the final element of timescale (T). The Chair stated that the final session of the Quality Summit on Friday 1 February 2019 had identified simple measures which would have significant impact on the Trust: • Correct hand washing to assist in infection control • Ambulance crews enabling admission avoidance by effectively supporting people at the point of contact • Engaging with primary care groups to also enable admission avoidance Mr Christian added that commissioners would provide the model for the community. South/North of the Mersey and North/North of the Mersey demonstrated different ways of working, with learning in the health economy and with providers as compelling evidence. The Chair agreed that that would benefit everyone including patients and Mr Christian concurred, stating that CCGs recognised and acknowledged that community provision required redesign. Ms Patten added that a conversation had also taken place on 5 February 2019 with paramedics. **RESOLVED:** The Board **received** the report.	**DoN** **DoN**
TB028/19	**Monthly Mortality Report, including a summary report of the External Mortality Review**	
	Dr Hankin presented the report. **External Mortality Review** (This was taken slightly out of order with the Mortality Report below**.)** In 2018, following a review of data identifying high levels of mortality, an External Review was commissioned which in May 2018 found that there was a chance of potentially excessive deaths from pneumonia and from stroke. 200 cases were identified for potential review from	

	those two Groups and 150 were reviewed using a Structured Judgement Review (SJR) methodology. Following those reviews, seven cases of very poor care were identified and the families of those patients were contacted. *Since then, detailed root cause analysis and investigation had been completed and the resulting report would be shared with individual families by 18 February 2019, if not sooner*. The Key Recommendations from the review had generated a high-level Action Plan, which grouped into three key domains which were: • Observation and documentation • Pneumonia – why do deaths occur? • Escalation to either Critical Care Unit or for End of Life Care as determined by the appropriate pathway It was recognised that the majority of patients die with pneumonia in addition to the original cause for hospital admission, with lack of mobility and deterioration of general health being contributory factors. Dr Hankin, as Medical Director, would drive work streams relating to Quality, Operational and Workforce to deliver on improvements in the next 12 months. Those would include engagement with the workforce to support the achievement of statutory targets and the use of correct documentation, plus a culture fostered by organisational development, staff engagement and Freedom to Speak Up (FTSU). Key actions which had been delivered for areas included: • Sepsis pathway • Acute Kidney Injury • Critical Care Outreach Team • Governance • Spend on Medical Workforce up by 7.5% The Chair commented that he had noted the communication earlier in the day to all staff from Dr Hankin entitled '*Learning from deaths pays dividend of better care'*. Dr Hankin acknowledged that that was a first step in driving the message into the workplace. Mr Nicholls stated that the 7.5% increase in spend on the Medical Workforce had resulted from a business case regarding medical staffing to enable better clinical care to be realised and was being monitored for effectiveness by the Business Development Investment Sub-Committee (BDISC). Mrs Royds added that Key Performance Indicators (KPIs) would also be used by the Human Resources Team to monitor quality and financial outcomes. Mr Birrell stated that he was not assured by the review, to which Dr Hankin responded that the Board should be satisfied that the work undertaken had been completed and that senior decision makers regularly reviewed patients. The message to the workforce was being delivered along with engagement via trainers. Ms Cosgrove stated that the investment in the Care of Older People was significant and it was reviewed in a timely manner.	**MD**

	Mr Birrell responded that Standard Operating Procedures must be in place and targets set. Dr Hankin agreed and Mrs Gibson added that the resources and the processes should be embedded along with engagement and accountability for behaviours. Dr Hankin further stated that responsibility was of utmost importance and it would be incorporated within the training of junior doctors, as the doctors of the future. Mrs Gibson stated she would like to see that evidenced as behaviour not simply as words. Mrs Gorry further commented that engagement and accountability were underpinned by effective communication and she asked how the message was being disseminated. Dr Hankin replied that risk and safety was at the forefront of the Trust's activity and standard operating procedures were being/would be shared with all staff via a communications network on a continuous basis. Mrs Gorry again asked how the Board was assured of how senior decisions on Do Not Attempt to Resuscitate (DNAR) or cardio-pulmonary resuscitation (CPR) were conveyed. Dr Hankin responded by stating that the Trust would draw on the expertise of the adjacent Queenscourt Hospice. Ms Patten reported that she, Ms Cosgrove and Mr Shanahan had recently visited Cramlington Hospital to see their clinical leadership in action and there are lesson from which the Trust could learn, including engagement with medical and clinical leadership within the Trust. The Chair noted that the report had outlined that 150 cases were reviewed, which had identified 11 key recommendations and seven cases of very poor care at a detailed level. *He requested that from a quality perspective, the Board would be further assured if the actions agreed and the timeline to achieve those were identified.* Dr Hankin stated that the Reducing Avoidable Mortality Group was undertaking that work, with mortality indicators measuring the overall quality of the organisation and pneumonia was now low in comparison with peer Trusts. **Monthly Mortality Report** The rolling 12-month Hospital Standardised Mortality Ratio (HSMR) was 115.7 and the Summary Hospital Level Mortality Indicator (SHMI) was 115.5 in August 2018 which demonstrated a reducing trend. Septicaemia was also reducing, attributable to antibiotics being administered in the first hour of diagnosis. Mr Birrell stated that the data was demonstrating that the trends were in the right direction, however, there was concern that some pathways had not been rolled out due to winter pressures yet the fundamental need was to have them in place to help deal with emergency admissions in the winter period. Dr Hankin commented that the pathways were now completed and would be rolled out week commencing 11 February 2019. Ms Patten noted that the Structured Judgement Reviews (SJRs) had been taking place and were evidencing a reduction. Dr Hankin added that the SJRs took two hours at minimum and five were reviewed at the monthly Mortality and Morbidity Reviews meetings which	**MD**

	identified what should be done differently and then reviewed the following month. It was an ongoing challenge to drive a cultural change to engage staff to embed risk and safety. Mr Birrell added that it was reported to the Quality & Safety Committee that too many early reviews were superficial so the numbers reviewed would be reduced in order to undertake a more in-depth, effective review. Dr Hankin stated that all Doctors needed to understand SJRs and their value. Mrs Gorry commented that the previous Deputy Medical Director had previously stated that time was a challenge to undertake them and she asked if that had been addressed. Dr Hankin responded that the number of reports and SJRs by clinicians was part of their work plan and were currently exceeding expectations, due in part to good systems and the substantial investments which had taken place. Mr Nicholls stated that the data for the rolling 12-month HSMR was likely to be 113 for September 2018, demonstrating further reduction. He added that the spider diagram within the report demonstrated the correlation of flow, emergency department and reduction of corridor care which contributed to that. Mr Nicholls went on to state that the culture of the organisation was of significant importance. In the first year the new Executive Team had stabilised the Trust and would now move to improving it, including resourcing. It was anticipated that the historical management was now a fading memory for staff and a tipping point had been reached. Clinical colleagues had observed that '*It was different at Southport'* and that the standard of care was now similar to comparable Trusts. Whilst that was encouraging, the Board should not be lulled into a false sense of security as significantly more work was required. Dr Hankin assured the Board that his role was predominantly to drive change. The Chair added that Vision 2020 included the aim that the Trust would either exceed or match national targets for mortality. It was recognised that the data available was historical and there was a lag in seeing the shift in trends. The target was for forward trends, with change expected. A huge amount of commitment and support had been evidenced and would continue. **RESOLVED:** The Board **received** the report.	
TB029/19	**Winter Plan Update**	
	Mr Christian presented the report. The Trust had made significant improvements to maintain the function and safe running of the hospitals across winter. Whilst there were many positives to take from the years' experience regarding the Trust's management of winter, the increased demand on hospital services had created imbalances between demand and capacity which had created bottlenecks and delays in the hospital. A practical action which had been undertaken to achieve that was the early and daily senior review of all inpatient care plans from admission. That had been clearly communicated and documented with the ward Multi-Disciplinary Team (MDT) on the required criteria for discharge.	

Southport Hospital A&E had achieved 70% performance in January 2019 against 55% in January 2018. Improved care was evidenced in the reduction of 12-hour breaches and corridor care. The detail of the comparison of last year with the current year's performance was contained within the Board report.

Mr Christian noted that the challenge was 14% extra attendance at A&E, which equated to 20 extra patients a day, and required four additional doctors to see them. Whole system efficiencies, including demand, the discharge bottleneck and other mitigating actions were necessary.

Escalation areas had been opened and had provided an extra 25 - 45 beds. Ward 1 (Physiotherapy Outpatients Department) was in use as an escalation area and was an adequate and responsive resource. Senior clinicians were at the ward on a daily basis, with consultants three times per week.

Demand was not reducing and no step change was occurring. Extra capacity was needed and consideration on the best way to achieve this safely had been undertaken. Mr Christian outlined that his team had reached out to the CCG to de-escalate the Southport site as quickly as possible and have received support from South Sefton CCGs Chief Nurse to explore the options available, including transfer to community provision and formal action by the CCGs Chief Accountable Officer. Mersey Care had offered therapy staff to Lancashire Care however the timescales and trajectory were at risk due to the availability of the workforce.

Mr Birrell commented that help from the CCGs was very useful; however, it had taken a very long time. The CCGs were advised months ago of the issues which were likely to occur. He congratulated everyone for their hard work and reiterated that a system solution was required. The process for winter planning needed to start earlier for partners and there was the added challenge that the closure of Royal Liverpool Hospital would mean less beds available in the system for the winter 2019/20 period.

Ms Cosgrove stated that there was *noise* in the regulatory system about that and Margaret Hitching Regional Chief Nurse and Vince Connolly, Regional Chief Medical Director, both of NHSI and NHSE had met with herself, Mr Nicholls, Mr Christian and Dr Hankin on Tuesday 5 February 2019 and had identified that the CQC was clear that the responsive pressures were perceived as being managed really well and there was confidence in the Trust and its management of the escalation areas, including actions taken for safety, from a regulatory perspective. That would be fed back to the regional CQC.

Mr Nicholls commented that regionally the systems approach was not pro-active and the results of a reactive approach would be scrutinised post-winter.

Mr Christian added that in response to Mr Birrell's earlier comment, a narrative was being undertaken with system partners to state a *single version of the truth*. There was ongoing concern regarding the lack of community provision and domiciliary care, neither of which was a hospital process and that was recognised and acknowledged by the

	CCGs. The Chair added his congratulations on the performance of the Trust and the Executives and all their Teams. He noted that Dr Bricknell had, in his written submission, commented that there were significant blockages to discharge and admission and that avoidance was necessary to unblock some of them. **RESOLVED:** The Board **received** the report.	
PERFORMANCE & GOVERNANCE		
TB030/19	**Alert, Advise and Assure (AAAs) Reports from:**	
	Audit Committee In Mr Clarke's absence, the Trust Chair who attended the Committee as an observer at the 16 January 2019 presented the AAAs report. He noted that that was the final Audit Committee Mr Clarke would Chair for the Trust, as his term as a Non-Executive Director would conclude at the end of March 2019. Mr Masom thanked Mr Clarke for his hard work and commitment. The Committee was alerted on: • The Internal Audit Progress Report had issued a limited assurance in respect of Duty of Candour. • Overall there had been a 52% increase in all security incidents • There had been a 44% increase in violence and aggression incidents towards staff The Committee advised on: • All staff involved with Duty of Candour process should be reminded of the importance of ensuring all actions were recorded and completed in a timely manner **Finance, Performance and Investment Committee** Mr Birrell, in his role as Chair of the Finance, Performance and Investment Committee, presented the AAAs report. The Committee alerted on: • An audit of the Trust's reference costs suggested that little assurance could be placed on historic costing data. Steps were being taken to improve both the reference costs and Service Level Reporting data for 2018/19. The Committee advised on: • A comparison of staff in post showed that medical numbers had increased by 7.5% and nursing numbers increased by 3.2% over the last twelve months, which represented a significant investment in improving quality. **Quality and Safety Committee** Mrs Gorry, in her role as Chair of the Quality and Safety Committee presented the AAAs report. The Committee alerted on:	

	• 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. The Committee assured: • Following a Serious Incident, regarding the insertion of Peripherally Inserted Central Catheters (PICC lines), a Root Cause Analysis was completed and Lessons Learnt were identified and were being reinforced. . **Workforce Committee** Mrs Gibson, in her role as Chair of the Workforce Committee, presented the AAAs report. The Committee alerted on: • Policies which were to be reviewed by the Committee should be required to include a front sheet, specifying what changes had taken place. The Committee advised on: • Sickness absence had continued to reduce for the 3rd month in a row, which provided some level of assurance. Significant activity was underway to support line managers with sickness absence management process and conversations. More importantly there were initiatives underway to shift towards supporting attendance rather than managing sickness absence. In particular Staff Side had been proactively supportive and attended in partnership the various training and education sessions. That continued to require support from everyone on the Board. The Committee assured on: • The Trust continued to make excellent progress in utilising the apprenticeship levy spend for 2018/19. There were 99 apprenticeship programmes registered to the value of £764,000. The Trust was on track to meet the target of 68 in a year, with 57 definite and a further 16 expressions of interest. The Trust was outstanding in that regard when compared to the local trusts and Staff Side had been vocal in commending this achievement. **RESOLVED:** The Board **received** the reports.	
TB031/19	**Integrated Performance Report (IPR)**	
	Mr Christian introduced the report, details of which could be found in the Board Pack. In December 2018, the Trust had delivered against the A&E 4-hour Performance NHSI trajectory. 18-week Referral to Treatment (RTT) Performance was well above target, which was a strong performance during the winter period. The monitoring of waiting lists and follow ups had been managed, addressed and recovered where required. West Lancashire CCG's Chief Operating Officer was supporting resolving the challenge of	

	Community Paediatrics. Diagnostics were performing well year on year. Three vacancies remained in Radiology and the focus on Endoscopy continued with Mrs Royds' team maintaining rigor and improvement within the Endoscopy Team with trajectories set and working to deliver these. Cancer 62 Day trajectory was being monitored by the FP&I Committee. Operational issues included the workforce. An urgent meeting would take place to review the progress on the improvement actions and confirm the next steps. Efficiency metrics for the Medically Optimised for Discharge (MOFD) were potentially inaccurate and would be checked for accuracy Theatre utilisation was subject to scheduling. The basics would be re-examined, plus monitoring and holding staff to account. Bed Occupancy was reported as 29.3% at Ormskirk. It had been established that the measure was taken at midnight of each day, 5 days a week, however, the same measure, undertaken at midday at Ormskirk was reported as 85%. Mr Singh asked what the bed occupancy report at Southport would look like if the measure was taken at midday, as referred to by Mr Christian. Mr Christian commented that it would demonstrate occupancy in excess of 100% due to the escalation beds. The Chair commented that Ormskirk had a number of empty wards which could be re-purposed for corporate use. Dr Hankin noted that Sepsis data reflected the Safer Surgery initiative, which had zero tolerance. Ms Cosgrove commented that Falls Management had seen no significant improvement. As part of the *Get It Right First Time* (GIRFT) initiative, educational and best practice would be focused on. She added that the Friends and Family Test was being relaunched, aligned with Duty of Candour and CQCs Well Led requirement. Mrs Royds reported that Personal Development Reviews (PDR) had increased to 70.91% in December 2018 which was a slight improvement. Work continued to achieve target of 85%, and ultimately beyond. CBUs and Corporate Services were currently reviewing their compliance trajectories to ensure an ongoing increase which would continue to be challenged at Performance Review meetings. Since October 2018 the Trust had provided Quality Appraisal Conversation training to managers and that had been well received, with the number of attendees increasing. That would continue to be delivered regularly until March 2019. Mandatory training rates continued to steadily increase and improve each month. In December the overall Trust rate was 84.76%. Work was ongoing to support managers to ensure rates were monitored and staff encouraged and given the opportunity to undertake mandatory training.	

	Sickness absence had decreased again in the month of December 2018 to 5.86%, from 5.94% in November 2018. That was the third consecutive month whereby sickness absence had reduced in month. The new Supporting Attendance Policy had been agreed and ratified for use and was launched on 28 January 2019. A focused action report of sickness absence was presented to the Workforce Committee in January 2019. The HR Team would also focus in "hot spot" areas of the Trust with exceptionally high sickness absence levels, including Theatres. *The Chair requested that the Integrated Performance Report include a target or forecast line to correlate with his QIP request*. **RESOLVED** The Board **received** the report.	**COO/DoF**
TB032/19	**Risk Management:** **Risk Register**	
	Ms Cosgrove presented the report. A Risk & Compliance Group would have its inaugural meeting on 18 February 2019 and would review the high-level risks and those risks which were between12-15. It would incorporate a rolling review of the progress made by CBUs and their compliance, or understand their non-compliance which would feed into the Risk Register and/or the BAF. Ms Cosgrove focused on two high level risks from the Corporate Risk Register: **1314 Management of Mental Health Pathways** Delays in the transfer of patients to safe environments had occurred with a number of 12-hour breaches in September to December 2019. This had impacted on both patients and staff, with one patient occupying a cubicle for two nights. **Actions** The profile of the risk had been raised with regulators and CCGs. An independent review of the pathway had taken place and the formal reports signed off by the Chief Operating Officer. Full system engagement had taken place, involving Mersey Care & Lancashire Care, both CCGs and the acute trust, with regular meetings carried out. An Operational Manager from Mersey Care would be based onsite. Mr Nicholls had confirmed that all patients with mental health requirements should stay in A&E and not be transferred to general or observation wards where there were fewer staff. Mr Birrell commented that an item on the local news had highlighted the challenge of staffing and funding. The Chair agreed that the statistics of the Trust's action demonstrated the right thing was being done. **1367 Failure to have a motivated and engaged workforce (culture)** There had not been an Organisational Development resource in the Trust for over three years, which was now being addressed by recruiting to the roles.	

	The *Friends and Family Test* had been publicised and supported by the HR using iPads to assist staff to complete it, which had seen a good increase. A *Valuing our People Working Group* had been set up to consider how best to have happy, healthy and motivated staff, plus a Charter for Staff and Managers. Mrs Royds thanked NHSI for their invaluable input and co-facilitation of the engagement of staff session. Culture, values, behaviours and bullying were being examined and the Group would share its findings to help co-design leadership and management. Mr Birrell asked if the Cultural Review report, which took place in early 2018 would be published. Discussion took place regarding the effectiveness of doing or not doing so, given how little benefit that might now have. It was stated that some staff had been deeply involved in that review and were likely to consider that time spent as wasted. Mr Nicholls added that there were potential legal implications in publishing a report based on the review. Dr Hankin suggested that individuals, who were identified in the review as having suffered harm, should be apologised to individually so that they were not ignored. The Chair stated that the report would now be out of date and there had been changes to the law in respect of GDPR which might impact upon it. The results of a Staff Survey were due shortly, which would be reviewed by the Workforce Committee. There would also be a report to the Risk & Compliance Group, which would then report to the Audit Committee in April 2019. **RESOLVED:** The Board **received** the monthly report.	
OTHER REPORTS FOR RECEIVING		
TB033/19	**Financial Position at Month 9 including:** • Forecast Outturn 2018/19 • Proposed Control Total 2019/20	
	Mr Shanahan presented the report and key highlights. The Trust's deficit at the end of December 2018 was £22.612m, £479,000 worse than plan. Key risks to achieving the £28.8m planned deficit and contract challenge from Commissioners on non-elective activity and income, contract sanction, cost of resourcing additional beds. Capital expenditure is forecast to spend its Capital Reserves Limit (CRL) and cash continues to require revenue support loans. The Trust had agreed to accept the 2019/20 Control Total as part of the planned submission on 12 February 2019. **RESOLVED:** The Board **received** the report.	
TB034/19	**Guardian of Safe Working (GOSW) Quarterly Report**	
	Dr Ruth Chapman presented the report. The Doctor's Mess/lounge was finished and the furniture was awaited. Exception reports were down by 80% year on year, which was encouraging and the Trust was in a much better place than 18	

months ago, when reporting commenced.

Dr Chapman thanked the Executive Team for their support which had revitalised senior medical staff, who were no longer of the opinion that there was no point raising concerns as no-one would do anything about them. Acting Down and Double Bleep carrying were amongst the successes during Dr Chapman's tenure.

Dr Sharryn Gardner had been appointed as interim GOSW.

The Chair commented that the work which had been achieved, including the lounge and the shift from 18 months ago was an appropriate legacy.

The Board thanked Dr Chapman for her work.

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

TB035/19 **Monthly Safe Nurse & Midwifery Staffing Report**

Ms Cosgrove presented the report.

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

Overall fill rate for December 2018 was 93.61% compared to November 2018 which was 95.76% and 93.25% in October 2018

- 84.59% Registered Nurses on days
- 94.36% Registered Nurses on nights
- 103.13% Care staff on days
- 104.12% Care staff on nights

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

	Funded WTE	Contracted WTE	Nov 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 had remained static in the month.
Non – registered vacancy reduced / improved in month by 6 wte

RESOLVED:
The Board **received** assurance on the actions taken to maintain safe nurse staffing.

TB036/19 **Freedom To Speak Up Quarter 3 Report**

The Chair suggested that the report be taken as read.

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

APPROVAL & RATIFICATION

TB037/19 **Items for approval/ratification**

The Board **ratified** the decision taken under Emergency Powers Section 4.3 of the Standing Orders to apply for an Uncommitted

	Revenue Support Loan of £2.64m for February 2019. **RESOLVED** The Board **ratified** the decision taken under Emergency powers and the action taken by the Private Board.	
CONCLUDING BUSINESS		
TB038/19	**Questions from Members of the Public**	
	Mr Ryan suggested that the issue of parking on site be managed by allocating spaces for patients visiting outpatients who were turning up early to park and then queuing in outpatients. Ms Patten stated that that was a good suggestion. Mr Ryan further suggested that the Trust interact with bus companies to see if the service offered to/from the hospital sites could be improved, to reduce the amount of vehicles in the car park, to which Ms Patten also agreed.	
TB039/19	**Any Other Business**	
	To **receive/discuss** any other business not on the agenda. Ms Patten proposed that Serious Case reviews be carried out as promptly as possible to improve the experience of patients and their families, to which Dr Hankin agreed. Mr Birrell noted that things were changing for the better in the Trust, which was also attested to in the Guardian of Safe Working and Freedom To Speak up Reports.	
TB040/19	**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	
TB041/19	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • *Mortality* • *Financial Control Total 2019/20* • *Chief Executive's Report* • *£1 for £1 investment* • *Increased attendance at A&E* • *Thanks to all staff for the work in the winter period* • *Length of waiting in outpatients*	**Communications**
TB042/19	**Meeting Evaluation**	
	To give members the opportunity to evaluate the performance of the Board meeting	
TB043/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 6 March 2019, **10.00** Ruffwood Suite, Ormskirk 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	✓	✓	✓	A	
Ged Clarke	✓	✓	✓	A		✓	✓	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	✓	✓	A	✓		✓	✓	✓	✓	✓	✓	
Steve Christian			A	A			✓	✓	✓	✓	✓	
Jane Royds	✓	✓	A	✓		✓	✓	✓	✓	✓	✓	
A = Apologies ✓ = In attendance, - = No response												

Public Board Matters Arising Action Log
as at 6 March 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
CEO Report	Jun 2017	**Human Resources Contractual Arrangement with St Helens & Knowsley (StHK)**	Board members to be apprised of the review's findings and implications	**DoHR**	Sep 2017	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. **February 2019** Further work and recruitment continues to transfer services back to the Trust by end March 2019. **March 2019** Individual consultation meetings almost completed.. Recruitment to vacant posts ongoing. Work in progress planning for where the team will be based. Weekly update to Executive Team on progress.	**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** The COO would work with a member of staff to consider solutions **March 2019** The COO has sent Trust-wide communication regarding the required processes and actions required following meeting with the member of staff who shared the patient experience. The member of staff is very happy with this outcome and will continue to raise concerns directly with the COO. In addition, the Trust will be introducing an Outpatient Improvement Programme for the financial year of 2019/20. The COO has requested that the project team review the potential of adopting custom-fitted white boards in clinics to improve communication to patients on critical areas such as waiting times to see a clinician. The COO has set a deadline of April 2019 for completion. The COO will provide an update via the FP&I Committee in order to offer assurance in delivery.	**GREEN**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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	Apr 2019	**February 2019** This item is on the forward agenda for March Board. **March 2019** The finalised BAF will be presented at the April 2019 Board, following the approval of the priorities, strategic objective and principal risks and consultation at ETM, HMB and assurance committees.	**GREEN**
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. A similar arrangement should be explored with the same company.	**DoF**	Feb 2019	Feb 2019	**February 2019** Meeting arranged for 8 February 2019 with the marketing company. **March 2019 Update** The DoF met with Plum Marketing to discuss a proposal to rebrand the hospital's charity and develop a fundraising role. A project start date of 1 March 2019 was agreed.	**AMBER**

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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** 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. **March 2019 Update** A revised protocol is being written to take account of how and where these are managed, monitored and reported and will be reported to both the Board and Audit Committee in April	**AMBER**

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OUTSTANDING ACTIONS

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TB027/19	Feb 2019	**Quality Improvement Plan and CQC Progress Report**	The Chair commented that the actions appeared to be on track and suggested that timelines be mapped by the Trust to provide assurance on how close the Trust was to achieving the outcomes required.	**DoN**	Apr 2019	Apr 2019	**March 2019** This is in progress and would be reflected in the April report	**AMBER**
TB027/19	Feb 2019	**Quality Improvement Plan and CQC Progress Report**	The balance of operational and assurance processes was required to deliver assurance referring to the timescale (T) element of SMART, to be added to the Board report.	**DoN**	Mar 2019	Mar 2019	**March 2019** A projection is included in the March 2019 report	**GREEN**
TB028/19	Feb 2019	**Monthly Mortality Report, including a summary report of the External Mortality Review**	Standard Operating Procedures to be incorporated in the training of junior doctors and evidenced as behaviour	**MD**	Apr 2019	Apr 2019	**March 2019** Dr Hankin to review ward by ward use of pro-formas to support daily activity	**AMBER**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB028/19	Jan 2019	**Monthly Mortality Report, including a summary report of the External Mortality Review**	The 150 cases reviewed had identified 11 key recommendations and seven cases of very poor care. From a quality perspective, the Board should receive further assurance if the actions agreed and the timeline to achieve those were identified	**MD**	Apr 2019	Apr 2019	**March 2019** Dr Hankin and Dr Goddard to review timeline and update Trust Board	**AMBER**
TB028/19	Jan 2019	**Monthly Mortality Report, including a summary report of the External Mortality Review**	Following the SJR reviews, seven cases of very poor care were identified and the families of those patients were contacted. Since then, detailed root cause analysis and investigation had been completed and the resulting report would be shared with individual families by 18 February 2019, if not sooner	**MD**	Mar 2019	Mar 2019	**March 2019** Letter sent to families on 18 February. The content stated that the reports to be returned to the Trust by 25 February for internal quality check and the reports would shared by11 March.	**GREEN**
TB031/19	Jan 2019	**Integrated Performance Report**	The report to incorporate a target or forecast line	**DoF**	Apr 2019	Apr 2019	**March 2019 Update** This is being progressed and will appear in the April report	**AMBER**

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COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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.	**Mr Clarke/CoSec**	Jan 2019	Jan 2019	**January 2019** An email was sent by Mr Clarke on behalf of the Board with no response. (Dec 18) **February 2019** An email was sent by CoSec on behalf of the Board and telephoned twice with no response. **March 2019** **COMPLETED**: 14 February 2019, Dr Glackin acknowledged receipt.	**BLUE**
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** Mrs Kitson (Matron, Patient Care) has been informed **March 2019** **COMPLETED**: This is an item on the March Board	**BLUE**

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COMPLETED ACTIONS

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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. **March 2019** **COMPLETED**: Apologies had been given to patients where care concerns had been identified.	**BLUE**
TB008/19	Jan 2019	**Monthly Mortality Report**	The February Board Report would be further streamlined	**MD**	Feb 2019	Feb 2019	**February 2019** **COMPLETED**: The monthly report has been streamlined as requested	**BLUE**

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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** **COMPLETED**: MD has examined the data and confirms its accuracy	**BLUE**
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** **COMPLETED**: Investigation had not demonstrated any correlation	**BLUE**
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** **COMPLETED**: COO confirmed the data was now correct	**BLUE**

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COMPLETED 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.	**BLUE**
TB031/19	Jan 2019	**Integrated Performance Report**	Efficiency metrics for the Medically Optimised for Discharge (MOFD) were potentially inaccurate	**COO**	Mar 2019	Mar 2019	**March 2019** **COMPLETED**: This action is completed and data on IPR should reflect actual performance.	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	**TB0048/19a**	**Report Title**	**Complaints and Compliments Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information		✓ To Note ☐ To Receive

Executive Summary

- The Complaints and Compliments Summary provides the themes and figures for the Trust in month.
- The report is a monthly report produced for the Board.

Recommendation:
The Board is asked to **note** 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

Complaints and Compliments

January 2019

This report will review the current numbers of complaints, and compliments received in the month of January, they often don't relate to care or experience received in month.

	Compliments	Complaints (Grade 3- 5)	Complaints (Grade 1-3)
Jan-19	100	25	36

Compliments

The compliments received across the Trust related to the Quality of care received by patients, communications with relatives and patients, staff behaviour, attitude and competence and End of Life care. Planned Care Business Unit received the most compliments with 46 in total and F (Ophthalmology) ward receiving 25 compliments in the month. Urgent Care received 40 compliments with Short Stay ward 9B receiving the most compliments with 14 in total. 13 were received across Women and Children's Business Unit with 9 compliments being received for the maternity services and neonatal services in month.

Complaints

The complaints data has been split into low level complaints (known as PALS) and formal complaints Graded 3 and above using the Trust grading tool. The complaints often include more than one area of complaint

The formal complaints relate to the following areas:-

- Staff attitude, 11 complaints mixed across all Clinical Business Units.
- Clinical treatment featured in 10 complaints received, these included patients not being observed, coordination of medical treatment, 2 complaints indicated a lack of pain relief in different areas, and a delay in investigations.
- Communications feature in 9 complaints re poor communication both with patients and relatives.
- Basic care was a feature in 4of the complaints received, 2 related to lack of feeding, 1 dirty laundry and lack of support with washing and dressing
- Bed pressures did feature in the complaints with 2 complaints being received, 1 related to lack of a single room and a second related to the patient being moved wards. Linked to the bed pressures, 2 complaints were received which cited poor discharge and follow up care at home.

The low level complaints received into the Trust featured a number of areas, staff attitude featured in 11 of the complaints, with poor communications featuring. Linked to bed pressures there were 6 complaints received which related to cancelled admissions. Car parking featured in 5 of the complaints with penalty notices being issued to all complainants.

All complaints are actively are going through the complaints processes within the Business Units, changes to practice will be indicated in future reports.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	TB049/19	Report Title	Chief Executive's Report
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Chief Executive's report signposts the following reports:

- Trust strategy 2019/20
- Winter performance
- Nurse staffing
- Quality improvement
- Financial position and year ahead
- Equality and diversity
- Investing in our hospitals

Recommendation:

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

CHIEF EXECUTIVE'S REPORT TO BOARD – 6 MARCH 2019

Trust Strategy 2019/20

Last year we worked hard to improve our services for patients. Investment in staffing, equipment, A&E, a Surgical Assessment Unit, a Day Surgery Unit and the new Discharge Lounge were among the highlights of this work.

The next couple of years are crucial to building on that success and making this organisation the model for smaller NHS hospitals in the 21st Century I know it can be.

That is the ambition and aspiration behind Vision 2020 launched in the autumn.

It is our road map to how we will become a successful and sustainable provider of healthcare for local people.

We have now further refined the Trust strategy under the mission statement "providing safe, high quality services for you and with you".

There were four themes at the heart of Vision 2020:

- Become a community general hospital skilled in the care of older people
- Be part of an integrated care system delivering seamless hospital-to-home care that works for patients
- Invest in our hospitals making them fit for the 21st Century
- Create a hub for routine planned care run from a dedicated hospital

We have now added a fifth – "become an employer of choice that attracts the best staff". Our strategic objectives have been refined to reflect our vision:

- Improve clinical outcomes and patient safety to ensure we deliver high quality services
- Deliver services that meet NHS constitutional and regulatory standards
- Efficiently and productively provide care within agreed financial limits
- Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

These, in turn, are underpinned by the Trust's SCOPE values – supportive, caring, open and honest, professional and efficient.

Planning for Our Future

The Trust met representatives of our commissioners, health and social care partners, and the Sefton Health and Care Partnership programme on 26 February to take stock of our acute sustainability programme.

We are drawing on the latest expert clinical opinion; NHS planning guidance which has a focus on a joined-up system approach; and the NHS Long Term Plan as a basis for our programme reset work.

	Total ED	Avg ED	Conversion Rate	Ave. Admissions

We committed to work together over the next four to six months on a system model of care which, in turn, will feed into the Sefton “place” five-year system plan. It will be clinically driven with engagement across the system.

Winter Performance

The NHS is facing a very challenging winter and national performance against the A&E four-hour standard has dropped significantly.

At Southport and Ormskirk there is a similar picture and the Trust has had to take significant escalation steps to maintain safe patient flows at Southport hospital to avoid crowding in A&E. As part of the Trust’s winter plan the team introduced a Safer Start campaign in January.

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)
- At times of extreme operational pressures the Trust has introduced 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 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.

Whilst the month of February has been exceptionally challenging, the overall headlines for February in comparison to last year are very good:

	Attendances	Attendances per day	Full Admissions	requiring an inpatient bed (per day)
Feb-19	3789	158	21%	36
Feb-18	3482	145	20%	32

	ED Attendances			12 Hour DTA Breaches	4 Hour Performance
	Managed <= 4 Hours	Managed 4-12 Hours	Managed > 12 Hours		
Feb-19	2672 (70.5%)	913 (24.1%)	204 (5.4%)	30	70.52%
Feb-18	2032 (58.4%)	1158 (33.3%)	292 (8.4%)	1	58.36%

It is important to note that, while the Trust has recorded high numbers of 12-hour Decision to Admit (DTA) breaches, the actual total numbers of patients managed >12 hours in the ED has reduced in comparison to the previous year (30% reduction).

As part of the Safer Start principles we have introduced early senior speciality review in the ED which puts pressure on the 12-hour DTA position as we work on timely review regardless where the patient is located – this keeps patients safe and ensure the right treatment plans are commenced and at the earliest opportunity.

In addition corridor care has reduced by 74% and ambulance handover delays >60 minutes have reduced by 43% (this year for February against last). This has all been achieved against a backdrop of increased demand (ED attendances 10% up) and worsened performance for the numbers of Medically Optimised for Discharge Patients (MOFD) occupying a hospital bed each day (from 56 to 60 year, an increase of four patients each day).

Since the turn of the New Year (and to date) the Trust has been operating between 25-45 escalation beds any given point in time to support patient flow. This has included the temporary opening of Ward 1 (formally the Outpatient therapy clinic).

The use of escalation areas (and in particular ward one) has resulted in a need to increase the numbers of doctors, nurses and allied health professionals to maintain timely and safe care.

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 – our commissioners, the Care Quality Commission and regulatory bodies have all been briefed throughout our management of winter.

We now need to ensure the additional physical bed capacity can be de-escalated as a matter of urgency as the action was only a short term measure as the environments do not meet the required standards for an inpatient facility. The Trust is working on full closure of Ward 1 by early March 2019.

The Trust will continue to support system partners in determining solutions to assist whole system patient flows in order to release the pressure being consumed at Southport hospital.

There is a wide acknowledgement and now a developing single version of the truth that the gaps in provision (and therefore restrictions in patient flow) are within the community setting.

The critical constraints for the Southport and Formby CCG footprint are a lack of an enhanced therapy step-down community offers and also significant capacity issues for local authority domiciliary packages.

Nurse Staffing

There has been a decrease in our overall fill rate for the second consecutive month. This is as a result of the number of additional beds that have been opened as a result of winter pressures and increased sickness absence.

In January, the Trust reported safe staffing against the national average (90%) at 90.52% with a fill rate of 84.42% for registered nurses on day shifts.

The non-registered vacancy has increased in month by four whole-time equivalent (WTE) but we expect this to improve in the coming months as recruited staff come into post. The registered nurse vacancy against overall establishment has reduced by four WTE.

The establishment review for the inpatient areas is almost complete and early indications are showing a need to increase both registered and non-registered staff, the majority in the non-registered workforce.

Quality improvement

The first meeting of the Quality and Safety Group took place on 30 January. Terms of reference for the group were established and detailed programme planning is underway with work stream leads.

This group is responsible for the operational oversight of the Quality Improvement Priorities identified in Vision 2020 and will report into the Improvement Board chaired by the Chief Executive.

As of January, of the 96 should and must-do actions, 57 were rated amber (on track to deliver), 34 green (action completed) and five blue (delivered and sustained). The next two assurance panels have been confirmed for 27 February to review North West Regional Spinal Injuries Centre actions and 11 March to review Emergency Department actions. Individual panels will meet in between to review any identified “quick wins”.

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

- Provider Information Return (PIR)
- Core Service Review

CBUs were requested to complete core service self-assessments to identify areas of strengths, areas for improvement and gaps against the Key Lines of Enquiry (KLOE) for each core service. Self-assessment returns are currently being reviewed; they will be triangulated with the outcome of the PIR to identify any gaps areas requiring improvement.

Financial Position in Year-to-Date

January's performance was on target. However, the Trust's year-to-date position remains £400,000 behind plan.

Our commissioners have not yet agreed to pay for both activity arising from the new Clinical Decision Unit and other non-elective activity despite NHSI/E recommendation that they should.

Winter pressures in January increased expenditure and contributed to higher sanctions being imposed due to compliance against performance standards.

The Trust remains on target to meet a planned £28.8m deficit. However, it is dependent on full payment from commissioners and retaining control over expenditure pressures in the final two months of the financial year.

Financial Planning for 2019/20

In January the Trust received its 2019/20 Control Total which is a deficit of £26.567m before non-recurrent Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) allocation. The Board agreed to sign up to this control total last month. As the control total has now been accepted the Trust will benefit from non-recurrent funding of PSF and FRF (total £18.271m); payment will be dependent on satisfactory performance against the financial plan. A number of assumptions have been made in developing the plan and agreeing the deliverability of the control total.

Equality and Diversity

The Equality Diversity and Inclusion Report 2017/18 gives a summary of the equality work undertaken by the Trust. The report supports compliance with the Equality Act 2010 Public Sector Duties. In addition to this report, the Trust has a number of governance procedures for equality to ensure progress and prioritisation of the work. Equality updates are provided to the various Trust committees/groups and externally to NHS England and our commissioners as part of the quality contract.

Investing In Our Hospitals
As part of our plans to invest in our hospitals, it is really important staff have the right equipment to do their jobs.

Following our core service review in December, staff told us some ward equipment was not always available. We have now developed a core ward equipment list which matrons check against for shortfalls and replacement needs. The Therapies team is doing a similar exercise.

The Trust is planning to spend £1.3m on new medical equipment in 2018/19 and almost £6m over the next five years. Orders in progress include replacement of all 30 anaesthetic machines with newer models; replacement of all hydraulic couches in Outpatients at both hospitals; and new drills for Maxillofacial.

In brief …

First for prostate treatment. The urology surgery team at Ormskirk celebrated being the first hospital in Lancashire to use a new, minimally-invasive steam treatment for benign prostate enlargement. The steam kills off some of the enlarged prostate tissue to ease symptoms. The dead cells are reabsorbed by the body.

Each of four patients' treatment was completed in less than 10 minutes. Traditional treatment lasts up to two hours and involves up to two nights in hospital. The men's symptoms are expected to improve more quickly than with standard treatment.

100th apprentice recruited. We welcomed Alexandra Prior, our 100th apprentice to the Trust in February. She is as an administration apprentice who is studying business administration level 3 at Southport College. Alexandra joins our hugely successful apprenticeship programme now worth £764,000, an outstanding performance compared to other local trusts.

50 years as a patient. The Trust was delighted to receive £500 from the friends and family of patient Gordon Styles who recently died. What made the donation particularly special was Gordon's unique 50-year association with the North West Regional Spinal Injuries Centre. He became a patient having sustained a spinal cord injury during the Second World War.

Silas Nicholls Chief Executive

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	TB050/19	Report Title	Monthly Mortality Report
Executive Lead	Terry Hankin, Medical Director		
Lead Officer	Dr Chris Goddard, Associate Medical Director of Patient Safety Rachel Flood-Jones, Project Delivery Manager Mike Lightfoot, Head of Information		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The report has the following content**:**

1.0 Measuring Mortality

- Summary Hospital-level Mortality Indicator (SHMI) – 12 month rolling from October 2017 to September 2018
- Hospital Standardised Mortality Ratio (HSMR) – September 2018
- Disease-Specific Mortality Ratios – September 2018
- Performance Distribution – August 2018

2.0 Reducing Avoidable Mortality (RAM) Project

The transition from the first to the second phase of the Reducing Avoidable Mortality (RAM) Project is reported with an overview of the revised plan and updates on existing project work.

3.0 External Mortality Review Action Plan Update

A full update is given on the External Mortality Action Plan, from which all documented activity will be subsumed into the Reducing Avoidable Mortality Project (RAM Phase 2). (The exception to this is actions which are already scoped into the Trust's Length of Stay Programme as noted where relevant in the detail of the report).

The Board is advised that the methods for retrieving and reporting data from the system (for the Mortality Report) are currently subject to change. During the transition period, the presentation of report will be subject to further adjustments. One notable change is the move from monthly reporting on the Structured Judgement Review to an update each quarter in the Learning from Deaths Report.

Recommendation:

The Board is asked to **receive** the report for **assurance** the measures for mortality alongside detail of the activity supporting the improvement of quality of care and 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*
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☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

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

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

☐ Compliance ☐ 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)*

Development of a detailed action plan, which will link with all aspects of the survey.

Previously Presented at:

☐ Audit Committee	✓ Quality & Safety Committee

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

1.0 Measuring Mortality

Executive Summary

This month's mortality report presents progress on the previous month.

- Maintained monthly HSMR and rolling HSMR, mainly associated with improved metrics of flow and matching of capacity with demand.
- The SHMI is yet to be released by NHS digital, this is calculated differently and importantly includes deaths within 30 days of discharge, which we have investigated previously and found this cohort to be dominated by patients known to palliative care services.
- Improvements in both are underpinned by capacity- demand management, senior clinical ownership and accurate data collection.
- Areas of clinical priority for improvement are
  - Availability and capacity of senior decision makers to provide daily oversight
  - Clear processes of escalation and non-escalation
  - Availability of diagnostics and reporting of diagnostics in minimal timescales
- Escalation planning in the latter years of life should become usual business across the health economy to include patients, families, acute trusts and community services.

Key national and local mortality indicators

	2017/18			2018/19									Target
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Rolling 12 Month HSMR	118.8	123.1	123.4	121.2	120.6	118.3	117.5	115.4	113.8				*100.0*
Monthly HSMR	138.6	136.0	124.7	105.0	125.6	98.9	123.5	91.8	93.5				*100.0*
SHMI			118.0			115.5							*100.0*
Local HSMR Bronchitis	110.5	126.1	165.9	154.5	161.6	154.5	169.7	157.3	151.1				*100.0*
Local HSMR LRTI	111.5	127.2	167.4	155.9	163.0	155.9	171.2	158.6	152.4				*100.0*
Local HSMR Pneumonia	134.8	145.0	144.5	142.5	135.9	133.0	135.8	125.7	127.6				*100.0*
Local HSMR Septicemia	93.5	94.3	88.4	93.8	92.5	90.1	87.1	87.1	86.9				*100.0*
Local HSMR Stroke	145.1	139.0	139.1	135.4	136.6	127.7	123.5	125.6	115.3				*100.0*
Local HSMR UTI	114.2	108.3	131.2	131.6	127.5	126.1	125.0	112.1	116.4				*100.0*
Local HSMR Acute Renal Failure	90.2	106.4	124.2	121.5	109.0	108.0	108.6	103.4	96.9				*100.0*
Mortality Screens - %	104.13%	91.01%	102.83%	106.76%	88.24%	90.77%	92.21%	72.73%	58.90%	53.45%	58.82%	50.62%	*100.00%*
SJRs									33	21	13	6	*0*
2nd Review									0	2	1	0	*0*
In Hospital Deaths	121	89	106	74	85	65	77	66	72	59	69	81	*77*
In Hospital Deaths Crude Rate	48.8	39.3	41.4	30.4	29.0	22.2	26.6	21.1	22.2	17.4	20.6	24.4	*31.0*
LD Deaths	0	0	1	0	1	1	0	1	0	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

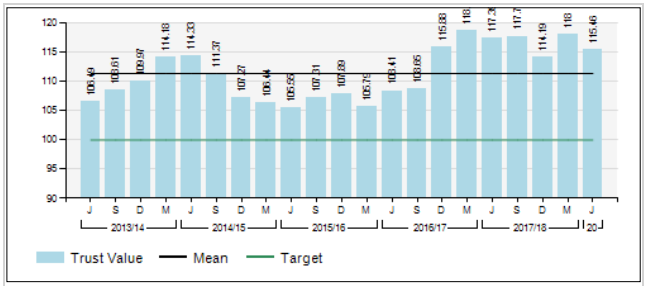
The rolling HSMR shows a slowly improving position, driven by the monthly HSMR. Looking further forward beyond September 2018, the monthly crude rate is remaining within tolerance, although this is a very volatile measure and shows significant seasonal variation under normal circumstances.

The trust has not had a death of a learning disabilities patient since August 2018.

Disease specific HSMR, which is a generic statistic applied to a specific illness – and therefore has an inherent inaccuracy – is used to focus areas of improvement where there might be improvements to make. Where we are able, we use best practice measures devised by Advancing Quality (AQ) to supplement this, or disease specific audits such as (SSNAP in stroke) to provide correlation. In practice, this means that despite a good SMR position in sepsis and an improved position in AKI, we continue to work in these areas to provide the best quality care.

While work in these areas is in the embedding phase, work on pneumonia, LRTI and Bronchitis, which is more complex, is ongoing. A pathway has been devised previously, and work around the accuracy of diagnosis, access to appropriate investigation and the risk assessment and escalation is ongoing.

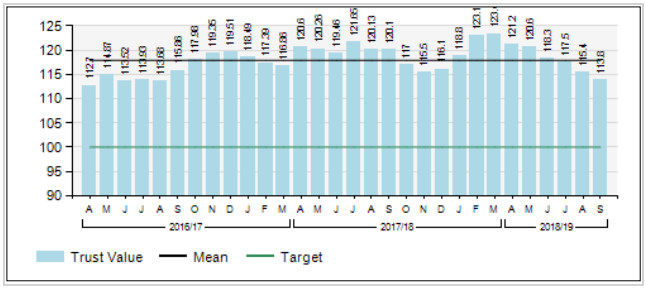
SHMI - Summary Hospital Level Mortality Indicator



We are still awaiting the revised SHMI to September 2018 from NHS Digital. As such the commentary for this figure is unchanged from the previous monthly report. The mortality dashboard indicates an expected rise in the 'observed' number of deaths however the overall effect of this on the SHMI also depends on the quarter lost from the calculation and the number of expected deaths in the quarter gained.

As reported previously, deaths within 30 days of discharge account for around 40% of all deaths. This category affects SHMI, but does not affect HSMR. There has been no increase in this proportion, suggesting that the improved HSMR is not due to any shift to earlier discharge, but this remains an important factor in the trusts SHMI figure. Previous work by Palliative Care services demonstrates that 88% of deaths within 30 days of discharge are known to Palliative Medicine. Given that 22/81 (27%) deaths from December were of patients admitted on the GSF for patients in the last year of life, all via urgent care, it is likely that better planning for deterioration with patients, families and community teams is needed.

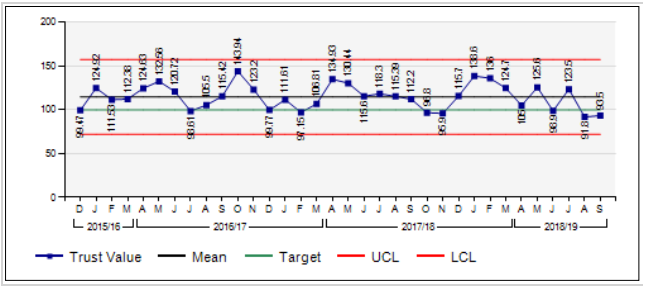
HSMR - Hospital Standardised Mortality Ratio (*Rolling 12 month*)



The HSMR continues to fall, and now stands at the lowest rolling figure for the past three years. The main factors driving this are likely to be more accurate collection of data for coding around the complex co-morbidity in our population and the significant advances in patient flow through the acute hospital and into the community.

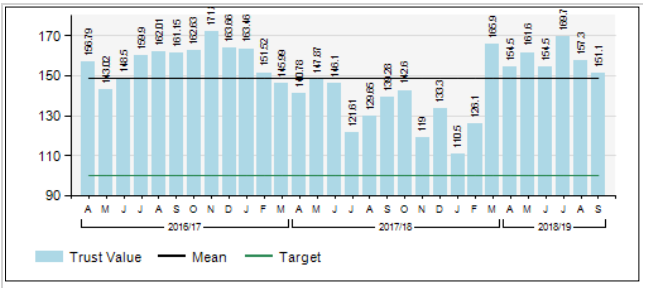
It is important that these improvements are sustained, and joined by planned improvements to staffing and digital infrastructure to support daily senior review, handover, escalation and basic care needs.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



The monthly performance distribution for the reporting month of September 2018 again demonstrates the relationship between system pressure and mortality. Metrics of AED flow in September were good and the monthly HSMR was below 100. Essentially, when the workload and staffing is matched, the system is safer for patients and staff.

Local HSMR Bronchitis



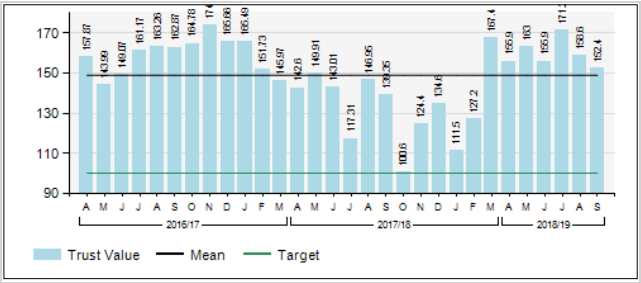
The SMR for bronchitis remains high and a priority to improve. As bronchitis is usually not usually a fatal condition, the expected mortality rate is consequently low. As diagnosis is taken from the first or second finished consultant episode, this may not represent the eventual discharge diagnosis or diagnosis at death.

Early senior review, with access to prompt diagnostics will improve the accuracy of diagnosis.

Improved access to community and hospital records through improved IT will allow better awareness of the de-compensation of chronic disease that should often be the primary diagnosis.

Equally, there is no accounting for the frailty element which is not considered a diagnosis for coding purposes currently in the NHS.

Local HSMR Lower Respiratory Tract Infection

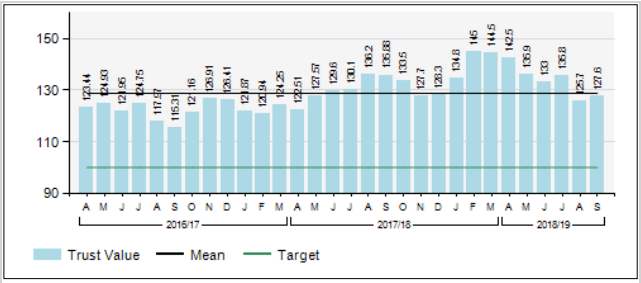


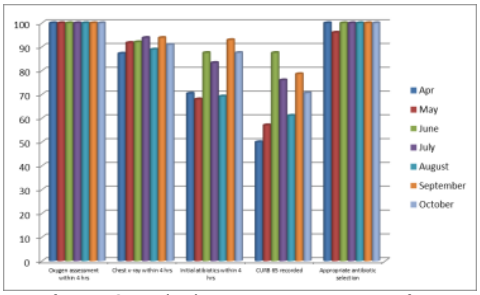
LRTI and Bronchitis are often diagnoses made in similar clinical circumstances. All points above for Bronchitis are considered for LRTI.

Priorities include:

- Accurate diagnosis
- Assessment of chronic ill health
- Consideration, availability and reporting of diagnostics
- Early and repeated senior review to challenge diagnosis

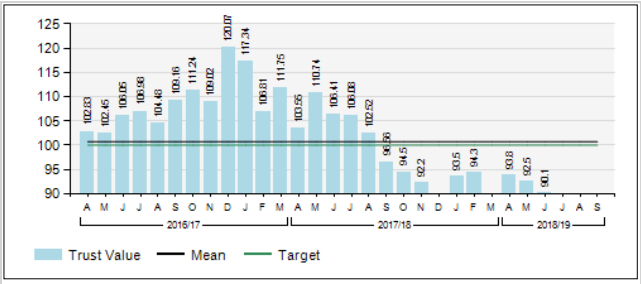
Local HSMR Pneumonia

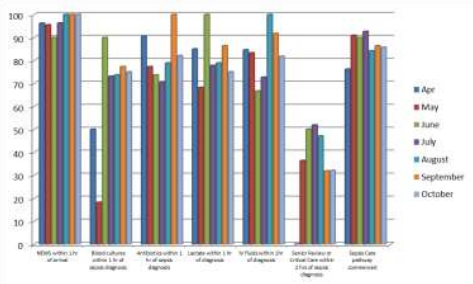




Data from AQ again demonstrates strong performance in the first four hour bundle for patients admitted with a diagnosis of pneumonia.
The aspect done least well is the CURB-65 risk assessment, which is in keeping with a general need for improvement in the areas of planning for escalation in 'at risk' patients. A new clinical escalation strategy is planned for implementation with NEWS2 in April 2019.
The revised pneumonia pathway is agreed which will help introduce diagnostic challenge and make escalation processes clearer.

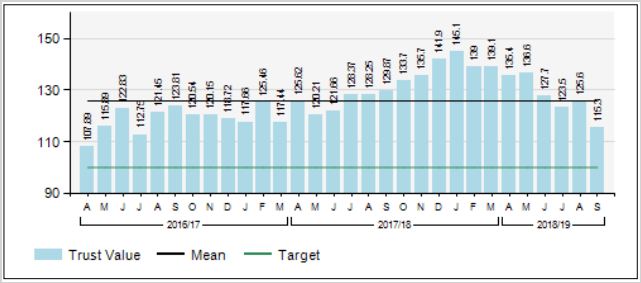
Local HSMR Septicemia





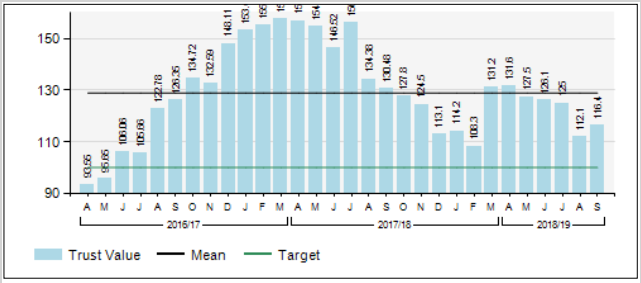
The Sepsis SMR remains in a good position historically, backed up with a good sustained performance in the AQ measures of initial sepsis care (although there has been a deterioration in performance from last month's region-leading figures). As mentioned earlier, the worst performing area is the prompt review by a senior decision maker at 2 hours, which reflects the overall process of risk assessment and escalation, coupled with the availability of senior decision makers in acute specialties. It is predicted that the implementation of 24/7 critical care outreach will improve this position.

Local HSMR Stroke



The HSMR for Stroke is on an improving trajectory. This is best compared with the annual SSNAP data which produced an SMR of 100 for this organization. This is most likely due to the improved collection of data regarding patient co-morbidity and palliative care.

Local HSMR Urinary Tract Infection

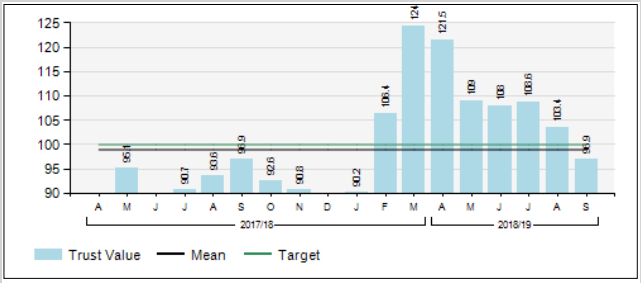


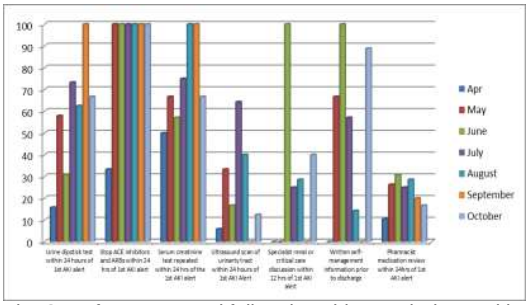
Similarly to LRTI and Bronchitis, UTI is a not a condition with a high risk of death. The elevation of this SMR most likely reflects either a missed diagnosis of sepsis of urinary origin, a lack of primacy of the decompensated chronic condition as the reason for deterioration, or frailty.

Ongoing work to improve the care of the older person in hospital to raise standards of basic care, mobility, continence, over-reliance on urinary catheterization, nutrition and hydration is ongoing and will impact.

Ongoing education around colonization, infection, antibiotic stewardship and diagnosis complements this.

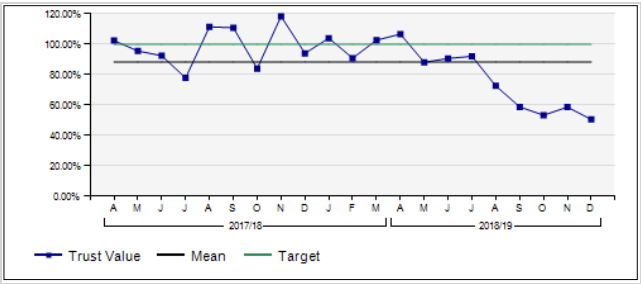
Local HSMR Acute Renal Failure





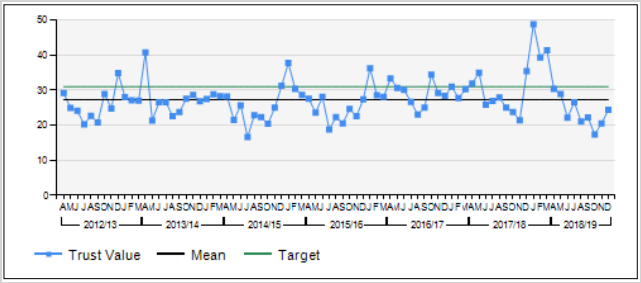
The SMR for acute renal failure has this month dropped below the statistically elevated level. The indicators of clinical performance however continue to require further attention. The AKI steering group has been established and has met. Common themes with other areas include access to diagnostics and appropriate escalation in a timely fashion. The introduction of AKI alerts into vitalpac and a 24/7 critical care outreach team to respond will help with some of these best practice indicators.

Mortality Screens - % Deaths Screened



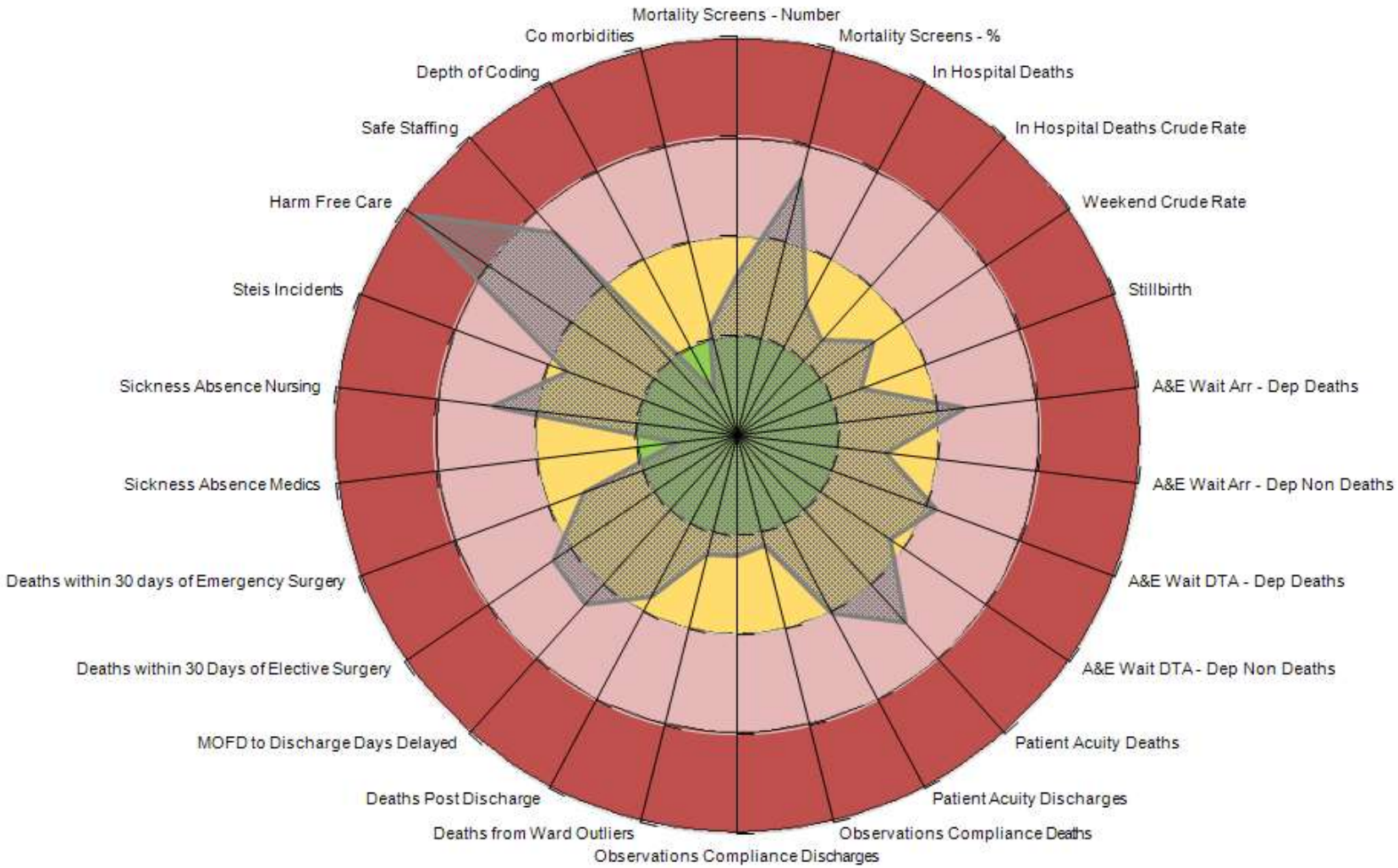
Performance for December in this aspect is disappointing, but there were mitigating circumstances with compute system failures. This has been addressed and more recent figures have shown an improvement with screening rates now up to above 60%. This is clearly below target level, but recent interventions via communication with junior doctors at February trust induction and the addition of a dedicated section to the trust junior doctors handbook is predicted to have impact.
Following on from this, a process of feeding back monthly performance to clinical meetings is being devised.

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



While the crude rate has risen over the past two months in line with seasonal changes, this rise has been moderate and presently remains below the mean. This is encouraging and probably reflects a system better prepared for winter pressure than in previous years with a focus on matching staffing to patient need and pro-active management of that need through the system (flow).

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



2.0 Reducing Avoidable Mortality Project Update – February 2019

Background

A group of key stakeholders were invited to attend the scoping session for the second phase of the RAM Project on 11th February 2019. (With the first phase having run from February 2018 to end April 2019, the proposal is that the second will run from April 2019 to March 2021).

Phase 1 was driven through six Work streams, which had been identified as the primary drivers to reduce avoidable mortality and in turn mortality ratios. (The Work streams were Care Pathways, Communication, Learning Culture, Future Care Planning, Information and Workforce, as illustrated in the first driver diagram below). We are clear that there is a significant delay between improvement activity and its impact on mortality ratios. (While SHMI and HSMR are reported six months retrospectively, they are also measured on a 12 month rolling basis). We will therefore continue to monitor the impact of specific activity (such as enhanced care pathways and the 24/7 Critical Care Outreach Team) against both national and local measures, as part of Phase 2.

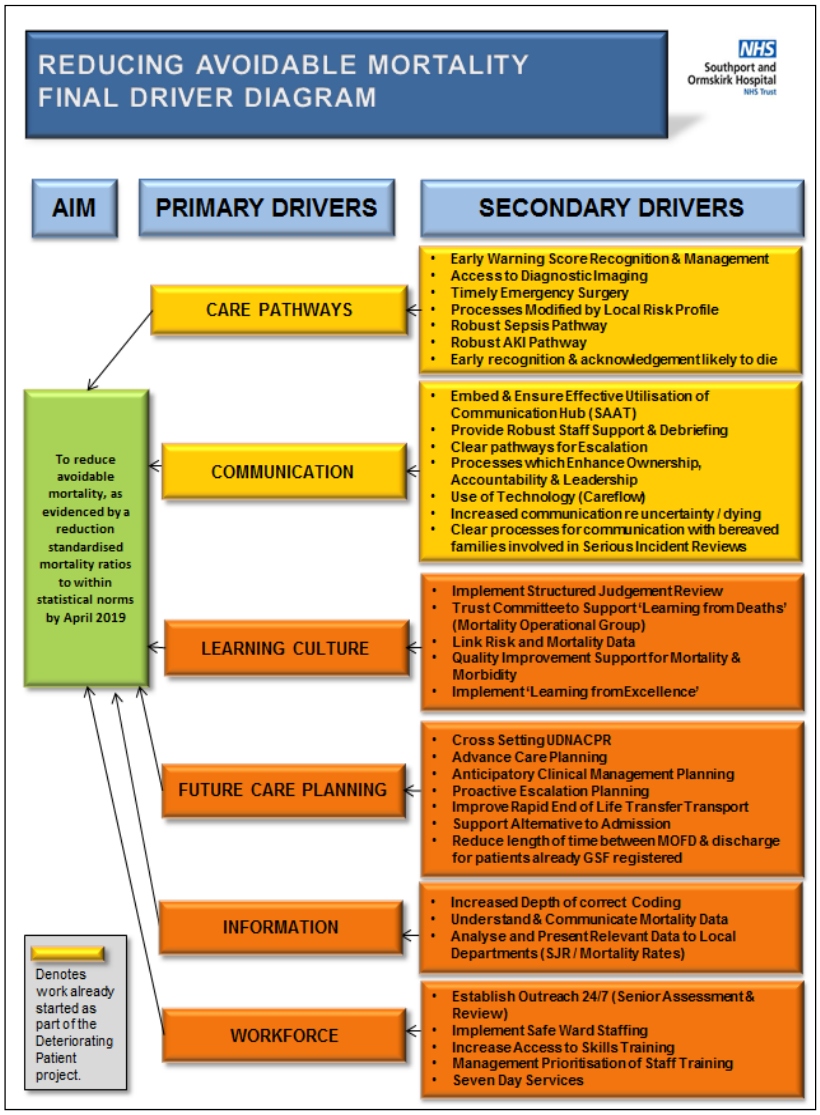


Diagram 1: RAM Phase 1 Driver Diagram (February 2018 to April 2019)

Reducing Avoidable Mortality - Phase Two

The key stakeholders for the scoping session for RAM Phase 2 included the Trust's Medical Director, the Associate Medical Director for Patient Safety, Consultant in Palliative Medicine and Medical Director of Queenscourt Hospice, the Director of IT, Lead for Clinical Audit and the Interim Director for Performance. There was also representation from Transform Palliative Care, the Risk Department, Respiratory Care and the Trust Programme Office.

The following mission statement and patient journey model were agreed by the group as the requirements from which the project is to be scoped.

"Only those requiring in-hospital care to be admitted, for the shortest possible length of stay. Patients to be placed on the correct care pathways by knowledgeable staff who are satisfied with the level care that they are able to give to ensure a great patient experience. No one dies unless it is expected and all to who are discharged to leave with a comprehensive care management plan. Those who are discharged to leave with a comprehensive care management plan."

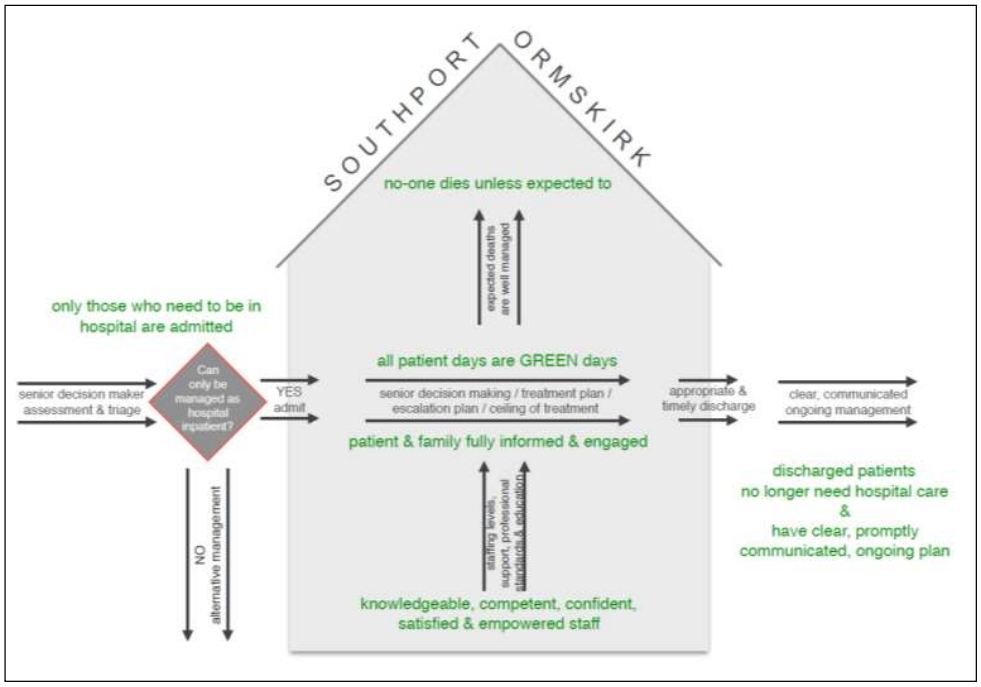


Diagram 2: The Patient Journey: Driving Avoidable Mortality by Dr K Groves. (Model as discussed & agreed at Phase 2 Scoping Session).

A revised mission and primary drivers were identified as detailed below. A series of short follow up meetings will be held up until the end of March to further develop the secondary drivers and SMART objectives and KPIs for the Work streams. Full project documentation will also be completed with sign off from a steering group.

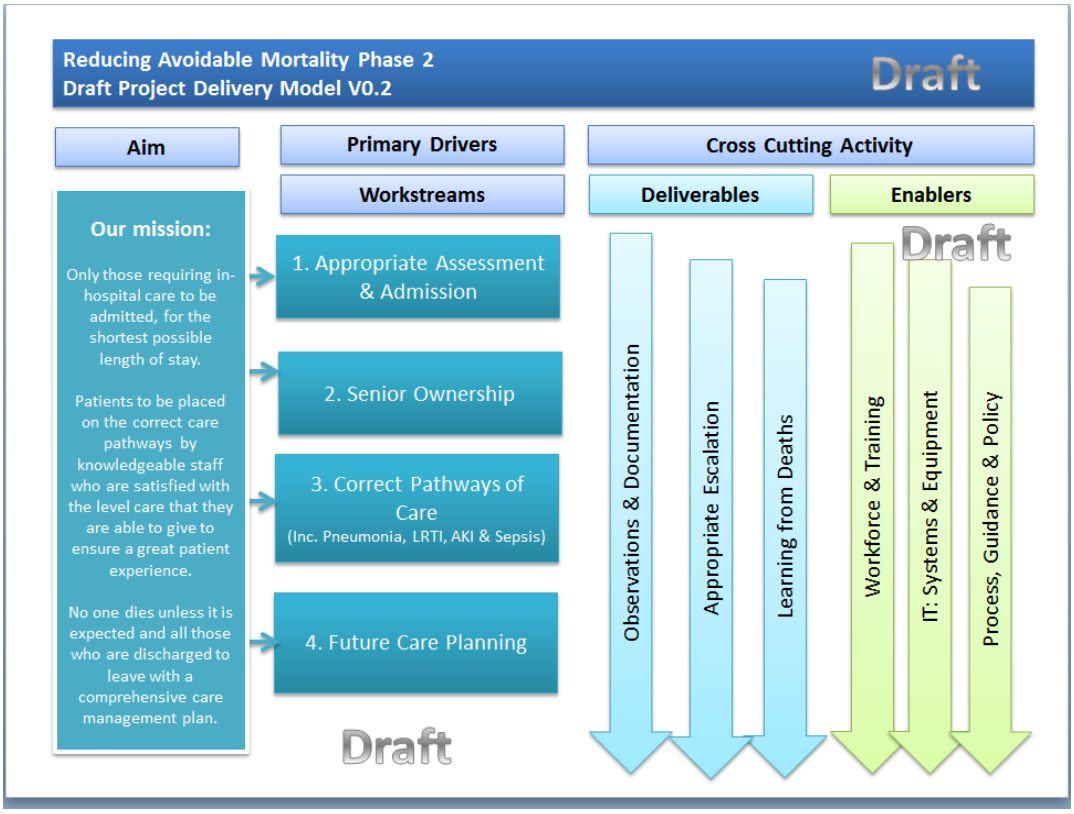


Diagram 3: Reducing Mortality Phase 2 Draft Project Delivery Model V0.2 [1]

[1] **(Updated from V0.1 as presented in the Mortality paper to the Quality and Safety Committee)**

The proposal from the group was that the delivery of the model should be through two wards in the first instance (one medical and one surgical). This proposal is being prepared for submission to the Executive Team for their consideration, ahead of being fed back into the March project scope development sessions.

Highlights of Current Activity – RAM Phase 1

Pneumonia Care Pathway

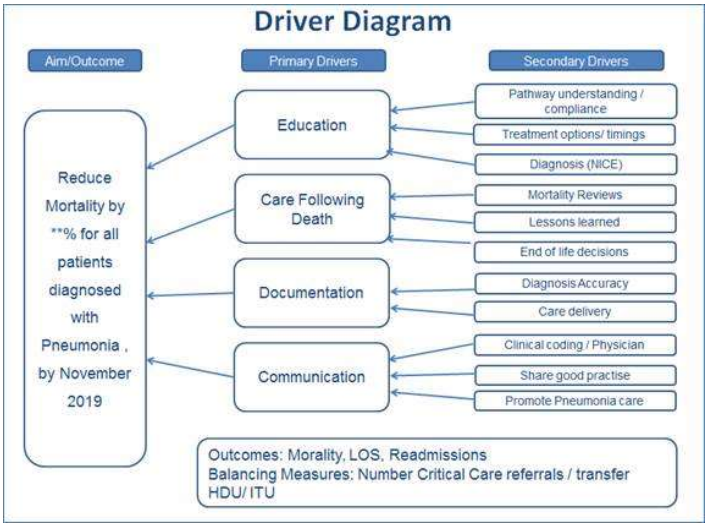


Diagram 4: AQUA / SOHT Driver Diagram for Pneumonia Care Pathway – February 2019

- As part of the Trust's Quality Summit, a meeting was held with AQUA to discuss their support for quality improvement for the management of Pneumonia. (See diagram 4 above).
- AQUA have analysed SOHT data for Community Acquired Pneumonia (CAP) patients (January to October 2018) which showed that patients were receiving NICE recommended care the majority of the time. They have recommended however that the Trust looks further at clinical coding, recording of diagnosis, and End of Life decisions to understand why patients are dying.
- A group of respiratory medics and nursing staff have been asked to attend a deep dive and quality improvement exercise to scope activity for the coming year on 21st March. This will look at not only at pneumonia but also LRTI and pneumonia as a complication of heart failure alongside the methods for treatment, documentation, coding and reporting.
- The Trust is already committed to participate in the regional Hospital Acquired Pneumonia (HAP) project with Liverpool University under Dr Wootton, Respiratory Consultant at Aintree Hospital. The findings of the project will be reported back at the AQ North West Pneumonia Collaborative 21st May 2019.
- The Pneumonia Pathway has been revised again and will be returned to the March Clinical Effectiveness Committee for approval.

AKI Care Pathway

- The new monthly AKI Steering Group, chaired by Dr Henry Gibson ran for the first time on 6th February. The group has been set up to review safe working practices for AKI within the organisation and to ensure that the AKI Pathway is effectively embedded and monitored throughout the Trust.
- Members of the Trust will be attending the AQUA Advancing Quality - Acute Kidney Injury (AKI) Collaborative on Friday, 26 April 2019. Where the agenda includes: Bury GP AKI evaluation, AKI detection tool, Sustainable AKI care delivery as well as 2018 AQ AKI data (for participating trusts including ourselves).

IT – Ward Boards

- The 'Ward Boards' subgroup met on 15th February to finalise the content for the single point of capture on-line form for Ward Boards / Board Rounds.
- A mapping session to align IT functionality with best practice process is being organised for 29th March with medics, nursing, ward manager and ward clerk representation.
- Hardware equipment requirements are to be confirmed with the group and IT before a go-live date for a trial can be finalised.

Workforce

- The 24/7 Critical Care Outreach Team remains on track to go live at the beginning of April 2019.

Next Steps: A full evaluation of RAM Phase One will be provided in the March Mortality Report to the Quality and Safety Committee with an overview of the project plan for RAM Phase Two.

3.0 External Mortality Review Action Plan Update – February 2019

External Mortality Review Action Plan 2018/19				
	External Mortality Review Recommendation August 2018		Recommendation Detail	Progress Update February 20197
1	**Improve Patient Flow**		*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:*	
	a.	**Alternative to admission**	*Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams*	**Workstream 1 of the Length of Stay (LOS) Project 'Emergency Admission, Triage and Assessment Units'** is developing ways of managing A&E attendances with increased efficiency at the point of arrival with: - A trial of a senior nurse at the font door and enhanced triage. - A review of the ambulatory care modelling by season is to be assessed. (The Clinical Decision Unit opened in September 2018, further work is being undertaken to maximise ambulatory care performance). - In-reach provision into A&E for COPD and Diabetes Additional work with Community Health Care partners has been identified by the Patient Flow Improvement Board to provide a framework to support alternatives to admission.This again will fall under the LOS Project, the scope of which is currently being refreshed to capture all The Integrated Frailty Pathway is being developed under the STP Programme Office. A business case has been submitted by the in-house Care of the Elderly Team for additional ortho-geriatrician cover that would be able to provide in-reach into ED to facilitate safe alternatives to admission.
	b.	**Criteria led discharge**	*Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging*	**Workstream 2 of the Length of Stay project** is focused on reducing long length of stay and delivering Red to Green. Weekly activity with community partners to drive best practice discharge has been running since November 2018 with 'Long Stay Tuesdays', 'Multi Agent Discharge Events' (MADE). The Trust has invested in 8 Discharge Facilitators, 6 of which are in post.
	c.	**Proactive escalation planning**	*Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders*	As part of the **Reducing Avoidable Mortality Project, the 'Ward Boards' subgroup** is tasked with designing structured Ward Rounds and Board Rounds supported by a computerised system with force function which requires the selection of either critical care, ward care or end of life care. The pilot for the new on-line single point of capture is anticipated for a pilot launch by April 2019 (IT equipment requirements permitting; requirements are currently being specified alongside behavioural process planning).
	d.	**Multi-Specialty Team Working**	*Team working to improve patient management through the pathway including in-reach to emergency department and critical care outreach to all areas.*	Multi-Speciality Team Working is being driven by: - The move to **24/7 Critical Care Outreach Team** cover which is to 'go-live' on 1st April 2019 providing additional resource for seemless cover. (An output of RAM Phase 1). - Proposed in-reach provision of ortho-geriatric medical cover into A&E as requested in the **Frailty Business Case for 2019/20.** - Plans for enhanced hospital specialist service in-reach into A&E for COPD and Diabetes and plans to scope community in-reach service options with healthcare partners (both as part of the **Length of Stay project**).
2	**Improve awareness of Sepsis**		*Improve awareness of Sepsis 6 guidelines and monitor adherence.*	Improved Sepsis SMR reflects AQ data which reports high levels of Sepsis 6 performance for the Trust. There is however room for improvement for the taking of blood cultures and senior review within 2 hours. Both activities will benefit from additional support by the new 24/7 Critical Care Support Team which 'goes live' on 1st April 2019. A Royal College Sepsis audit for emergency care has been proposed by Length of Stay Workstream 1. The last audit was held in 2016, since which time the Trust's Sepsis Pathway has been revised. The audit would provide an additional assurance as to whether there are any issues with the misdiagnosis (including overdiagnosis) of sepsis.
	a.	**Improve awareness of Sepsis 6 Guidelines**		
	b.	**Monitor compliance with Sepsis Pathway**		

External Mortality Review Action Plan 2018/19

	External Mortality Review Recommendation August 2018	Recommendation Detail	Progress Update February 20197
3	**Review or establish Pneumonia Pathway in line with national guidelines**	*Review and/or establish a pneumonia pathway to ensure that it meets national guidelines.*	A group of respiratory medics and nursing staff have been asked to attend a scoping session for Pneumonia related quality improvement as part of the RAM Project. This will look at not only at pneumonia but also LRTI and pneumonia as a complication of heart failure alongside the methods for treatment, documentation, coding and reporting. The Trust is working with the Advanced Quality Alliance (AQUA) who have analysed SOHT data for Community Acquired Pneumonia (CAP) patients (January to October 2018). This has showed that patients were receiving NICE recommended care the majority of the time. They have recommended however that the Trust looks further at clinical coding, recording of diagnosis, and End of Life decisions to understand why patients are dying. The Pneumonia Pathway has been revised again (for the second time since the External Mortality Review was undertaken in June 2018) and will be returned to the March Clinical Effectiveness Committee for approval.
4	**Review antibiotic guidelines to ensure that they meet recent national guidelines.**	*Review antibiotic guidelines to ensure that they meet recent national guidelines.*	Antibiotic Guidelines have been reviewed by the microbiology department in May 2018 and it has been confirmed that we are meeting the required national standard (we are using the Mersey Micro App with St Helens and Knowsley NHS Trust). The issue with compliance is in the application of tguidance by staff. An antibiotic prescription audit by antimicrobial pharmacist is required to investigate this assumption. This activity sits under the Drug and Therapeutics Committee and the Infection Prevention and Control Committee from which updates will be fed back into this Action Plan.
5	**Review doctors' rotas to ensure sufficient daily senior cover and that junior doctors are not unsupported or working beyond their capabilities.**	*Review doctors' rotas to ensure sufficient daily senior cover and that junior doctors are not unsupported or working beyond their capabilities.*	To be incorporated into the second workstream for **RAM Phase 2 "Senior Ownership".** Scoping of the detail for the new workstreams and deliverables to take place in March 2019. (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019")
6	**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.**	*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.*	To be incorporated into the cross-cutting deliverable for **RAM Phase 2 "Observations and Documentation".** Scoping of the detail for the new workstreams and deliverables to take place in March 2019. (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019").
7	**Review nursing and AHP documentation to ensure that it is fit for purpose in focusing and promoting essential care, particularly fluid balance and nutritional needs.**	*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.*	To be incorporated into the cross-cutting deliverable for **RAM Phase 2 "Observations and Documentation".** Scoping of the detail for the new workstreams and deliverables to take place in March 2019. (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019").
8	**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.**	*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.*	To be incorporated into the cross-cutting deliverable for **RAM Phase 2 "Observations and Documentation".** Scoping of the detail for the new workstreams and deliverables to take place in March 2019. (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019").
9	**Review escalation and ceilings of care policies to include timely access to critical care and end 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).**	*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).*	The Trust's Track and Trigger policy is being revised to provide clear guidance on the thresholds for escalation to support the the new National Early Warning Scoring system (NEWS2) which will be rolled out as part of VitalPAC Version 3.6 in March 2019. VitalPAC will be also become available in A&E in April 2019. "**Appropriate Escalation"** is one of the cross-cutting key deliverables of **RAM Phase 2.** (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019").

External Mortality Review Action Plan 2018/19

	External Mortality Review Recommendation August 2018	Recommendation Detail	Progress Update February 20197
10	**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.**	*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.*	The Trust's End of Life policy has been reviewed and there is no requirement for it to be revised. In order for the required activity to become implemented and embedded, increased senior engagement is required. This objective will sit under both **'Senior Ownership' and 'Future Care Planning'** within the new RAM Phase 2 Project Plan.
11	**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 readmission for patients approaching the end of their life.**	*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 readmission for patients approaching the end of their life.*	To be incorporated into **RAM Phase 2 "Future Care Planning" workstream.** Scoping of the detail for the new workstreams and deliverables to take place in March 2019. (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019").
12	**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.**	*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.*	To be incorporated into cross-cutting deliverable **"Learning from Deaths" within RAM Phase 2.** Scoping of the detail for the new workstreams and deliverables to take place in March 2019. (C.f. Draft Project Delivery Model V0.2 under "RAM Project Update - February 2019").

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PUBLIC TRUST BOARD

6 March 2019

Agenda Item	TB051/19	Report Title	Equality Diversity & Inclusion Annual Report 2017-18 and Objectives
Executive Lead	Jane Royds, Director of HR and Organisational Development		
Lead Officer	Laura Hilton, Head of Human Resources		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The Trust Equality Diversity & Inclusion Report 2017-18 provides a summary of the equality work undertaken by the Trust. The report highlights how the Trust has been compliant with the Equality Act 2010 Public Sector Duties. The report also highlights how it has met the various equality objectives of the quality contracts and a number of NHS England equality requirements i.e. Workforce Race Equality Standard (WRES).

A set of Trust Equality Objectives are a legal requirement and a set of equality objective have to be set by the Trust.

Work is being done in partnership with staff and various partners i.e. Sefton Clinical Commissioning Group (CCG) Navajo and Healthwatch to ensure that the Trust embeds equality diversity and inclusion within the Trust and the services it provides to staff patients and carers. The equality objectives set will ensure the Trust develops specific areas of equality and diversity that benefits Trust staff, patients, carers and the public.

Executive Leads have to ensure that they are aware of the Trusts legal and contractual equality obligations. In addition to the various equality reports that must be complied equality updates must be provided to the various Trust committees / groups and externally to NHS England and the Clinical Commissioning Groups (CCG's) as part of the quality contract.

To ensure the Trust is compliant moving forward an equality action plan will be complied and regular updates will be provided to Trust board and the various Trust committees and groups.

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

Strategic Objective(s) and Principal Risks(s)

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

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

✓ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
✓ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
✓ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
✓ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

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

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

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

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

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

- The Equality Diversity & Inclusion Annual Report 2017-18 and equality objectives will be shared across the Trust and with partners
- The report and equality objectives will be upload onto the equality and diversity section of the Trust website
- The Trust will provide a copy of the report and objectives to the Sefton CCG as part of the E&D section of the quality contract
- An equality action plan will be complied and updates provided to the various Trust groups / committees and board.

Previously Presented at:

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

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EQUALITY, DIVERSITY & INCLUSION ANNUAL REPORT 2017-2018

1. FOREWORD

Welcome to the Southport and Ormskirk NHS Trust Equality Diversity & Inclusion Report for 2017/2018. This document includes information about our patients, workforce and our local population and outlines the Trust's commitment to promoting equality in all its functions and to valuing the diversity of staff patients and the local communities.

The provision of high quality patient care is our key driver and the principles of equality, diversity and human rights are intrinsic to the Trust's core business. We are committed to delivering high quality services that are accessible, responsive and appropriate to meet the needs of all our patients. In this respect, patient pathways have been designed to reduce variations in care and improve outcomes, whilst recognising the needs of individual patients.

We aim to be an employer of choice and ensure that all our staff have equality of access to jobs, to promotion and to training opportunities.

The Trust is committed to creating an environment where everyone is treated with dignity, fairness and respect and to developing a culture of support and inclusion for all our employees and for those patients who access our services.

Contents:

2. ABOUT US

2.1 Our Hospitals

Acute care is provided at Southport and Formby District General Hospital and Ormskirk and District General Hospital. This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities. Women's and children's services, including maternity, are provided at Ormskirk hospital.

The North West Spinal Injuries Centre at Southport hospital provides specialist care for spinal patients from across the North West, North Wales and the Isle of Man.

2.2 Our vision and values

The Trust aims to establish and embed exemplary healthcare. Our values are expressed through "Scope", developed from what staff told us was important to them about the Trust.

They are:

- Supportive
- Caring
- Open and honest
- Professional
- Efficient

2.3 Objectives of the Trust strategy

The Trust's corporate strategy contains five objectives or "strategic domains":

- Work with our partner organisations to provide lifelong, integrated care across the local health economy
- Ensure excellence in treatment and care
- Deliver performance, within resources, comparable with the best the NHS can offer
- Empower and develop staff to achieve their objectives
- Maintain organisational sustainability

3. OUR POPULATION

Southport and Ormskirk Hospital NHS Trust provides healthcare to a population of 258,000 people across Southport, Formby and West Lancashire.

After a review of the 2011 census for the local demographics of Sefton and West Lancashire the following information is available that covers ethnicity and commonly used languages:

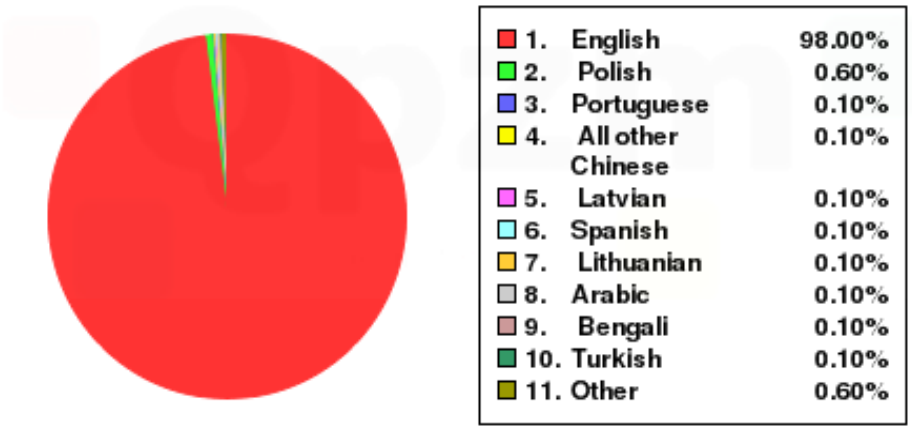
Sefton: Ethnicity Population Summary: Census 2011

Ethnicity		% Percentage of the Population in Sefton
White		97.40%
Mixed		1.1%
Asian		0.5%

Black		0.3%
Other		0.7%
Totals		**100%**

Source: ONS, 2011 Census: Note: BME includes all other ethnicities besides White. Within Sefton, 97.4% of the population has a White ethnic background and 2.6% of the Sefton population has a Black, Minority Ethnic background (BME).

Sefton's most commonly used languages:
98.0% of people living in Sefton speak English. The other top languages spoken are 0.6% Polish, 0.1% Portuguese, 0.1% All other Chinese, 0.1% Latvian, 0.1% Spanish, 0.1% Lithuanian, 0.1% Arabic, 0.1% Bengali, 0.1% Turkish.

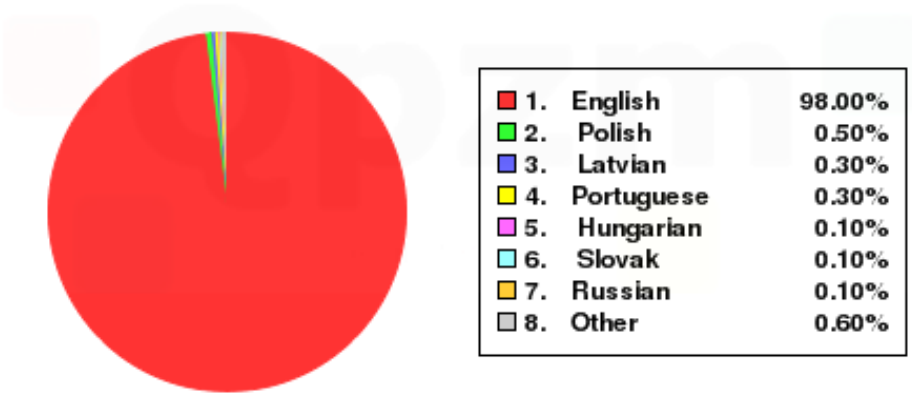


West Lancashire: Ethnicity Population Summary: Census 2011

Ethnicity		% Percentage of the Population in West Lancashire
White		98.10%
Mixed		0.7%
Asian		0.9%
Black		0.1%
Other		0.2%
Totals		**100%**

Source: ONS, 2011 Census : Note: BME includes all other ethnicities besides White. Within West Lancashire, 98.1% of the population has a White ethnic background and 1.9% of the West Lancashire population has a Black, Minority Ethnic background (BME).

West Lancashire's most commonly used languages: 98.0% of people living in West Lancashire speak English. The other top languages spoken are 0.5% Polish, 0.3% Latvian, 0.3% Portuguese, 0.1% Hungarian, 0.1% Slovak, and 0.1% Russian.



4. THE LEGAL CONTEXT

4.1 The Equality Act 2010

The Equality Act 2010 ("the Act") provides the legislative framework to protect the rights of individuals and advance equality of opportunity for all. The Act harmonises and simplifies previous equality legislation with the aim of delivering an accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The Act consolidated 116 separate pieces of equality legislation, principally:
Sex Discrimination Act 1975
Race Relations Act 1976
Disability Discrimination Act 1995

The Act introduced the new terminology of "protected characteristics" to which it then applies, in a consistent way, the traditional elements of direct and indirect discrimination, victimisation and harassment.

The protected characteristics are as follows:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race (includes ethnic or national origins, colour or nationality)
- religion or belief (Including lack of belief)
- sex
- sexual orientation

4.2 Public Sector Equality Duty

The Equality Duty is a duty on public bodies and others carrying out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees.

The Equality Duty supports good decision-making – it encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective. The Equality Duty therefore helps public bodies to deliver the Government's overall objectives for public services.

The Equality Duty has three main aims. It requires the Trust, in the exercise of all its functions, to have "due regard" to the need to:

- eliminate discrimination, harassment, victimisation and other conduct prohibited by the Act

- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it

- foster good relations between people who share a relevant characteristic and those who do not share it

(In respect of the protected characteristic of marriage and civil partnership, only the duty to eliminate discrimination applies)

Having "due regard" means that the Trust must always consciously think about the three aims of the Equality Duty as part of process of day to day decision-making. This means that consideration of equality issues influences the Trust's decision-making process in how we act as employers; how we develop, evaluate and review policy; how we design, deliver and evaluate services and how we commission and procure from others.

4.3 Equality Impact Assessment (Analysis)

Equality Impact Assessment/Analysis (EIA) is a requirement for all Policies and is part of the Cost Improvement Programmes (CIPs) process which contains both a quality impact assessment and an equality impact assessment. The responsible manager must complete both sections. These steps will help the Trust to ensure that it pays due regard to its obligations under the Public Sector Equality Duty of the Equality Act 2010.

The Trust in 2018-2019 aims to develop the Equality Impact Assessment Template which will increase the level of guidance in the template and will increase staffs understanding of completing the EIA.

Further information about the Equality Act 2010 can be found at the Equality and Human Rights Commission. http://www.equalityhumanrights.com/

4.4 Workforce Race Equality Standard (WRES)

The NHS Equality and Diversity Council agreed in July 2014 that action across the NHS needs to be taken to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The move follows recent reports which have highlighted disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst the BME population.

Following a period of consultation, the NHS Equality and Diversity Council agreed two measures that complement each other whilst being distinct to improve equality across the NHS and these would be mandatory requirements embedded within the NHS Contract from April 2015.

1. The Workforce Race Equality Standard (WRES)
2. NHS Equality Delivery System 2 (EDS2)

There are nine WRES metrics. Four of the metrics are specifically on workforce data and four of the metrics are based on data derived from the national NHS Staff Survey indicators. The latter will highlight any differences between the experience and treatment of White staff and BME staff in the NHS, with a view to closing the gaps highlighted by those metrics. The final metric requires provider organisations to ensure that their Boards are broadly representative of the communities they serve.

The CQC will take this into account within the 'Well Led' domain.

Workforce Race Equality Standard Indicators:

Workforce: For each of these four workforce indicators, the Standard compares the metrics for White and BME staff were the figures don't equate to 100% this is due to the information not stated / not given.

	Indicator	Data for reporting year 2017-18		
1	This question has been amended this year: **2017:** Percentage of staff in each of Afc Bands 1-9 or Medical and Dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-clinical Clinical staff –of which Non-Medical Staff	Non - Clinical Staff Band 1 Band 2 Band 3 Band 4 Band 5 Band 6 Band 7 Band 8a Band 8b Band 8c Band 8d	BME 7.0% 1.3% 4.3% 0.6% 1.9% 2.2% 3.3% 5.0% 0% 0% 14.3%	White 84.7% 93.7% 84.5% 95.8% 90.4% 93.5% 90.0% 95.0% 100% 100% 66.7%

	Medical and Dental Staff **2016:Question** Percentage of staff in each of Afc Bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Band 9 0% 100% VSM 33.3% 66.7% CQIR 0% 100% IRPM 0% 100% WCOO 0% 100% WQZZ Not Stated Board BME White 0% 100% Clinical Staff BME White Band 2 9% 80.2% Band 3 3.2% 92.2% Band 4 0% 98.1% Band 5 7.5% 87.2% Band 6 4.8% 90.6% Band 7 2.0% 91.2% Band 8a 8.9% 85.7% Band 8b 0% 90.5% Band 8c 0% 100% Band 8d 0% 100% VSM 0% 100% Med & Dental Consultant BME White 45.9% 40.5% Med & Dental Consultant Non – Consultant Career Grade BME White 54.2% 30.1% Medical & Dental Trainee Grades BME White 24.7% 65.6% BME White FMWC 0% 100% MT01 Not Stated WH03 0% 100% WH07 16.7% 66.7%

		Board BME White 33.33% 66.67%

2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts	Recruitment: The information below highlights the ratio of BME and White Staff being appointed from short listing; please note this refers to both internal and external posts

	Head Count		Ratio	
WRES Category	**Shortlisted**	**Hired**	**Shortlisted**	**Ratio**
BME	393	7	0.98	0.02
White	2289	98	0.96	0.04
NULL	10	2	0.83	0.17
Not Stated / Not Given	47		1.00	

3	Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year	Disciplinary Process: Overall breakdown of cases by ethnic origin categorised in line with WRES requirements as at 31.3.2018

WRES Category	Head Count
BME	1
White	38
Not Stated	4
Total	43

4	Relative likelihood of staff accessing non-mandatory training and CPD	Training: The information below highlights the ratio of BME and White staff accessing training in 2017-18

WRES Category	Head Count	Enrolment Headcount	Ratio
BME	242	223	0.92
White	2603	2447	0.94
NULL	12	10	0.83
Not Stated / Not Given	206	191	0.93

NHS Staff Survey (WRES):

The 2017 NHS Staff Survey was completed by 1265 staff this is a response rate of 45% which is average for combined acute and community trusts in England (43%) and compares with a response rate in the Trust in 2016 of (49%) ,

For each of these four staff survey indicators, the Standard compares the metrics for each

survey question response for White and BME staff.

Key Findings KF25, KF26, and KF21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.
Note that for question Q17, the percentage featured is that of "Yes" responses to the question.

Key Finding and question numbers are the same in 2017 as 2016.
Figures in green highlight an improvement in last year's figures

	Indicator	Data for reporting year 2017	Data for previous year 2016
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Experiences of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has seen a reduction of 3% for white staff and 10% for BME staff.	White staff 29 % BME staff : 20% Average (median) for combined Acute and Community Trusts White staff– 26% BME staff- 27%	White staff: 32% BME staff: 30%
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months Experiences of experiencing harassment, bullying or abuse from staff in last 12 months has seen the same % figure for white staff and an increase of 4% for BME staff.	White staff: 24% BME staff: 33% Average (median) for combined Acute and Community Trusts White staff– 23% BME staff- 29%	White staff: 24% BME staff: 29%
7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion Experience of white staff has seen a reduction of 1% for white staff and an increase of 2% for BME staff.	White staff: 79% BME staff: 75% Average (median) for combined Acute and Community Trusts White staff: 88% BME staff: 73%	White staff:80% BME staff: 73%
8	Q17b. In the last 12 months have you	White staff: 7%	White staff: 8%

	personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues Experience of white staff has seen a 1% decrease from 2016 and there has been a decrease of 50% from 2016 for BME staff.	BME staff: 10% Average (median) for combined MH/LD and Community Trusts White staff: 6% BME staff: 15%	BME staff: 20%

Board Representation Indicator (WRES):
For this indicator, compare the difference for White and BME staff

	Indicator	Data for reporting year
9	Percentage difference between the organisations' Board and its overall workforce	The information below provides information on the headcount and percentage difference between the organisations board membership and its overall workforce for BME and White Staff By executive membership of the board Board Directors: White: 60% BME:30% Not Stated:10%

Board members:	
BME	3
White	6
Not Stated	1
Total	10

WRES Category	Head Count	Head count %	Board Head Count	Board Headcount %
BME	242	7.9%	3	30%
White	2603	85.01%	6	60%
Null	12	0.39%	0	0.00
Not Stated /Not Given	206	6.7%	1	10%

Trust Actions taken to be compliant with the WRES

- WRES Reporting template completed and sent to NHS England
- WRES Report completed and uploaded onto the Trust website
- WRES Action plan completed and to be reviewed and updates to be provided at each Valuing Our Peoples Assurance Group and Workforce Committee meeting
- WRES report to be presented to the Trust board and appropriate Trust groups / committees

The various Trust Groups / Committees are asked to:

- Note that the NHS Workforce Race Equality Standard came into effect on the 1st April 2015 and is completed by the Trust on a annual basis.
- Note that the Trust has put in place WRES action plan and agree that the performance against the plan will be reported through the various Trust wide Groups / Committees
- An annual WRES report will be complied for submission to the NHS England Coordinator, Commissioner outlining progress on the Workforce Race Equality Standards.
- Workforce Race Equality Standard report will be published on the Trust website
- A copy of the WRES Indicators has been sent to NHS England

5. EQUALITY GOVERNANCE

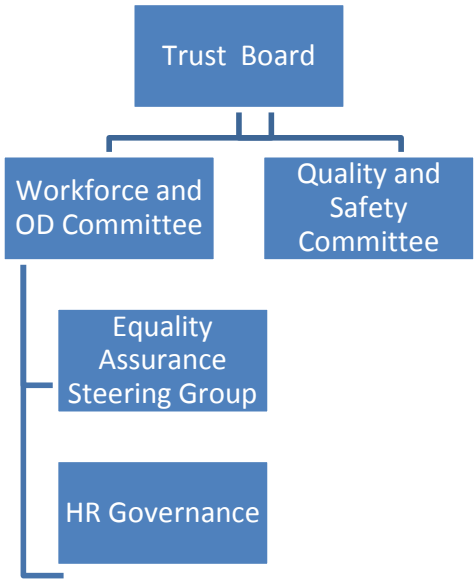
The Equality Act 2010 and the Human Rights Act 1998 provide the legal framework within which the Trust operates its equality governance. Additionally, the Health & Social Care Act 2008, NHS England, the Operating Framework and the NHS Constitution all highlight the need to reduce discrimination in services, improve accessibility and reduce health inequalities for all.

The refreshed Equality Delivery System (EDS2) is the framework by which the Trust can demonstrate how it is performing on issues of equality and health inequality to its patients, staff, communities and commissioners.

At Board level the lead accountability sits with the Director of HR and there is a Non-Executive Director who also acts as an Equality Champion.

The Trust's Valuing People Group, reports through the Workforce Committee and ensures that the Trust complies with externally set standards and establishes, monitors and reviews content and methods of assurance to the Workforce Committee and Patient Experience Groups in relation to all areas of Equality and Diversity.

Governance Structure: Fig 1.



6. THE EQUALITY DELIVERY SYSTEM (EDS2)

Department of Health's Equality and Diversity Council (EDC) developed the original Equality Delivery System (EDS) to help the NHS improve its equality performance and embed equality considerations into mainstream business. It was designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS2 is about making positive differences to healthy living and working lives. In November 2013 a refreshed EDS2 was launched, EDS2, which encouraged local adaptation with a strong focus on local issues and problems.

The EDS2 assessment grading for 2017 was as follows:

Goal	Number	Southport and Ormskirk
Better health outcomes	1.1	Developing
	1.2	Developing
	1.3	Developing
	1.4	Developing
	1.5	Developing
Improved patient access and	2.1	Developing
	2.2	Developing

experience	**2.3**	Developing
	2.4	Developing
A representative and supported workforce	**3.1**	Developing
	3.2	Developing
	3.3	Developing
	3.4	Developing
	3.5	Developing
	3.6	Developing
Inclusive leadership	**4.1**	Developing
	4.2	Developing
	4.3	Developing

Moving forward the Trust will be part of the EDS2 Merseyside Collaborative Group that consists of NHS Merseyside organisations who aim to work together on implementing the EDS2 toolkit to develop robust and effective equality objectives across the area jointly and collectively on a number of key priority areas that advance equality of opportunity.

7. CARING FOR OUR PATIENTS

7.1 Learning Disability

The Trust has a learning disability liaison service which supports care of a patient with a learning disability in a number of ways. The service can be contacted by patients, carers, and community teams regarding any reasonable adjustments required to support access to health services within the Trust i.e. quiet waiting areas in out-patients, specific appointment times, and facilities for carers/ family to stay with patient. The Trust has purchased a number of beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission.

Patients who have moderate to severe learning disability can be assessed to have their own funded carer to stay with them throughout admission. This supports familiarity in a strange environment, support with nutritional needs and compliance with treatment which contributes to a positive patient experience and outcome for the patient. The use of Medway alerts allows us to identify patients who have a learning disability and benefits the patient by allowing the communication of any necessary reasonable adjustments, the use of the LD health/hospital passport also supports the sharing of information of the needs of the patient. The service also has a strong relationship with both West Lancs and Sefton Community LD

teams, which enhances care and communication for both planned and unplanned admissions of a patient with a learning disability.

7.2 Accessing Trust Services

The Trust are legally obligated under the Public Sector Equality Duty 2010 to ensure that our services are fully accessible for all people who access Trust services and the provision of a high quality communication service is an essential element that demonstrates compliance with the act.

The Trust aim to actively promote information on the Accessible Information Standard which was implemented on 31 July 2016; the Accessible Information Standard will begin to address any disparity in the care received by disabled people. It will ensure that information is provided to all people who access Trust services in a way they can understand.

Southport and Ormskirk Hospital NHS Trust aim to provide a full range of interpreting and translation services to ensure that the services provided by the Trust are equally and easily accessible to the diverse communities it serves.

The Trust offers the following interpretation and translation services and will provide other services as requested:

- Foreign language translation of Trust documents
- Braille translation of Trust documents
- Face-to-face and telephone interpretation
- British Sign Language interpreting
- Easy-read or large font translation of Trust documents
- Moon Literacy

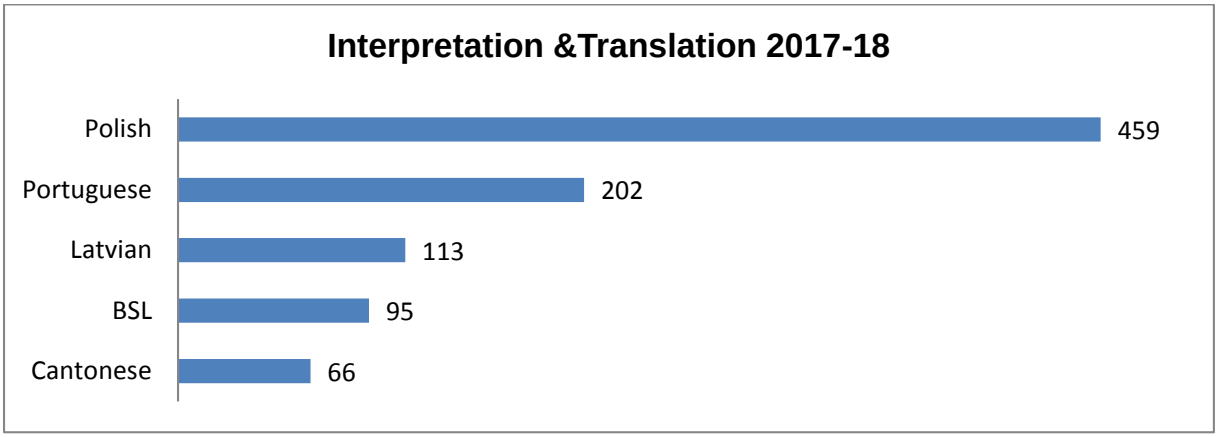
The Trust has an Interpretation and Translation Service Policy CORP 30 (Appendix A) that provides general guidance for staff on the process and organisations they should use for interpretation & translation.

7.3 Monitoring and analysing quarterly translation / interpretation use across the Trust

In order for the Trust to understand who is using our services and to obtain an understanding of the various languages used by carers and patients who access Trust services, quarterly translation and interpretation usage is compiled by the Trust. The information allows the Trust to analyse what languages are most frequently used. We are then able to cross reference the information against the local demographics of the various localities.

7.4 Translation / interpretation use across the Trust April 2017 to March 2018 Trustwide

The 5 most used languages for non-English speakers across the Trust in 2017-18



The chart above highlights the top 5 most used different languages and the number of occasions an interpreter was used for non-English speakers across the Trust from April 2017 to March 2018 in total the Trust provided interpreters for 34 different languages.

The 5 most common languages requested for interpretation and translation were as follows (1) Polish (2) Portuguese (3) Latvian (4) British Sign Language (BSL) (5) Cantonese.

The chart above also highlights the use of British Sign Language (BSL) interpreter's for members of the Deaf Community April 2017 to March 2018 in total a BSL interpreter was used on 95 occasions.

7.5 Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) 2005, covering England and Wales, provides a statutory framework for decision-making in relation to people who lack capacity to make decisions for themselves.

The MCA applies to everyone involved in the treatment, care, or support of someone who lacks capacity (including carers and family carers). The Trust staff providing care and treatment to these individuals have a legal obligation to comply with the MCA and associated Mental Capacity Act 2005 Code of Practice. The Trust has a policy which outlines the working practice to embed the requirements of the Act into usual custom, practice and commissioned contracts.

The Mental Health Act 2007 has amended the MCA to introduce a system known as the "Deprivation of Liberty Safeguards" (DoLS). The safeguards came into force on 1st April 2009. The Mental Health Act 2007 has amended the MCA to introduce a system known as the "Deprivation of Liberty Safeguards" (DoLS). The safeguards came into force on 1st April 2009.

The manager must look at all the circumstances of the individual's case and take into account all relevant information, in deciding whether there is a risk of deprivation of liberty.

Trust managers are required to look at all the circumstances of the individual's case and take into account all relevant information, in deciding whether there is a risk of deprivation of liberty.

The Trust has a named clinical lead for DOLS.

7.6 Patients with Mental Health Needs

The Trust recognises the evidence that one third of all inpatients are likely to have some sort of mental disorder. This means that managing patients with mental health needs is a mainstream part of Trust activity.

Within the Accident and Emergency department there is a designated room for mental health patients under 136 mental health section. The clinical team in the department work closely with Mersey Care NHS Trust to ensure timely assessments and plans for care are implemented. The frail elderly unit have an in reach service from a mental health practitioner to support/advise on the care of patients on the ward .The wards work closely with the mental health liaison nurses from Mersey Care completing timely referrals for mental health assessments. The mental health liaison nurses are integral part of the MDT when best interest meetings are held. Patients are assessed as individual and care is tailored to their needs, additional support with close or continuous supervision is available. Side room facilities are available, with open visiting for relatives / families to support the patient as required.

7.7 Carers Support

The Trust has signed up to John's Campaign to welcome carers whenever they are needed. The campaign recognises the rights of carers to stay with people with dementia at all times. This may be during the day or night. The Trust has purchased a number of beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission.

There are also a number of areas in the Trust which have facilities for carers to utilise to have some quiet space away from the patient bedside. There is a relative's room on critical care, Ward 15a has developed a room for carers to rest and make refreshments, and there is the OASIS room to support family members of patients who are receiving end of life care. For patients on the Regional Spinal Unit, carers who are not local residents are supported in finding local accommodation, for individual cases the Spinal Unit Action Group may also offer an amount of financial support towards this. On the Paediatric unit there is a parent's room where they store food and make refreshments. Comfort bags are available with showering facilities for parents who have children admitted as an emergency.

The Trust Patient Experience Strategy – 'Developing The Experience of Care' is a two year strategy which was launched in July-17. The strategy was co-produced and used themes from complaints, listening events and results from National Surveys to develop and implement eight pledges which aim to improve the patient, family and carer experience. The pledges include implementation of a carer/family charter, improving access to information, improving the collection and profile of patient feedback within the Trust and reviewing discharge processes.

8. PATIENT INFORMATION

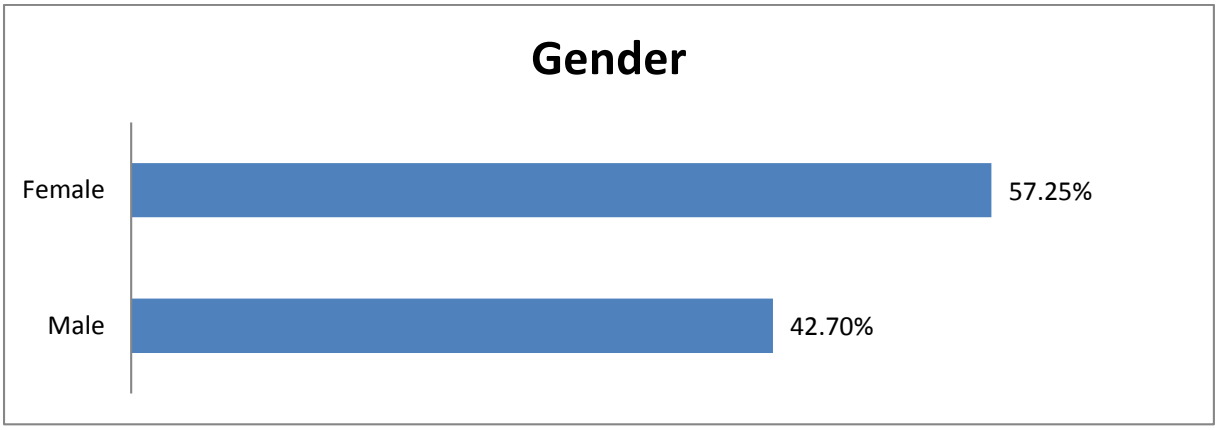
8.1 Patient Profile Highlights

Headlines: As of March 2018 Southport and Ormskirk Hospital NHS Trust provided services to 35,886 Inpatients and 92,638 Outpatients a total of 128,524 of which:

- **Gender:** 57.2% of patients are Female and 42.7% Male
- **Age:** 28.6% of the patients are aged 34yrs and under, 18.2% of patients are 35yrs to 54yrs of age and 53.1% are aged over 55 years of age
- **Ethnicity:** The patients accessing Trust services consists of 4.1% from Black Minority and Ethnic groups 89.5% White and 6.4% Not Stated or Unspecified.
- **Religion & Belief**: the 4 highest religions & beliefs for patients accessing Trust services are as follows 42.4% Church of England, 19.2% Roman Catholic, 10.8% unknown 3.5% Christian, 2.3% Methodist
- **Marital Status**: 43% of patients are Married or in a Civil Partnership, 34.7% Single, 8.2% Widow / Surviving Civil Partnership, 5.7% Divorced/Dissolved Civil Partnership, 4.3% All Others 4.1% Unknown

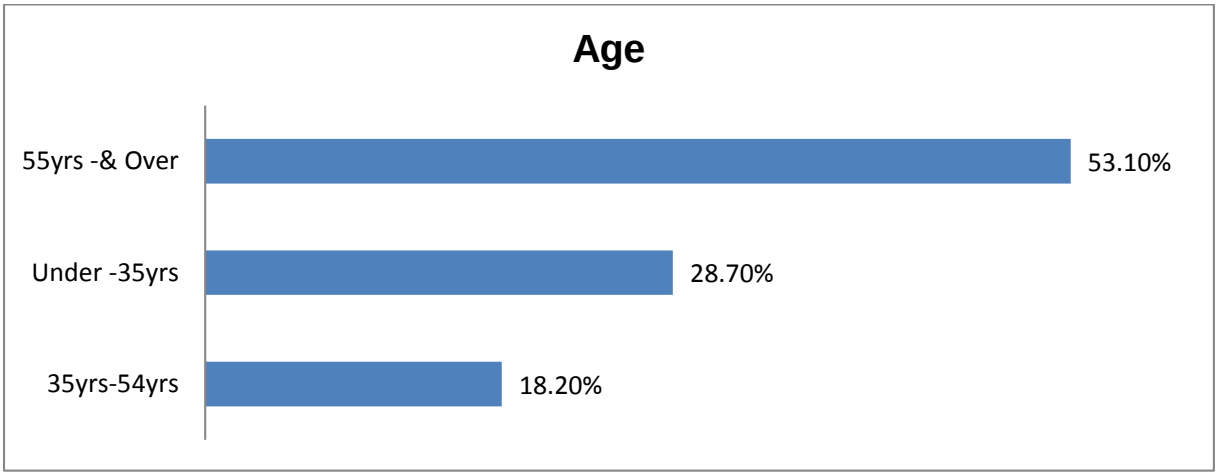
Patient data below provides a general overview of patient gender, age, ethnicity, religion and belief, marital status. Appendix A provides a more comprehensive overview of all the data for the 5 protected characteristics. Data figures in the various graphs are rounded up to the nearest point.

Gender: 57.2% of the patients are Female and 42.7% are Male



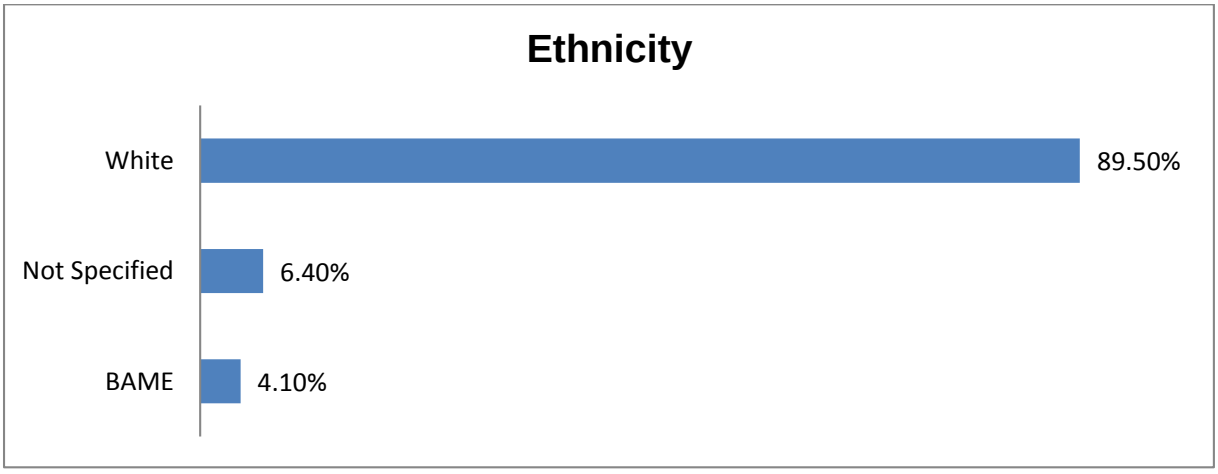
Gender	Headcount	Percentage %
Female	73,551	57.2%
Male	54,967	42.7%
Not Known / Specified	6	0.01%
Grand Total	**128,524**	**100%**

Age Profile: 28.7% of Patients are aged 34yrs and under, 18.2% of patients are 35yrs to 55yrs of age and 53.1% are aged over 55 years of age



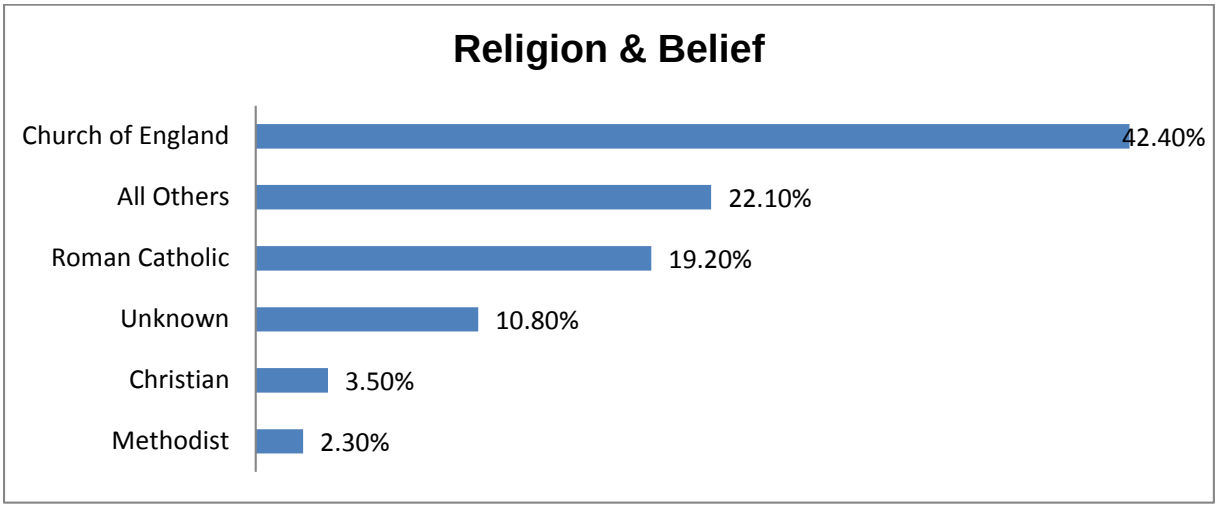
Age Band	Headcount Inpatients	Headcount Outpatients	Headcount Inpatients & Outpatients
<=18 Years	5933	12239	18172
18-24	1548	4440	6024
25-34	3410	9272	12682
35-44	2476	7291	9767
45-54	3257	10481	13738
55-64	4146	12794	16940
65-74	5555	16289	21844
75 +	9525	19832	29357
Total	**35886**	**92638**	**128524**

Ethnicity: The ethnicity of patients accessing Trust services are 4.1% from Black Minority and Ethnic groups 89.5% White staff and 6.4% Not Specified.



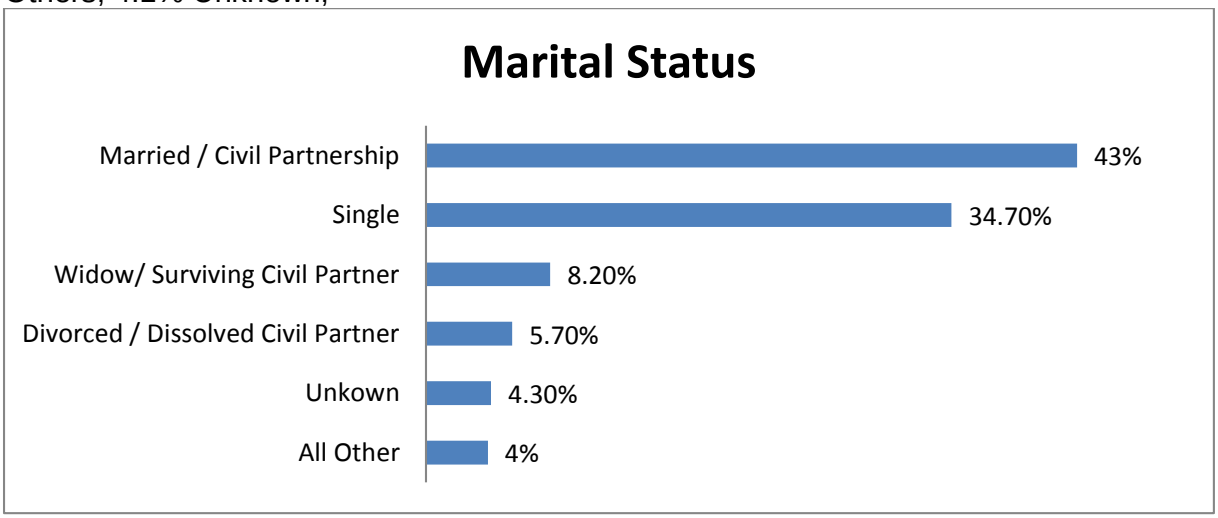
Ethnic Group	Headcount	%
White	114,856	89.5%
Not Specified	8,308	6.4%
BAME	5,360	4.1%
Total	**128,524**	**100%**

Religion & Belief: The 4 highest religions & beliefs for patients accessing Trust services are as follows 42.4% Church of England, 19.2% Roman Catholic, 3.5%Christian, 2.3% Methodist, 10.8% Unknown and 22.16% All Others



Religious Belief	Headcount	Percentage %
Church of England	54,505	42.4%
Roman Catholic	24,804	19.2%
Christian	4,626	3.5%
Methodist	3,063	2.3%
Unknown	13,966	10.8%
Others	27,560	22.1%
Total	**128,524**	**100%**

Marital Status: 43% of patients are Married or in a Civil Partnership, 34.7% Single, 8.2% Widow / Surviving Civil Partnership, 5.7% Divorced/Dissolved Civil Partnership, 4.3% All Others, 4.1% Unknown,



Marital Status	Headcount	Percentage %
Divorced/Dissolved Civil Partnership	7362	5.7%
Married/Civil Partnership	55154	43%
Not disclosed	37	0.2%
Not Set	4390	3.4%
Separated	957	0.7%
Single	44632	34.7%
Unknown	5373	4.1%
Widow / Surviving Civil Partnership	10619	8.2%
Grand Total	**128,524**	**100%**

9. OUR WORKFORCE

Each year the Trust produces information in relation to the make-up of its workforce. Whilst being a legal requirement, this information is also useful for workforce planning. This section of the Equality Diversity Inclusion Annual Report 2017-18 outlines what we know about the make-up of our workforce.

Staff Profile Highlights

Headlines: As of March 2018 Southport and Ormskirk Hospital NHS Trust employed 3062 people of which:

- Gender: 78.10% of the workforce are Female and 21.90% are Male
- Age: 24.82% of the workforce are aged 35yrs and under, 51.01% of staff are 36yrs to 55yrs of age and 24.17% are aged over 55 years of age
- Ethnicity: The Trust workforce consists of 9.50% from Black Minority and Ethnic groups 84.40% White staff and 6.1% Not Stated or Unspecified. 4.06%
- Disability: 2.60% of the Workforce have disclosed that they consider themselves to have a Disability, 63.80% of staff have told us they don't consider themselves to have a Disability with the remainder 33.5% either not declaring, preferring not to say and the others unspecified.
- Sexual Orientation: 80.89% of staff have disclosed their sexual orientation as Heterosexual or Straight, 1.05% as Lesbian, Gay, 0.13% Bisexual with the remainder Not stated (person asked but declined to provide a response) 8.16% and 9.76% Unspecified.
- Religion & Belief: the 3 highest religions & beliefs at the Trust are as follows 63.65% Christian, 7.77% Atheists the third biggest group is Islam and Hinduism both at 1.44% with Not Disclosed Other and Unspecified 25.7%
- Employment Status: the workforce consist of 50.74% Fulltime Staff that consists of 34.49% Female and 16.25% Male, Part time Staff consists of 43.6% - 49% Female and 5.65% Male.
- Length of Service: The highest proportion of the workforce have been employed by the Trust for between 1-5 years 30.99%, 11.37% of the workforce have been with the with the Trust for under 1 year and 3.27% of the Trust have been employed by the Trust for 30 years and above

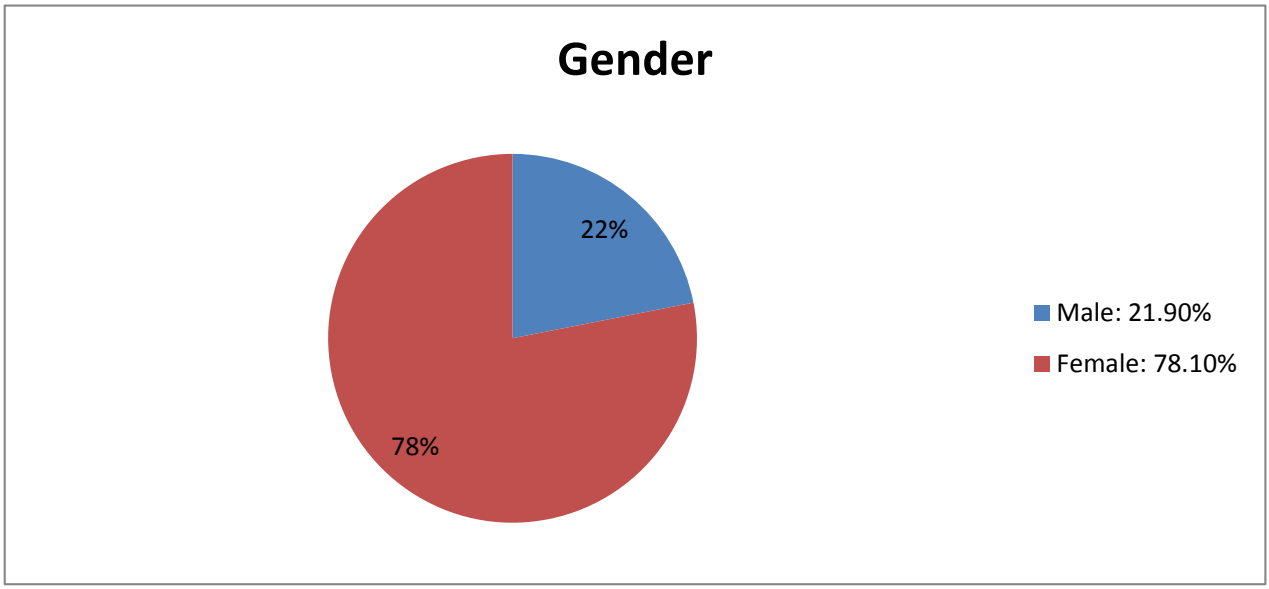
Workforce data below provides a general overview of staff ethnicity, gender, religion and belief, sexual orientation, disability employment status and length of service, disciplinary, training and recruitment.

Data figures in the various graphs are rounded up to the nearest point, the exact data figures are highlighted to the right of the graph.

Workforce pay banding and grades highlight by percentage White and BME staff in each band or grade, the data in Appendix A was compiled as part of the evidence submitted for the Workforce Race Equality Standard (WRES) 2017 -2018.

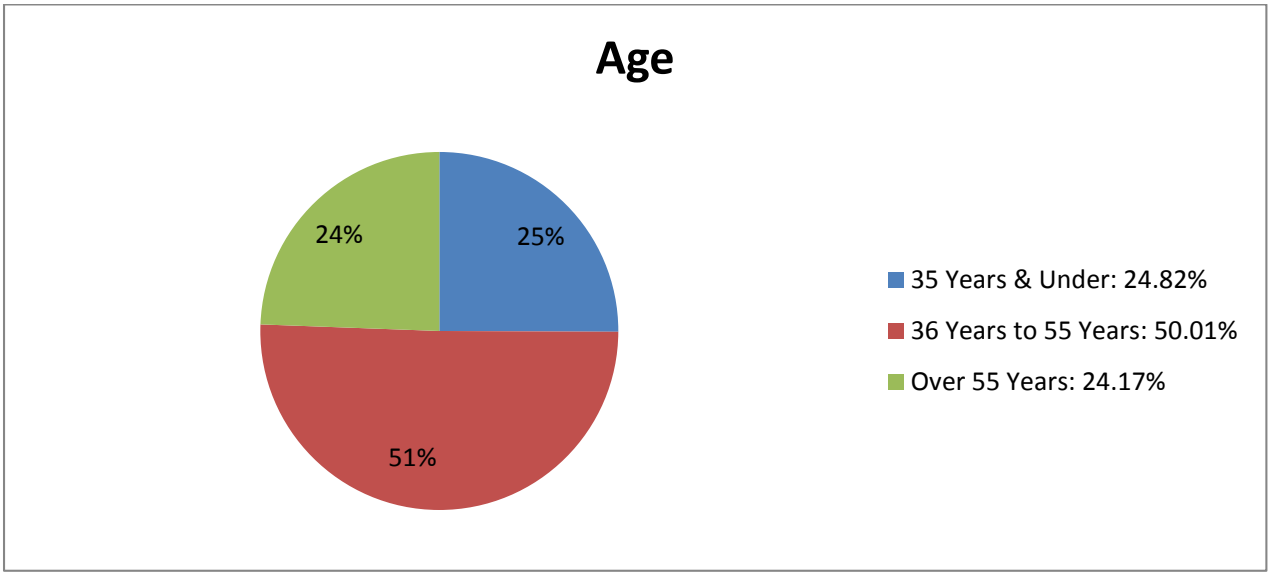
Consensus data for 2011 Appendix B highlights the ethnicity of residents in the Sefton and West Lancashire area, this data has been used as a comparator to cross reference the Trust workforce the evidence highlights that the Trust is representative of the local regions

Gender: 78.10% of the workforce is Female and 21.90% are Male



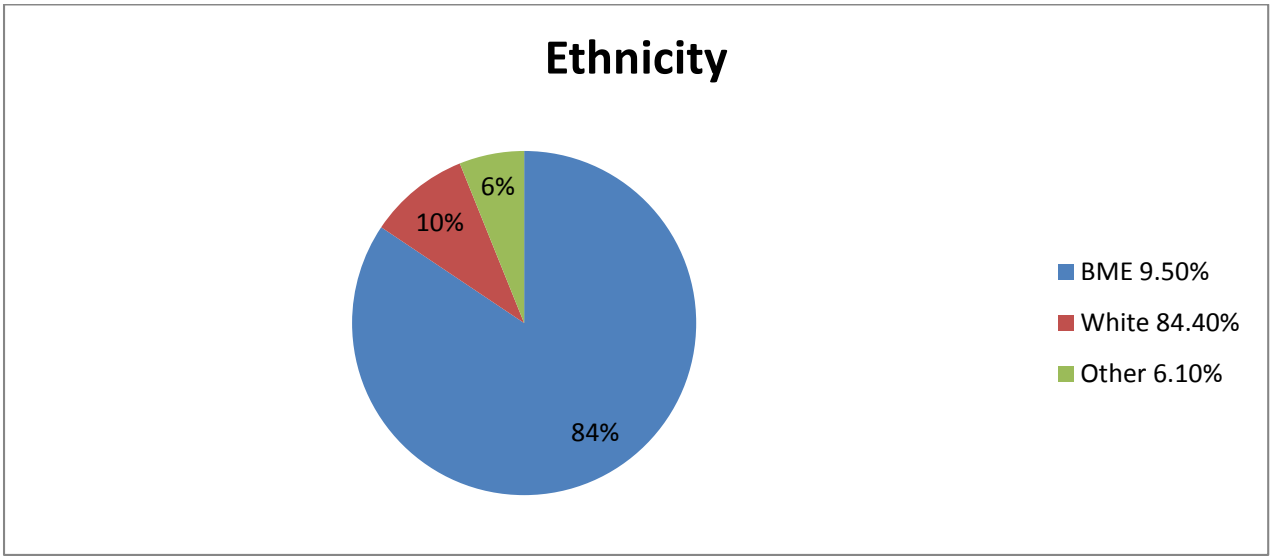
Gender	Headcount	%	FTE
Female	2,391	78.1	1905.93
Male	671	21.9	576.71
Grand Total	**3,062**	**100.0**	**2482.64**

Age Profile: 24.82% of the workforce is aged 35yrs and under, 51.01% of staff are 36yrs to 55yrs of age and 24.17% are aged over 55 years of age



Age Band	Headcount	%	FTE
<=20 Years	22	0.72	7.42
21-25	178	5.81	147.42
26-30	262	8.56	215.69
31-35	298	9.73	244.92
36-40	312	10.19	263.06
41-45	332	10.84	281.23
46-50	422	13.78	356.59
51-55	496	16.20	421.54
56-60	425	13.88	330.65
61-65	232	7.58	167.72
66-70	71	2.32	42.51
>=71 Years	12	0.39	3.89
Total	**3,062**	**100.00**	**2482.64**

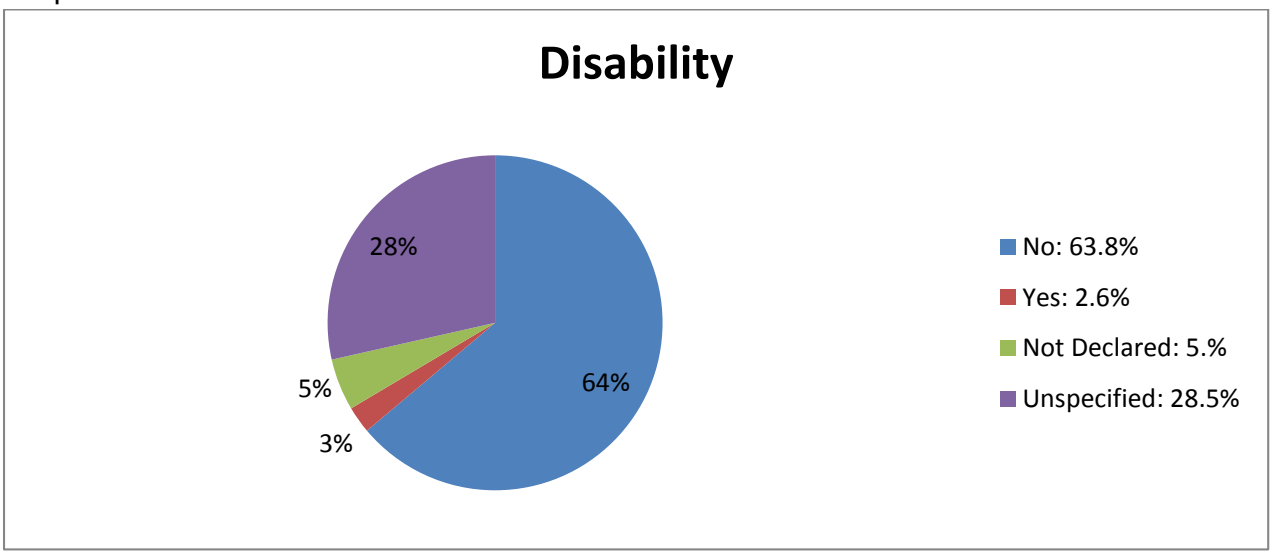
Ethnicity: The Trust workforce consists of 9.50% from Black Minority and Ethnic groups 84.40% White staff and other 6.1%



Ethnic Group	Headcount	%	FTE
A White - British	2,499	81.6	2014.79
B White - Irish	28	0.9	23.47
C White - Any other White background	54	1.8	48.59
C3 White Unspecified	1	0.0	0.64
CA White English	2	0.1	1.67
CFWhite Greek	2	0.1	2.00
CK White Italian	1	0.0	0.00
CP White Polish	5	0.2	4.67
CY White Other European	10	0.3	9.80
D Mixed - White & Black Caribbean	8	0.3	7.60
E Mixed - White & Black African	4	0.1	3.75
F Mixed - White & Asian	6	0.2	6.00
G Mixed - Any other mixed background	6	0.2	4.64
GD Mixed - Chinese & White	2	0.1	0.00
GF Mixed - Other/Unspecified	1	0.0	1.00
H Asian or Asian British - Indian	76	2.5	70.18
J Asian or Asian British - Pakistani	17	0.6	14.44
K Asian or Asian British - Bangladeshi	1	0.0	0.80
L Asian or Asian British - Any other Asian background	46	1.5	41.57
LE Asian Sri Lankan	2	0.1	2.00
LG Asian Sinhalese	1	0.0	1.00
LH Asian British	4	0.1	3.24
LK Asian Unspecified	6	0.2	5.80
M Black or Black British - Caribbean	2	0.1	1.56
N Black or Black British - African	19	0.6	16.86
P Black or Black British - Any other Black background	1	0.0	1.00
PC Black Nigerian	1	0.0	1.00
PD Black British	2	0.1	2.00
R Chinese	5	0.2	4.43

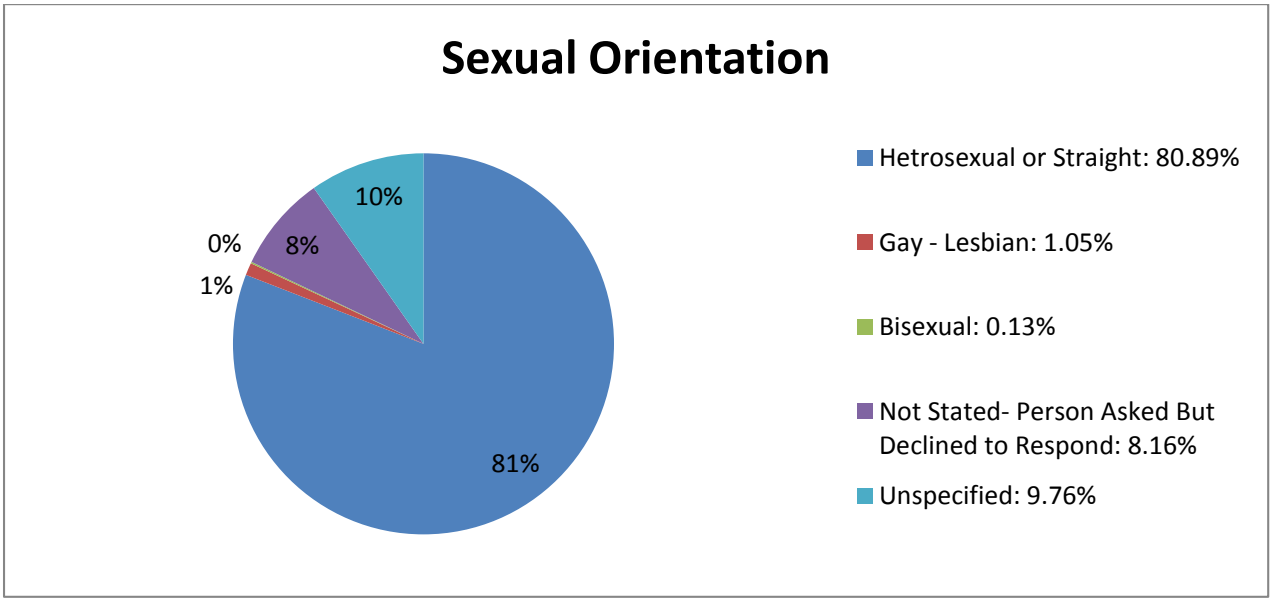
S Any Other Ethnic Group	21	0.7	17.37
SC Filipino	7	0.2	6.86

Disability: 2.60% of the Workforce informed the Trust that they consider themselves to have a disability, 63.80% of staff have told us they don't consider themselves to have a disability with the remainder 33.5% either not declaring, preferring not to say and the others unspecified



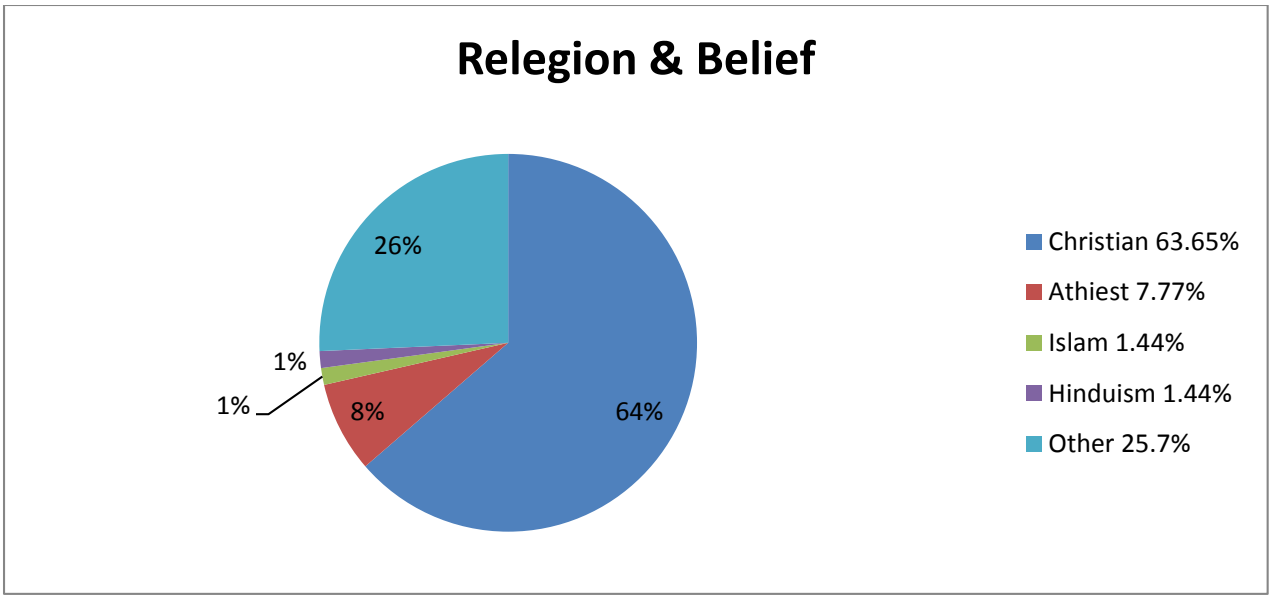
Disability	Headcount	%	FTE
No	1,955	63.8	1564.18
Not Declared	152	5.0	121.47
Prefer Not To Answer	1	0.0	1.00
Unspecified	873	28.5	730.27
Yes	81	2.6	65.72
Total	**3,062**	**100.0**	**2482.64**

Sexual Orientation: 80.89% of staff have disclosed their sexual orientation as Heterosexual or Straight, 1.05% as Lesbian, Gay, 0.13% Bisexual with the remainder Not stated (person asked but declined to provide a response) 8.16% and 9.76% Unspecified.



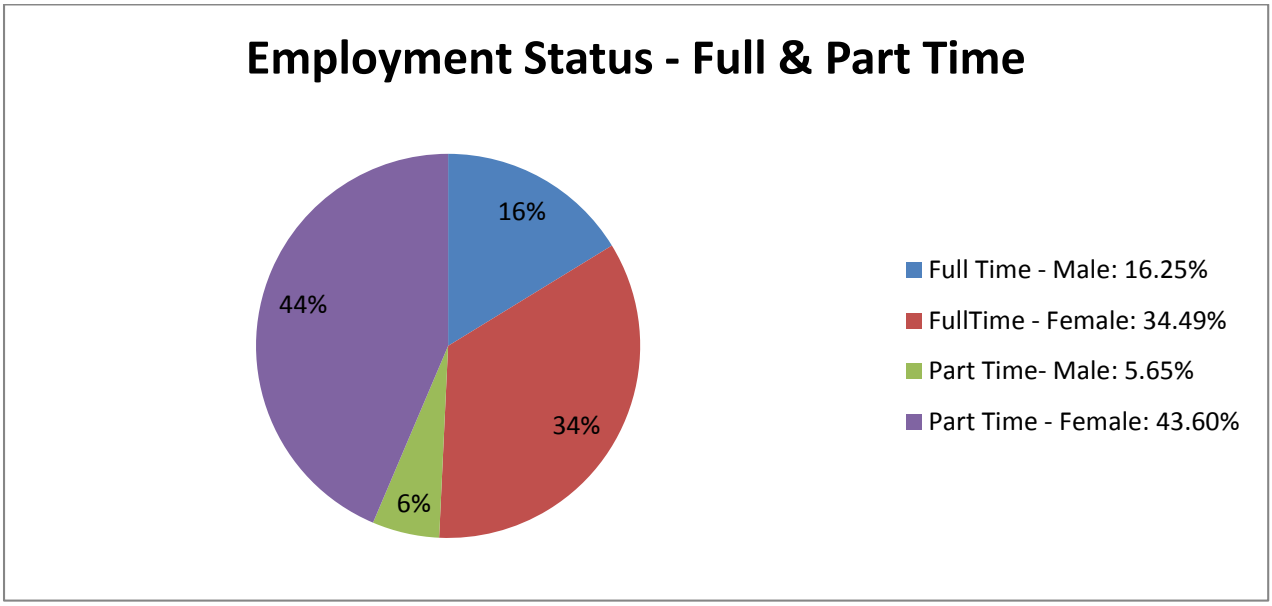
Sexual Orientation	Headcount	%	FTE
Bisexual	4	0.13	3.45
Gay or Lesbian	32	1.05	26.32
Heterosexual or Straight	2,477	80.89	1999.23
Not stated (person asked but declined to provide a response)	250	8.16	207.28
Unspecified	299	9.76	246.36
Total	**3,062**	**100.00**	**2482.64**

Religion & Belief: the 3 highest religions & beliefs at the Trust are as follows 63.65% Christian, 7.77% Atheists the third biggest group is Islam and Hinduism both at 1.44% with Not Disclosed Other and Unspecified 25.7%



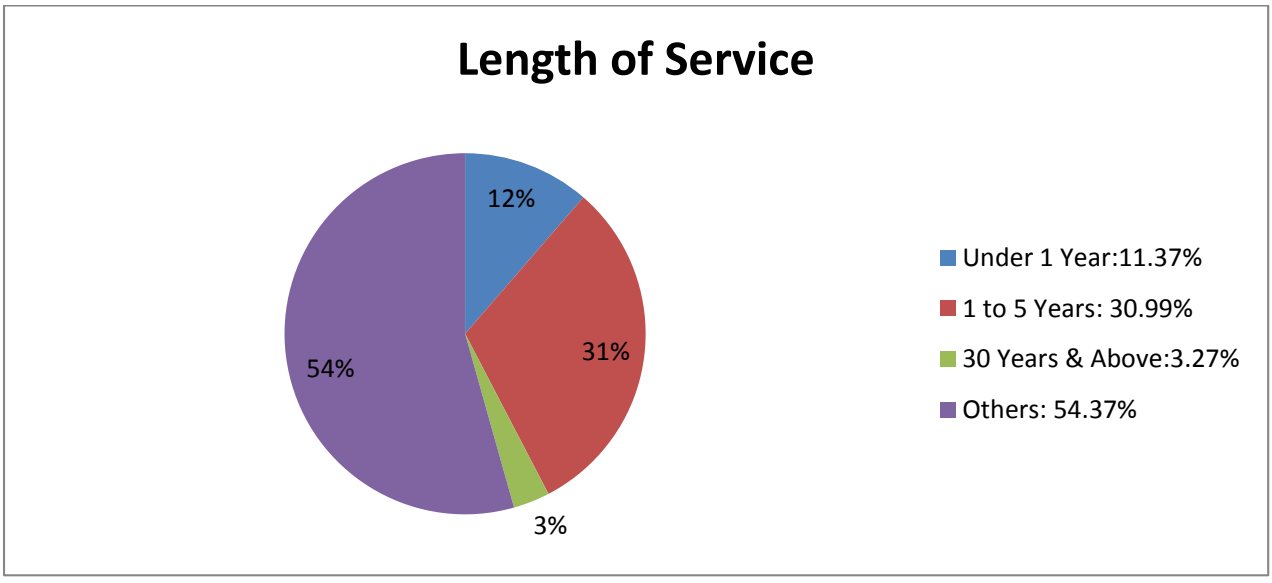
Religious Belief	Headcount	%	FTE
Atheism	238	7.77	193.09
Buddhism	12	0.39	10.29
Christianity	1,949	63.65	1558.06
Hinduism	44	1.44	41.54
Islam	44	1.44	36.52
Judaism	3	0.10	2.64
Not Disclosed	377	12.31	306.20
Other	92	3.00	80.69
Sikhism	2	0.07	2.00
Unspecified	301	9.83	251.61
Total	**3,062**	**100.00**	**2482.64**

Employment Status: The workforce consist of 50.74% Fulltime Staff that consists of 34.49% Female and 16.25% Male, Part time Staff consists of 49.25.% - Female 43.60% and 5.65% Male.



Employment Status	Female	Male
Part Time	43.60	5.65
Fulltime	34.49	16.25

Length of service: The highest proportion of the workforce have been employed by the Trust for between 1-5 years 30.99%, 11.37% of the workforce have been with the with the Trust for under 1 year and 3.27% of the Trust have been employed by the Trust for 30 years and above



Length of Service Band	Headcount	%	FTE
<1 Year	348	11.37	280.10
1<5 Years	949	30.99	720.25
5<10 Years	539	17.60	442.49
10<15 Years	420	13.72	354.60
15<20 Years	403	13.16	344.91
20<25 Years	170	5.55	141.49
25<30 Years	133	4.34	114.42

30+ Years	100	3.27	84.36
Total	**3,062**	**100.00**	**2482.64**

Recruitment: The information below highlights the ratio of BME and White Staff being appointed from short listing; please note this refers to both internal and external posts

	Headcount		Ratio	
WRES Category	Shortlisted	Hired	Shortlisted	Hired
BME	393	7	0.98	0.02
White	2289	98	0.96	0.04
Z NULL	10	2	0.83	0.17
Z Not Stated/Not Given	47		1.00	

Training: The information below highlights the ratio of BME and White Staff accessing training in 2017-18

WRES Category	Headcount	Enrolment Headcount	Ratio
BME	242	223	0.92
White	2603	2447	0.94
Z NULL	12	10	0.83
Z Not Stated/Not Given	206	191	0.93

10. GENDER PAY GAP

The Trust is passionate about creating a fulfilling, diverse and inclusive place to work, with equality and fairness at the heart of our values, policies and everyday practices. That is why we are committed to be an employer of choice and work hard to ensure that our staff have equality of access to jobs, promotion and training and why we highlight to all our staff strategies to overcome Unconscious Bias in all manner of decisions. This and other supportive policies are making SOHT a more inclusive place to work.

As from 30 March 2018 we must publish on our website and on a government website, the following:

- mean gender pay gap
- median gender pay gap
- mean bonus gender pay gap
- median bonus gender pay gap
- proportion of males and females receiving a bonus payment
- proportion of males and females in each pay quartile

The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website.

11. OTHER TRUST EQUALITY INFORMATION

11.1 NAVAJO Chartermark (LGBT)

The NAVAJO Chartermark was first achieved in March 2015 the Trust was reassessed at the beginning of 2018 and was awarded the NAVAJO charter mark for another year. The NAVAJO Merseyside & Cheshire LGBT Charter Mark is an equality mark sponsored by In-Trust Merseyside & Sefton Embrace and supported by the LGBTI Community networks across Merseyside– a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, and transgender (LGBT) people in Merseyside.

11.2 Disability Confident Employers Scheme

The Disability Confident scheme is an initiative which shows employers how to commit to recruiting, retaining and developing disabled people. Through Disability Confident, the Government aims to work with employers in the UK to: challenge attitudes towards disability; increase understanding of disability. The Trust signed up to the Scheme in 2017.

12. NEXT STEPS

12.1 Action Plan and Next Steps

It is acknowledged by Southport and Ormskirk NHS Trust that positive actions to support Equality, Diversity and Inclusion underpin the principles of positive staff engagement.

The Trust has developed an action plan to address the areas of shortfall identified. The Action Plan is attached as Appendix1 and is monitored through the Equality Steering Group, HR Governance and Workforce Committee which is a subcommittee of the board of directors. The Trust has a separate WRES Action Plan which is monitored through the same governance structure.

Appendix 1 Equality Action Plan 2017/2019

This action plan will be updated as progress is made and or the objectives are reviewed/amended as appropriate including making any additional objectives to the action plan.

RAG Rating	Incomplete	In Progress/on track	Ongoing	Complete

Objective	Action	Progress	Lead	Target/Review Date	RAG Rating
Equality Act 2010 (including Public Sector Equality Duty)					
Publication of annual workforce strategy including the workforce report in December each year	Produce draft report for publication		Assistant Director of HR Governance	December 2017/ 2018	
Review of Equality Impact Assessment documents for policies and procedures	Update toolkit		Equality & Diversity Lead	December 2018	
Equality is mainstreamed through the organisation's business through effective implementation of the Equality Delivery System (EDS2) and equality analysis	Equality impact assessments are used for all CIP's, Policies, Service changes and organisational change.	Equality Impact Assessments are conducted for all CIP's, Policies, Service Changes and Organisational Change	CBU ADO's/HR Managers, PMO Office	Ongoing	
Benchmarking with other NHS Trusts and sharing of best practice	Conduct benchmarking exercise		Equality & Diversity Lead	January 2018	
Publication of WRES Indicators and progress against these	Board sign off of WRES Action plan and publication on intranet alongside associated data. Report results and progress against action plan to Equality and Diversity Assurance Group and HR Governance group	Action plan developed and circulated to board for sign off.	Assistant Director of HR Governance	March 2018	

All papers to Executive and Board include equality impact declaration by author	Company secretary to monitor papers and ensure equality impact assessed		Company Secretary	December 2017	
Governance systems in place to clearly demonstrate compliance with Public Sector Equality Duty.	Equality & Diversity Lead to attend HR Governance and Workforce Committee to ensure compliance and involvement across Trust activity		E&D Lead	Ongoing	Post not yet appointed to
Revise Equality & Diversity Assurance Group Terms of Reference	ToR to be revised and circulated at and agreed with attendees and sent to Workforce Committee for sign off		Assistant Director of HR Governance and E&D Lead	December 2017	
Establish Navajo Task & Finish Group for re-assessment in 2018	Ensure stakeholder involvement from all staff groups and schedule of dates publicised on internet	Not yet started	Exec lead for Equality/Assistant Director of HR Governance	December 2017	
Establish responsibility for E&D Lead for service	E&D Lead post to be put in in place with responsibility for Equality Duties associated with service delivery and Equality Impact Assessments.	Not yet progressed	Director of Nursing	November 2017	Post not yet appointed to
Update Transgender Staff Support Policy	Policy revisions to be agreed with sign off from E&D Assurance Group, JNC and QA		Assistant Director of HR Governance	December 2017	
Circulate schedule of HealthWatch meetings 2017/18 for specific focus on EDS2 progress	Meetings to be circulated to E&D Assurance group members and attendees identified.	Not yet progressed in absence of E&D Lead	E&D Lead (?)	Ongoing	

Review Equality Policy to include Equality and Inclusion			E&D Lead	December 2017	
EDS2 Self assessment and submission and sign off by HealthWatch against Outcomes	Submission completed and published on intranet	E&D Lead not yet appointed to	E&D Lead	December 2017	
EDS Goal 2. Improved patient access and experience					
Ensure all services are accessible – consider both physical access and access to information Accessible Information Standard (from April 2016)	All services accessible to required regulations and standards	E&D Lead not yet appointed to	Director of Nursing	Ongoing	
EDS Goal 3: A Representative and Supported Workforce					
WRES – publish data and continue with actions in line with action plan	Data published and action plan monitored through E&D Assurance and HR Governance	Action plan developed for board sign off. Actions progressing in accordance with timescales.	Assistant Director of HR Governance	April 2017 -– March 2018	
Employee Network Groups are well supported and actions are delivered as appropriate	Currently the Trust has an established disability staff network. Currently promotes LGBT and BME staff network formation via the internet. The take up is very low. Associate Director of HR and Assistant Director of HR Governance to take forward focus groups also in line with WRES action plan	Start December 2017	Associate Director of HR/Head of HR	December 2017 – March 2018	
Recruitment & Retention Strategy reflective of Equality and Diversity Initiatives	Review R&S policies and strategy to ensure compliance		Recruitment Manager	December 2017	
EDS Goal 4: Inclusive Leadership					
Senior Leaders are engaged and drive equality through attendance at	Board to identify E&D Exec Lead and Equality Champion NED.	WRES report presented at July board. E&D champion to be	CEO and Company	Sept 2017	

E&D group. .		identified at future board.	Secretary		
Training and development opportunities are available to all staff irrespective of background	Training and development opportunities to be advertised on the training and development website Training data to be added to workforce diversity report	Training and development opportunities are advertised on the training and development website	Head of Education and Training	June 2017	
Leaders are equipped with the skills to manage a diverse workforce	Development of a module to be delivered within Leadership and Management programmes facilitated by Education & Training		Head of Human Resources	March 2018	
Workforce Race Equality Standard – increase diversity at all levels of organisation	Proposed internal talent management programmes to support the development of junior staff into senior positions		Assistant Director of Organisational Development	Ongoing	
Workforce Race Equality Standard – increase diversity at all levels of the organisation	Review recruitment practices to gain assurance of the removal of unconscious and conscious bias.		CBU HR Managers/ADO's	March 2018	Not yet started

Southport and Ormskirk Hospital NHS Trust

Southport & Ormskirk Hospital NHS Trust Equality Objectives 2018-2020 Update – Discussion paper for Exec / Board

Purpose
To provide an update to the Trust Board on the setting of a set of Equality Objectives for 2018 to 2020, the equality objectives are usually set for a period of 4 years (2016-20) and to fall in line with other NHS Trusts the proposed objectives will carry forward to March 2020 when they will be reviewed.

Under the Equality Act 2010 the Trust are required to develop and publish their equality objectives, and set out how they will measure improvements against them over the next four years. The purpose of setting equality objectives is to strengthen performance in meeting the general equality duty and ensure that the Trust are making year on year progress in advancing equality and human rights for all protected groups, both for our patients their carers and those who work at the Trust

The proposed Trust objectives are:

- Improving our intelligence
- Developing our staff
- Working with our communities

How the objectives were set
The Equality Delivery System 2 (EDS2) evidence collated by the Merseyside NHS Trusts (equality leads) and the Sefton CCG was used to assess equality performance across the four EDS2 goals to identify areas for improvement, other items of Trust evidence has also been used :

- Workforce Race Equality Standard (WRES)
- Workforce & Patient Equality Monitoring Data
- National Regional and Local equality information from various groups representing the diverse communities

The equality objectives will strengthen performance in meeting the three aims of the general equality duty of promoting equality, removing discrimination and fostering good relations between people with different protected characteristics and will ensure that the Trust continue to make progress in advancing equality and human rights for all protected groups for patients, carers and those who work at the Trust.

How we will monitor progress
The Trust will compile an action plan after the EDS2 Trust assessment takes place in February 2019 and the equality objectives will be reviewed annually by the Board, progress will also be reported to the Valuing our People Group and other Trust committees groups and organisations. The Equality Objectives and action plan will be published on the Trust website

The Exec Team/Board are requested to note the content of the update and agree to the Equality Objectives proposed

Southport & Ormskirk Hospital NHS Trust Equality Objectives 2018-2020

Southport & Ormskirk Hospital NHS Trust Values: SCOPE
Supportive Caring Open & Honest Professional Efficient

Improving our Intelligence	Developing our Staff	Working within our Communities
• Develop a Trust-wide approach to collecting equality information • Review current patients accessing Trust services data/information in order to address gaps in equality and diversity information reporting. • Develop in partnership with representatives of local community group processes and information sessions for improving staff collection of equality data / information • Work with patients and carer representatives who access the Trust to assist the Trust in developing its E&D objectives and action plan • Formalise relationship with Local Authority, third sector and other statutory bodies to enable greater sharing of data and intelligence information in relation to equality groups and health inequalities	• Provide training and development opportunities for all staff across the Trust and provide a summary of mandatory and non - mandatory training by ethnic groups providing data for the Trust wide Valuing Peoples Group • The Trust to develop a diverse workforce in the various bandings and attract minority staff across the range of job opportunities and in particular into senior roles. • Develop a range of successful community and staff engagement events and activities that highlight different communities and demonstrate the Trusts commitment to being a personal, fair and diverse organisation • Develop successful Staff Network Groups and a Equality Champions Network that plays a meaningful role within the Trust and local community	• Corporately and locally develop robust partnership working with third sector providers including the sharing of information and intelligence, partnership service delivery and shared training events • Develop leaflets with partnership organisations to ensure they are reflective and meet the needs of our targeted communities and ensure our website is truly reflective of our personal, fair and diverse services we deliver • Invite representatives from the various diverse community to present information and training sessions on issue relating to their specific group, • Support local community events across the Trusts footprint

Underpinning Requirements
The Equality Act 2010 NHS Equality Delivery System (EDS2) Workforce Race Equality Standard (WRES) Care Quality Commission

Alert, Advise, Assure (AAA) Highlight Report	
Committee/Group:	Finance, Performance & Investment Committee
Meeting Date:	25th February 2019
Lead:	Mr 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 nursing review is nearing completion and early indications suggest there will be a need for additional investment in the nursing establishment in excess of £1.0m.
- The Trust is still aiming to achieve the deficit plan of £28.8m, but there is an ongoing discussion with the CCGs over the payment of non-elective care and CDU activity, which represents a potential risk of £3.8m.
- Staffing shortages in key areas continue to make it difficult for the Trust to meet 62 day cancer waiting time targets.
- The number of 12 hour AED Breaches in February is substantially higher than last year, reflecting the significant growth in attendances.
- Concern was expressed that the IM&T Committee was not quorate for the third consecutive month. Executive Directors were asked to reinforce the importance of this group.

ADVISE

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

- Work on the 2019/20 Cost Improvement Programme is progressing. Directors are confident that the baseline target of £3.1m will be achieved and are developing ideas to deliver the stretch target of £6.1m.
- The winter escalation beds remain open, partly because alternative community provision has not been made available.
- The development of clinical specialty indicators to supplement mortality and other medical quality indicators is being progressed by the Medical Director.

ASSURE

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

- The draft Accountability & Performance Framework was received and the Committee agreed that further work is required to strengthen the concept of accountability within the Trust.
- Whilst noting ongoing operational challenges within AED, the Committee were keen to note that performance is materially better than last year and congratulated all staff for their tremendous efforts over the winter period.

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:	25th February 2019
Lead:	Mrs Julie Gorry, 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 Stroke Service is overly-reliant on a single stroke physician so consideration is being given to options for creating a more robust and resilient service.
- The Trust is still experiencing winter pressures and in addition to coping with a significant increase in attendances, on average for each day in February 2019 the Trust admitted 5 extra patients and managed 5 additional Medically Optimised Fit For Discharge patients over and above the same period in 2018.
- There has been further deterioration in meeting the Fractured Neck of Femur target. The Medical Director is personally overseeing the Action Plan and will bring a progress report to the April Quality & Safety Committee.

ADVISE

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

- An unexpected and unfortunate consequence of winter pressures has been a slowing down of progress on delivering the Quality Improvement Plan. However, it is intended that the various working groups will recommence action plans in the near future
- The latest SHMI figures, (October 2017 - September 2018), show a further improvement in mortality figures.
- There are some lengthy delays in closing off complaints and serious incidents so the Committee asked for a more in-depth analysis of the current position and plans to improve performance.
- Recognising the importance of improving the patient experience, the Committee expressed its support for Trust-wide action to increase the rate of patient feedback on services provided.
- Discussions continue to take place with both Mental Health providers and commissioners regarding the time Mental Health patients spend in AED whilst awaiting access to the appropriate mental health services.
-

ASSURE

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

- The Committee considered a report on Board member visits to wards and departments and it was noted that the programme for 2019/20 is being developed.
- Following the successful Phase 1 programme, the Reducing Mortality Group is finalising its Phase 2 programme, which will hopefully commence in the near future. The Committee have asked for a report on of the close down of the Reducing Avoidable Mortality (RAM) project for Phase 1.

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

Review of the Risk Register

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

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group:	Workforce Committee
Meeting Date:	21 February 2019
Lead:	Dr David Bricknell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Delay in Policies being Published
It was highlighted that there is a delay in policies being published after being agreed at the Committee. This issue has been escalated and added to the risk register. Raised as an alert as this impacts on workforce training since there aren't the policies accessible to reinforce that training.

Sickness Absence
The headline data for January 2019 has increased in sickness absence possible due to general health trends e.g. Norovirus.

PDR Compliance
The compliance for PDR's is at 73.48%. It is unlikely that the target of 85% compliance for February 2019 will be met. The Committee has raised the issue as an alert as the system and timings of PDR's need to be reviewed as a matter of urgency.

Nursing Agency
The level of Thornbury agency reached a new peak in January 2019 due to the opening of Ward 1 and an excess of 40 additional beds. Due also to short term notice as the Trust needs to deliver appropriate levels of nursing staff.

Policy Schedule
Certain HR policies are out of date but are being reviewed as matter of urgency. Scheduled to be resolved by mid-year. To meet the target HR will need the necessary amount of Executive support.

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)

Agenda for Change Panels
Concerns over staff being released by managers to sit on Agenda for Change panels as the number of posts awaiting review has significantly increased due to a number of large organisational changes.

ASSURE

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

FTSU reporting: trends and duplication of reports/concerns/queries
It was fed back to the Committee that the Straight to Silas and FTSU systems are running in parallel since it was found that there is no duplication within the two systems.

Nurse Staffing Establishment Review
The process of the business plan was discussed and it was agreed that the Committee would focus on the safety aspect of data in March, prior to being reviewed by the FP&I Committee in terms of financial approval.

Workforce H&WB Sickness Absence Strategic Action Plan
To assure the Board that the studies are in place in the keys areas requiring focussed intervention have been identified. Work within the action plan is ongoing.

Retention Action Plan
A comprehensive piece of work with support from NHSi on recruitment and retention. Now in action.

Equality Diversity & Inclusion Annual Report 2017/18
A high quality report which reflects an enormous amount of work which the CCG have signed off.

Trust Equality Objectives 2018/20
Recommended to be reviewed by the Board.

Valuing Our People
The new Valuing Our People group had a constructive inaugural meeting where a number of important areas were looked at and identified. The Terms of Reference are currently being resolved.

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 March 2018

Agenda Item	TB052/19	Report Title	Integrated Performance Report
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Anita Davenport, Interim Performance Manager		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The report highlights the indicators that require discussion by Trust Board. Some of these indicators require corrective action to be taken. A brief narrative has been provided in order to provide assurance that corrective measures are in place.

Indicators within the Integrated Performance Report form part of the Trust's performance management framework and are discussed with the relevant teams in monthly performance forum meetings.

The report contains the following components:

- Performance Dashboard
- Executive Assurance
- KPI Graphs and Narrative

Recommendation:

The Board is asked to **receive** the report and **highlight any further assurance** necessary in relation to areas of poor performance.

Strategic Objective(s) and Principal Risks(s)

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

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

☐ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

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

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

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

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

The IPR will be updated as required by the Board after review and discussion.

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 March 2019

NHS
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Board Report - January 2019

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%		151			
Harm Free (Safety Thermometer)	94.99%	98.3%	97.3%	7			
Falls - Moderate/Severe/Death	1	2	0	2			
Patient Safety Incidents - Low, Near Miss or No Harm		763	5895	763			
Safe Staffing	90%	90.5%		N/A			
Fractured Neck of Femur	90%	57.7%	70.6%	15			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
SHMI (Summary Hospital-level Mortality Indicator)	100.1	113.2		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	111.7	111.7	N/A			
WHO Checklist	99.9%	100%		1			
Stroke - 90% Stay on Stroke Ward	80%	78.6%	78.4%	6			
Sepsis - Timely Identification	90%	100%	97.6%	N/A			
Sepsis - Timely Treatment	90%	63.3%	78.2%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	31	119	31			
Written Complaints	44	23	231	23			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	89.1%		53			

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%	84.9%	88.6%	1565			
Accident & Emergency - 12+ Hour trolley waits	1	13	30	13			
Ambulance Handovers <=15 Mins	99%	45%	44.1%	883			
Diagnostic waits	1.01%	2.7%		76			
14 day GP referral to Outpatients	93%	95.1%	94.7%	37			
31 day treatment	96%	97.5%	98.3%	1			
31 day treatment (Surgery)	94%	100%	97%	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%	71.6%	78.6%	9.5			
Referral to treatment: on-going	92%	94.8%	94.8%	529			
Bed Occupancy - SDGH	93%	91.5%		N/A			
Bed Occupancy - ODGH		41.5%		N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	100%	82.9%	0			
Duty of Candour - Evidence of Letter	100%	100%	68.3%	0			
I&E surplus or deficit/total revenue	-1%	-17.5%	-19%	N/A			
Liquidity	-23	-54	-54	N/A			
Distance from Control Total	0%	0.3%	-7.9%	N/A			
Capital Service Capacity	-2.423	-2.582	-3.559	N/A			
% Agency Staff (cost)	5.6%	8.1%		N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	41.5%	-5.6%	N/A			
Staff Turnover	0.76%	0.6%	6.8%	N/A			
Staff Turnover (Rolling)		11%		N/A			
Vacancy Rate - Medical		7.1%	7.1%	N/A			
Vacancy Rate - Nursing		9.2%	9.2%	N/A			
Sickness Rate	3.9%	6.4%	5.8%	N/A			
Personal Development Review	85%	73.4%	73.4%	N/A			
Mandatory Training	85%	84.6%	84.6%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.2		N/A			

Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month		58		58			
DTOC - Number of Beds lost per month		4		3.57			
Length Of Stay		7		N/A			
New:Follow Up	2.64	2.5	2.4	N/A			
DNA (Did Not Attend) rate	8%	7.1%	7.3%	1654			
Cancelled Ops	0.61%	0.9%	0.3%	20			
Theatre Utilisation - SDGH	90%	40.3%	51.7%	N/A			
Theatre Utilisation - ODGH	90%	57.4%	61.5%	N/A			

Reporting Frequency is monthly except for SHMI which is quarterly.

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Executive Assurance

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

Overview

Vision 2020

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

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

Assured/Most Improved

Board Leadership & Development and Fitness to Govern

The Board Development Programme was approved by the November Trust Board. There is a schedule of masterclasses up to May 2019
The annual board self-assessment and board observation has been undertaken for the last financial year and will be undertaken again at the end of the 2018/19 year.
The Senior Leadership Programme continues to run concurrently with the Board Development Programme
We are working with the Leadership Academy to roll out a Shadow Board geared at aspirant Board directors; this will have its first meeting in May 2019.

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 and has been meeting on a monthly basis.
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. AQuA and MIAA are due to give feedback at the end of the March Trust Board
Further, we are having discussions with HealthSkills to agree and roll out a programme focusing on High Performing Teams

Board Governance

A quarterly review of the Board Assurance Framework takes place. This now has the KPIs from the IPR mapped thus creating synergy between the two key documents.
Corporate Risk Registers are reviewed monthly at the board and assurance committees
In January and February two sessions around strategic planning were held by the Trust Board at which key priorities were discussed and

drafted
At the March Board the priorities for 2019/20, strategic objectives and principal risks will be discussed and approved
Following the above a new Model BAF for 2019/20 will be drafted and presented at the April Board for approval.

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
The Risk and Compliance Group met for the first time on 18 February and will convene monthly.

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 Workforce in February. 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 in March
Roll-out of MCA & DoLs pathway documentation continues
NEWS2 training programme in placed re-energised to support the new NEWS2 implementation planned for 26th March 2019. Outreach Team will commence 24/7 from April 2019
Relaunch Dementia Steering Group who are reviewing Dementia Strategy
Quality Improvement Group – Monthly meeting commence in February following inaugural meeting in January 2019
Southport & Ormskirk Nursing Assessment & Accreditation System (SONAAS) – extensive review of original documentation in progress.

2b – QI Methodology
AQUA training plan in progress
Theatre team participating in NHS I Pressure Ulcer collaborative

2c – Safe Staffing
Ward nurse establishment review in progress, to be completed in March. Briefing paper to Executive Team in February 2019
Setting N& M Establishment Review SOP to be ratified by Nursing & Midwifery Group in February 2019
Safe Staffing compliance above 90%

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

2e – Quality & Safety Governance
Ward Co-ordinator & Ward Manager checklist in draft form, commenced in February 2019
Draft Quality Care indicators (QCI) developed for trial in Feb/March 2019.

Operational Overview:
Safe Staffing is complaint with national average (90.52%) is positive.
Performance in Harm Free Care (98.25%)
VTE - 96.9%
Slight increase the number of complaints in January to 23.

Assured/Most Improved

Duty of Candour reporting 100% in January for documentation of the discussion and letter.
There have been no C. Diff. in December 2018 or January 2019.

Not Assured/Most Deteriorated

Seven patient pressure ulcers have been reported in January; however all were classified as grade two.

Delivering single sex accommodation breaches have increased to 31 pt. for January 2019.

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

Friends & Family Test (FFT) decreased during the month of January to 89%

Continued expenditure in nurse Bank & Agency due to vacancies, sickness and additional capacity across the Trust.

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 modest increase from 91.8 (August 2018) to 93.5 for September 2018.
The SHMI is down to 113.2 from 115.5 (June 2018) to September 2018.
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 (SJR) methodology for Learning from deaths is now being used across CBUs.
A decline in performance of SJRs and screening noted.
External Mortality review will be presented to the Public Board on the 6th February 2019
Reducing Avoidable Mortality project phase 1 completed, phase 2 defined.
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 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 January was 84.8%, January 2018 it was 80.9%.
- This is mainly due to performance at Southport which has improved in the year from 53.9% to 68.1%, despite an increase in attendances of 699 patients in the month.
- This is the fifth consecutive month that performance has been better than last year and February is so far continuing this trend despite further increases in demand as we continue the winter period.
- January unfortunately failed to meet the trajectory target agreed with NHSI but only by 1.1%.
- The Trust was ranked 60th nationally out of 135 acute Trusts

Ambulance Handover Times

- The Trust had 86 ambulance handovers greater than 1 hour in January 2019. In January 2018 this was 150 – an improvement of 43%.
- 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

- January 18-week performance was 94.8% which, although a drop from December is still well above target. It is the third consecutive drop though.
- The ongoing waiting list is 10,400 – 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, Oral Surgery, Vascular Surgery and Trauma & Orthopaedics.

Is assured

Length of Stay

- Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 7.04 days in January, 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 January has 10% fewer stranded patients and 7% fewer super stranded patients than last year

Diagnostics

- Performance for January against the 6-week-wait target was 2.7%, this follows two months of encouraging performance below 2% and is a result of increased pressure

from demand and staff resource.
- Last year in January 2018 diagnostic performance was much worse at 3.7%.

Not Assured/Most Deteriorated

Cancer 62 Day
- Performance for December was below the 85% target at 71.6%, despite October showing great improvement this has not been sustained and performance has dropped again to a similar level as seen in September for the past 2 months.
- This is also a drop from last year's performance when the target was met in December at 88%.
- The Trust Board must note that delivery of the trajectory will not be delivered for Q4.
- The Trust has challenges in workforce across a number of tumour groups and Medical Director with COO are meeting with clinical & service leads to determine issues and critical interventions

Overdue Follow Ups Backlog
- With a reduction in outpatients activity in January the number of overdue follow up patients has grown marginally to just over 2000.
- January 2018 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

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

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

Overview

Vision 2020

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

Month 10

Month 10 financial performance was £64,000 better than plan resulting in YTD adverse variance of £0.4 million. Expenditure levels were higher in month 10 reflecting the increased medical and nursing costs required to resource additional bed capacity. There are a number of risks that will impact on whether the Trust will deliver the planned deficit of £28.8 million as follows:

- Total sanctions were forecast to be £2.1 million for the year; January performance has increased this by a further £124,000.
- CDU income - despite recommendations from NHSI/E that support the Trust's income for CDU tariffs this issue has not been fully accepted by commissioners.
- Non elective income – NHSI/E also advised that the CCG should pay for all the non-elective activity undertaken by the Trust and this issue is still outstanding.
- There is a risk to income of £3.5 million for these two issues.
- Income received for additional activity does not mitigate the cost of resourcing additional beds in February and March.

Assured/Most Improved

- December monthly deficit was in line with forecast discussed with NHSI.
- Elective income balanced to plan in month.
- Clinical income continues to over perform across all points of delivery (POD) with the exception of electives
- Financial rigour, grip improved as a result of increased governance measures such as PAG, BDISC, revised schemes of delegation, finance training
- Deficit plan of £26.6 million (before non recurrent central funding) shows improvement from 2019/20 and ensures Trust remains on trajectory to reduce deficit below £25 million by 2020.
- Although increased agency costs in January there has been successful recruitment of medical staff which will assist in reducing the reliance on locum medics.

Not Assured/Most Deteriorated

- Agency Spend has increased significantly in January and could continue at this high level if de-escalation does not take place.
- Non elective income and activity subject to CCG contract challenge.
- Elective activity is on plan in month but needs to be sustained over a number of months to demonstrate improvement is embedded.
- CIP forecast year end gap of £0.6 million not yet resolved.

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 offering and delivering Essential HR Skills training to as many managers as possible.

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 73.48% in January 2019 which is a 3% improvement. Work continues to achieve target of 85%, and ultimately beyond this target. This is the third month of consecutive improvement however improvement is slow. All CBU's have revised their PDR improvement plans report to meet 85% improvement target by end of February 2019. This would require the CBU's to make a 12% improvement in month which would be unprecedented based on historical trends.

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 was launched in December 2018, 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 January the overall Trust rate was 84.55%. 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 March 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’ Free Yoga across both sites commences in March 2019.

Organisational Development

Work has begun to deliver activities identified in the Workforce & OD Plan and an update was provided to Workforce Committee in January 2019. A draft Staff Engagement Strategy is under development based on HR/OD & the wider Valuing our People Group members working with NHS Elect to initiate our staff engagement approach “Big Conversations” in May 2019 with the aim of developing a Trust Values & Behaviour Framework, whereby all staff know “how we do things around here”. The Shadow Board Development programme is due to commence on 8th May working with the NHS Leadership Academy and Inspiring Leaders Network. The Board & Senior Leaders Programme continues each month with a Trust wide leadership event on 3rd April as Professor Michael West talks about “Leading change through compassionate leadership”. Board & Senior Leader Development will be further developed on receipt of and informed by the outcomes of the Well Led Development Review. OD is looking to develop a coaching strategy to inform a coaching culture across the organisation, initial work commenced in February 2019 with the launch of a CMI Level 5 Award Management Coaching & Mentoring programme, a second Cohort is due in May/June 2019.

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 composed in March 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 significantly increased in month to 6.43% which was anticipated after the challenging festive period but continues to be a concern. The % rates remains above the Trust target. In winter 2018 the monthly trend was a month on month reduction in sickness absence with the exception of October 2018. November and December 2018 saw a reduction in rates once again which was promising however as noted January 2019 is highly disappointing. There is a need for a consistent reduction month on month. The Trusts new Supporting Attendance Policy was implemented on 28th January 2019 along with revised support materials and ongoing training for all those staff who manage sickness across the organisation. 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 ensures 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

An update report of sickness absence was presented to Workforce Committee in January 2019.

Executive's Assessment of Overall Position	Executive: Director of Strategy	AMBER

Overview

Vision 2020

To develop a strategy for Acute Sustainability that will secure the quality and financial future of local services for the population and its future needs
Pre Consultation Business Case time scales currently under review in light of the Sefton Transformation programme reset and the delay in securing capital monies

Assured/Most Improved

CLINICAL SCENARIOS
The Frailty, Urgent & Emergency Care, Elective and Children's Clinical Models are in the final stages of the design phase for review at the next Clinical Leadership Group.
The Women's clinical model continues to be worked through with a roadmap for delivery to be reviewed at the next Clinical Leadership Group.
The Clinical Leadership Group (CLG) met in January and have agreed the scope to be wider to include the Acute Sustainability Programme and the wider Place programme for the North of Sefton and West Lancashire populations. The CLG have agreed to review and approve Design Principles for the clinical model developments and a clinical engagement strategy to enable effective assurance to the Sefton Transformation Board.
ESTATES SOLUTIONS
The mid-term GIRFT review of the Trauma and Orthopaedics pilot took place which identified the need to proceed at greater pace to ensure the delivery of a hot/cold site model. A site visit to Cramlington took place on 1st February 2019 and a site visit for Glasgow's Golden Jubilee Hospital will took place on the 21st February 2019.
Therese Patten has taken on the role as Sefton Place's Estates SRO
Acute estates planning – work continues to provide a site control plan for both Southport and Ormskirk sites
FINANCE SOLUTIONS
Work has commenced to explore system Financial models with priority work focusing on the Frailty model
OPERATING MODEL
Target operating models to emerge from the clinical scenarios

KEY ACHIEVEMENTS/PROGRESS IN MONTH
A priority setting workshop for the acute sustainability programme took place on the 26th February with good representation of partners across the system including the CCGs, Liverpool Women's, Aintree and GP representation. A refresh of the programme was agreed and work is underway to define the programme and delivery vehicle.
Children's workshop focussing on acute pathways took place in December, Maternity workshop took place in January and a Women's Health and Sexual Health workshop planned for early February. External expertise to accelerate the work has been sought with two programme leads appointed by the Sefton PMO to help mobilise the Women and Children's, Urgent & Emergency Care and Frailty workstreams with a dedicated GIRFT programme manager appointed by the S&O PMO to accelerate the GIRFT programme within the Elective Care workstream

Not Assured/Most Deteriorated
Clinical workforce disengagement in the transformational process which may hinder delivery of the transformation Estate may not be best utilised to support the new clinical models due to the lack of an estates development plan aligned with a no capital/limited capital funding availability

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KPI Graphs and Update

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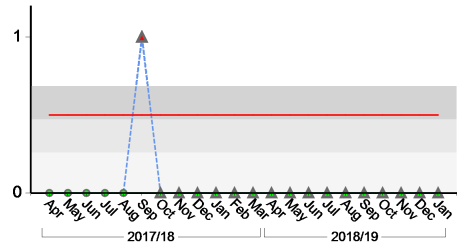
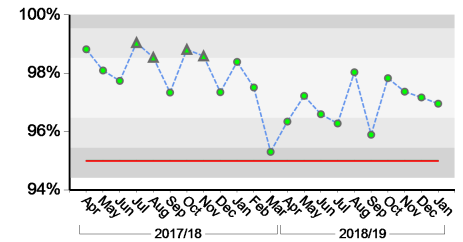
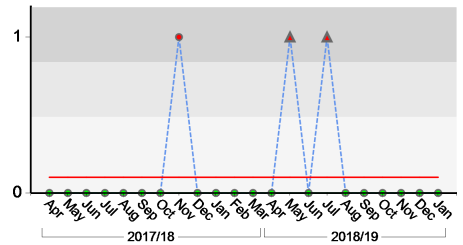
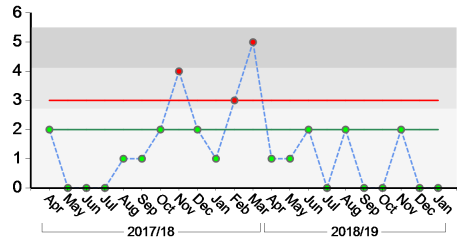
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	The Trust remains compliant with no MRSA Bacteraemia Since September 2017 - Nationally there is a zero tolerance for MRSA Bacteraemia within acute NHS Trusts - since October 2017 the Trust has been able to maintain zero cases.	
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	Performance of 96.96% for January continues to be above required compliance level - Although performance for January has marginally dipped from December's compliance level this must be viewed in the context of increased number of discharges across the month (756) Wards who do not achieve 100% will be advised accordingly so corrective action can be taken.	
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.	0 Never Events in January - There were 0 never events for the Trust in the month of January	
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.	This is the 2nd Month in succession with no Hospital Acquired C diff Cases; The Trust remains below trajectory - The Trust target for C diff as set by NHSI is to have no more than 35 cases this fiscal year; since the Trust had just 21 cases last fiscal year it was agreed to have an internal stretch target of having no more than 20 cases in the year. The current Trust total is 8 cases, therefore on our current trajectory the Trust is 9 cases below or stretch target.	

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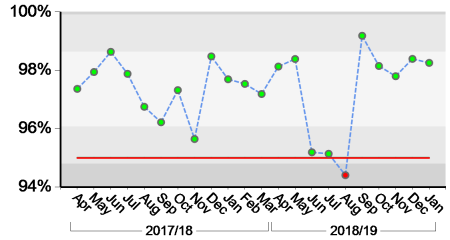
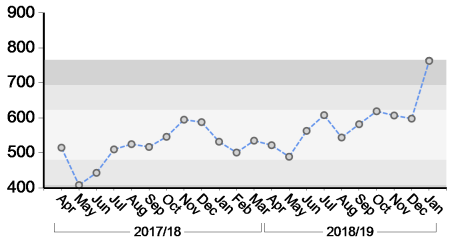
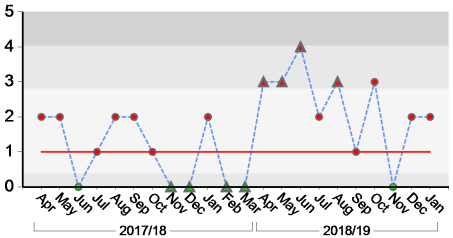
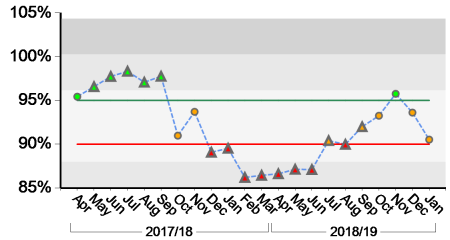
NHS Trust

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.	Compliance remains above threshold of 95% - Compliance remains above the threshold for January 2019 at 98.25% During the census period the Trust reported 7 new patient harms which were made up of; 2 x Grade 2 pressure ulcers on 9b and Spinal ward 2 x low harm falls on 14a and observation ward 1 x catheter related UTI on spinal ward and 1 x new PE on ward 14b	
Patient Safety Incidents - Low, Near Miss or No Harm	The number of incidents relating to patients where the severity was Low, Near Miss or No Harm caused. A lower number is good.	There has been an increase in reporting lower level incidents in January for the Trust , 750 reported compared to 598 last month , this is mainly due to bed management issues - In January there were 750 lower level incidents reported - 34 Near miss incidents, 581 No harm and 135 Low harm incidents. 68 of these were DoL's applications. The other categories with the highest reported incidents relate to Bed management issues such as delay in transfer to the ward -96 reported , same sex breaches 31 reported and patients nursed in the corridor in A&E -28 reported , the other category relates to patient falls were 96 incidents were reported.	
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	Two Falls in January 2018 causing Moderate/Severe Harm - 01/01/2019 (67968) - Patient was trying to get out of bed in the middle of the night to use his bottle and lost his footing and fell on his side. The patient remained fully conscious. The patient sustained un-displaced fracture of the left, fifth, sixth and seventh ribs. Falls care bundle completed on admission to 7B and identified as 'amber'. Falls care plan was already in use at time of fall had and had individual notes documented 72 hour report to SIRG on 15/01/2019 - Outcome - internal investigation 24/01/2019 - (68681) - 83 year-old patient with some confusion, known falls risk, yellow wrist band (alert) in place patient unsteady on her feet due to polio as a child and usually wears a calliper on leg to mobilise. Patient mobile around the side room and slipped to the floor. Assistance given and patient made comfortable. X-ray the following day (25/01/2019) confirmed fracture to left NoF Patient optimised in HDU before theatre due to fast AF. Left hemi arthroplasty performed on 28/01/2019. 72 hour report presented to SIRG on 05/02/2019 - outcome STEIS reportable.	
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%.	Safe Staffing compliance has reduced in January 2019 to 90.52% but is still within tolerance - The on-going work with Ward Managers to review E roster compliance will improve over the next 2-3 months however, this is also dependent on the reduction of escalation capacity that has reduced staffing flexibility over the winter period.	

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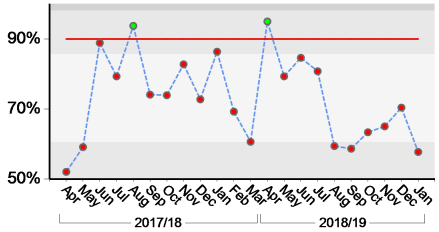
Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	There was significant decline in performance in January of 57.69% compared to 70.37% in December (19/27 patients). 15 out of 26 patients were treated within the 36 hour timeframe - Orthopaedic teams are now nearly fully staffed - 9 orthopaedic consultants now in position with 1 vacancy remaining. Consultant of the week is still on track to commence week beginning 4/3/19	

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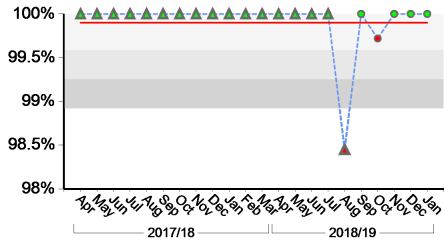
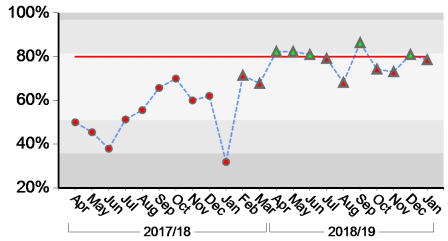
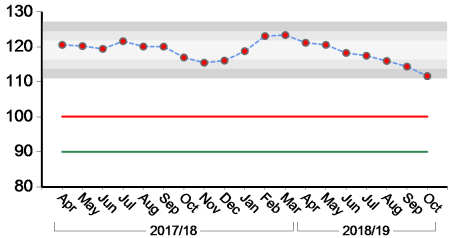
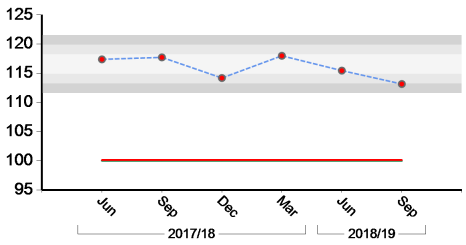
NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
WHO Checklist	WHO Checklist.	Performance remains at 100% compliance for January 2019 - Checklist audits 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 although slightly under the 80% target in January - 78.57% 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 is improving sequentially. - The current HSMR of 113.8 is the best figure since the commission of the Reducing Avoidable Mortality project, is the lowest single figure on the reported data since April 2017 and represents an improved position on the comparator period in 2017. This improved position is due to multiple factors improved through the individual workstreams.	
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.	The Trust can report an improved position on same period previous 12 months. - SHMI, by its construction changes very slowly and will alter after crude mortality and HSMR. The current figure represents an improved position on the comparator period of 2017. The narrative for the Remedial Action plan is as per HSMR report. With the exception of palliative care coding which does not feature in the SHMI calculation.	

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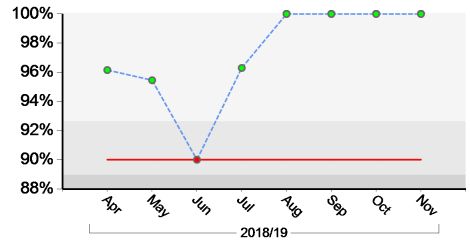
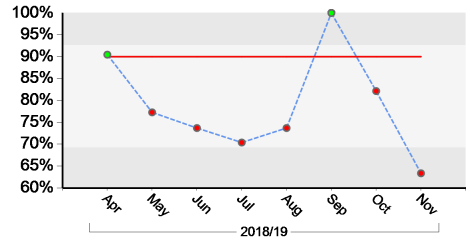
Effective

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 remains 100% compliant - There were 33 patients diagnosed with Sepsis in November 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.	Performance has declined for the second month running from 100% in September, to 82.14% in October, then 63.33% in November - In November 19 out of 30 patients were treated with antibiotics within one hour of diagnosis	

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NHS
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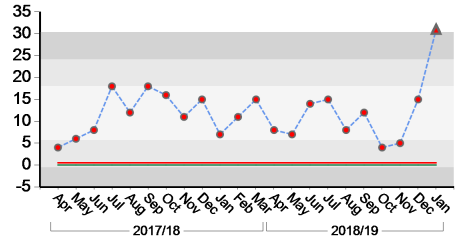
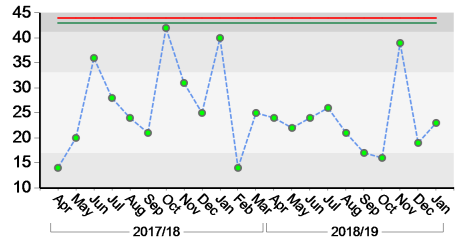
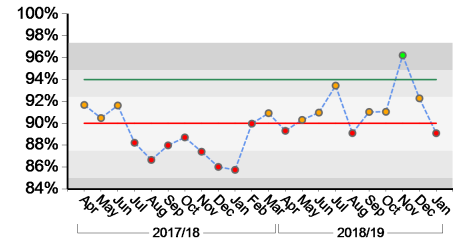
NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	January saw a significant rise is DSSA breaches. In total there were 31 patients -	
Written Complaints	The total number of complaints received. A lower number is good.	There were 23 complaints in January. This is higher than December (19) however this remains within normal range - the themes are as follows 1. staff attitude/behaviour 2. clinical treatment issues – including co-ordination of care/failure to perform observations 3. lack of support after discharge 4. incorrect treatment/diagnosis issues 5. staff shortages 6. discharge issues – support after discharge/discharge destination. Also communication issues. The number of complaints received suggests that patients are aware of the complaints procedure. the complaints continue to be reported into 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. The trust target is being considered and may be set at a different level form 1 April.	
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance has declined compared to the previous two months - The figure decreased by 3.19% for the month of January to 89.09%. Trust FFT response rates have also decreased by 1.84% to 5.09% for Jan-19. A review of the small number of FFT comments from those who would not recommend the Trust identifies a main theme of extended waits in both Southport and Ormskirk A+E departments. Awaiting a statement of case to be reviewed with the aim to improve FFT response rates by implementing SMS/IVM in areas where patients are more transient i.e. A+E. National Inpatient Survey 2018 results expected in May -19.	

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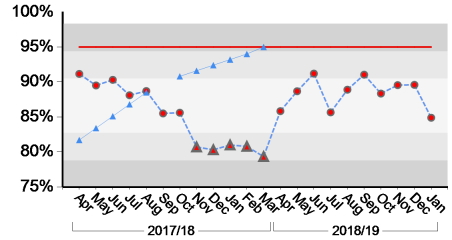
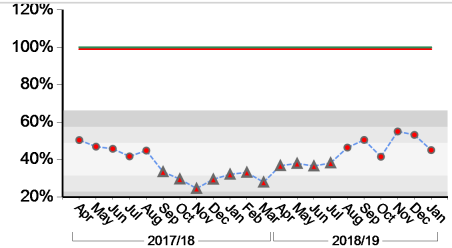
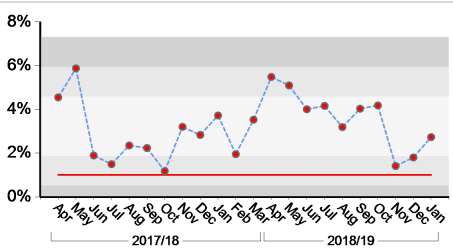
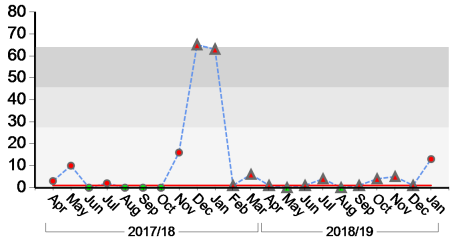
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	There is a 4.8% improvement in overall Trust performance compared to January 2018 - The Southport site alone saw an increase of 813 patients compared to Jan 2018; of those, an additional 686 patients were classed as majors category compared to last year, which puts huge pressure on the clinical resources and estate available to meet this increased demand. Performance against the 4-hour standard on the Southport site saw a 14.9% improvement compared to last year, which demonstrates the collective work across the system to address pressures in patient flow and maintain patient safety. 299 fewer patients waited longer than 4-hours in ED compared to Jan 2018 and patients nursed on the corridor reduced from over 1600 in January 2018 to below 400 in 2019. although there has been some good progress made in recruiting to the agreed ED workforce strategy (with another substantive consultant interview taking place in February along with overwhelming interest in the Physicians Associate posts), challenges remain at middle grade level in developing an expanded Tier 2 workforce. There is another review of ED workforce underway alongside activity levels to consider any further opportunities to support the current rotas, particularly night shifts when patient flow is challenged.	
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.	Whilst ambulance handovers completed within 15 minutes fell to 45% compared to the previous month, compared to January 2018, this was a 13% improvement. - January 2019 saw an additional 813 patients, 130 of who arrived by ambulance. Ambulance delays over 60 minutes continues to show improvements and care delivered on the corridor reduced significantly compared to January 2018. However pressures continue to be experienced as a result of exit blocks from ED (due to bed pressures, results of surges, or staffing shortfalls), which lead to delays in timely transfer of patients from the ambulance cubicles into assessment space. The Trust continues to work with NWAS to identify further areas for improvement.	
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 deteriorated in the last month, from 1.8% in November, to 2.73% in January - The breaches were: Cardiology - Echo - 21 patients - 6.5% (1% in January) - unexpected staff sickness which is now ongoing. Colonoscopy - 8 pts- 8.9% (6.2% Jan) - patient choice. Cystoscopy - 7 pts - Cystoscopy (Gynaecology) - 3pts - 6.9% - patient choice, ongoing lack of capacity (gynae). Dexa - 4 pts - 1.9% - capacity due to retirement. Flexi Sigmoidoscopy - 1 - 1.7% - patient choice. MRI - 17 - 2.9% - difficulty in contacting patients/patient choice. Non-obs Ultrasound - 14 - 1.8% - unable to contact patient, patient choice, cancellations, 1 appointment rearranged by department. Urodynamics - 4 - 7.5% - 1 - long term staff sickness Out of 2781 patients in total, 76 breached beyond the 6 week wait. There has been prioritisation of inpatients over routine due to winter pressures to facilitate discharges. MRI has increased significantly from 634 in December to 747 in January. Dexa is antipicated to be back on track in May following training Echo should be back on track in April.	
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.	Unfortunately there were x 13 12-hour breaches across the month of January. 2 of these were due to delays in accessing mental health beds. - Timelines have been completed and RCAs are now underway. The other x11 breaches were as a result of bed delays at Southport (x2 on 2/1/19, x1 on 7/1/19 and x8 on 21/1/19). Bed occupancy levels at Southport remain high, coupled with reliance on escalation areas to bridge shortfall in discharges compared to admissions, and on frequent occasions across January a large number of patients were bedded in ED as a result. 9 of the breaches were following bed pressures experienced at weekends. It should be noted that January saw a huge increase in attendances compared to January 2018, which put pressure not only on ED but also the hospital bed base, in addition to some infection control pressures which resulted in bed closures. Significant efforts have been made to improve inpatient flow across the week with MADE reviews, Red to Green, investment in a dedicated Discharge Lounge and an Integrated Discharge Team, a drive for ongoing assessments to take place in community beds, alongside enhanced medical staffing models at weekends in medicine. However, the timely release of beds, and aligning discharges and admissions remains a challenge, particularly across weekends. Daily senior medical support continues to inreach into ED until 9:30pm ensuring that alternative pathways to admission are considered wherever appropriate.	

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NHS
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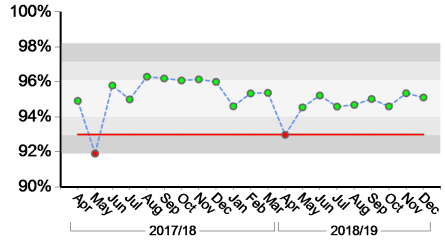
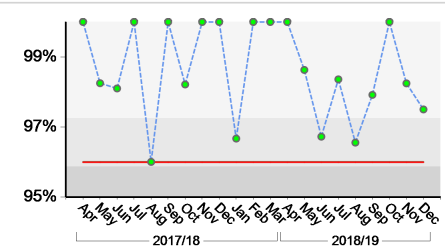
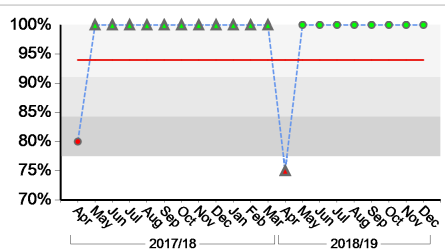
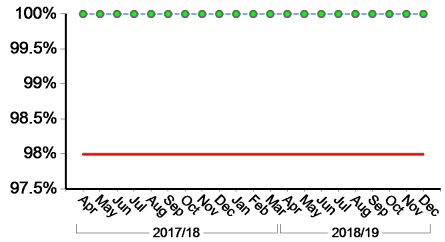
NHS Trust

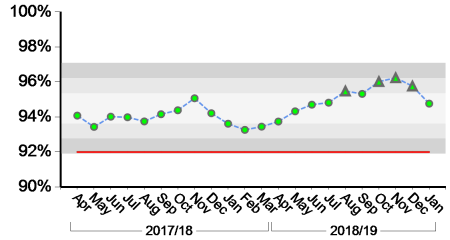
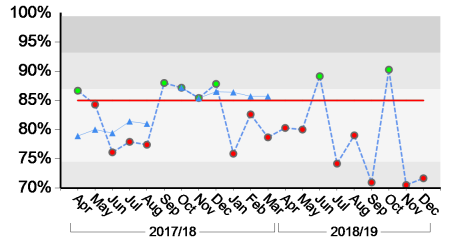
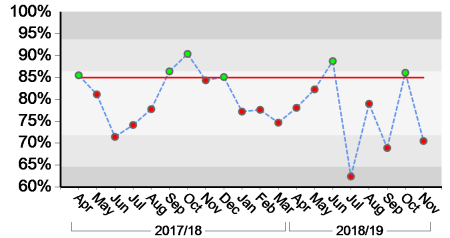
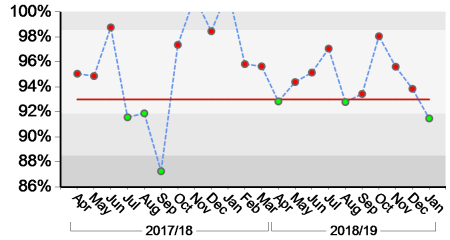
Responsive

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 is currently compliant against this target - We are looking into the feasibility of reducing the polling range from 14 days to 7 to comply with the 7 day pathway that has been adopted by the Trust as part of the Cancer Improvement Plan	
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 continues to be compliant with the 31 day standard - The Trust continues to provide treatment within 31 days of the decision to treat for the majority of its patients.	
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 continues to be compliant - 100% of the patients who received a surgical subsequent treatment for their cancer last month, did so within 31 days of date of decision to treat.	
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').	The Trust continues to be compliant against target - 100% of patients receiving anti cancer drug therapy as a subsequent treatment for their cancer received these with 31 days of date of decision to treat.	

Board Report - January 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher.	The Trust remains compliant at 94.76% - Performance has decreased to 94.76% but is still above threshold of 92%. This is considered to be as a result of activity lost due to Winter Bed Pressures.	
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.	The Trust remains below the standard - The Cancer Improvement Board has been set up to address areas where there are bottlenecks in the cancer pathways and hold areas to account for their poor performance against the agreed 7 day pathway.	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	The Trust is non-compliant against 62 day standard - Of the 37 patient treated under this standard in November, 12 failed to meet the 62 day target. These were 3 gynaecology, 1 head & neck, 2 lower GI, 1 upper GI, 5 urology. Cancer Services is working closely with the directorates to develop and implement an improvement plan to address our poor performance.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Bed occupancy achieved target - additional bed capacity opened on ward 1 to support winter pressures; closed beds due to infection. #longstayuesday with system partners, review of patients with LOS 20+ days commenced weekly. introduction of daily discharge huddle with LCFT and LA to support cross system working; trusted assessment document developed by community following PDSA with all parties continues. red2green on all in-patient wards at SDGH; ward closures and restricted movements throughout January due to infection led to delays in discharge and reduced bed occupancy	

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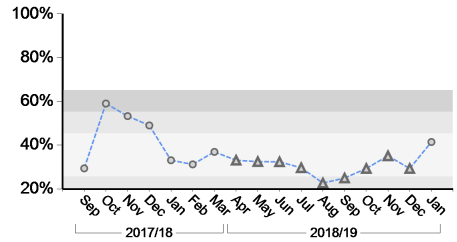
NHS
Southport and Ormskirk Hospital
NHS Trust

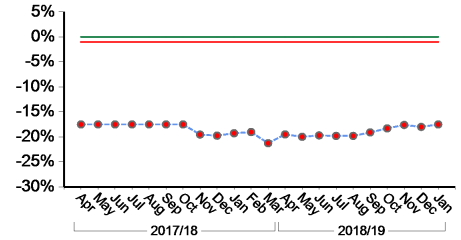
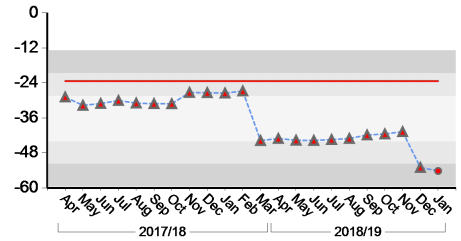
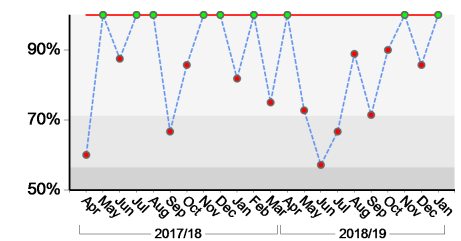
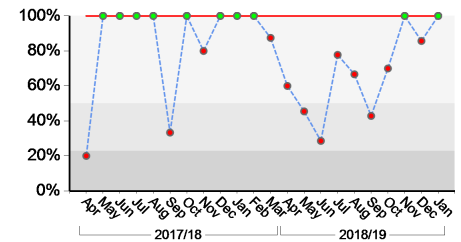
Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site. A lower percentage is good. Threshold is 93%.	Bed occupancy increased in January to 41.45% - Bed occupancy data is currently being validated to only count 'overnight' beds A number of beds in wards that are classed as 'day only' beds are often used for patients overnight as well. There is no obvious statistical pattern to enable the exclusion of these beds at this time. We are continuing to analyse the bed use on the Ormskirk site to validate these numbers.	

Board Report - January 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Performance is consistent across the last 3 months - No material improvement expected until 2019/20 which requires a number of issues to be resolved. The Trust accepting the 2019/20 control total will significantly reduce the amount of sanctions that CCG's can apply. The future rules around CQUIN and non recurrent funding in 2019/20 for Trusts in deficit will also help to improve this metric.	
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	A marginal decrease in performance - The Department of Health are now changing the classification of loans that are technically due for repayment within 12 months as current liabilities. This is having an adverse affect on liquidity and as more loans fall into this category the metric will continue to get worse.	
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	Duty of Candour - Evidence of Inital Disussion - This month the CBUs reached 100% compliance this demonstrates that staff are engaged with this statutory duty. The daily Duty of Candour alerts allow the Trust to track compliance, take action to ensure patients and families are informed of incidents. The Integrated Governance Team continues to support staff with this duty via education and support	
Duty of Candour - Evidence of Letter	The proportion of patients who have received a letter of apology when something that has gone wrong with their treatment or care.	Duty of Candour - Evidence of Letter - This month the CBUs reached 100% compliance this demonstrates that staff are engaged with this statutory duty. The daily Duty of Candour alerts allow the Trust to track compliance, take action to ensure patients and families are informed of incidents. The Integrated Governance Team continues to support staff with this duty via education and support	

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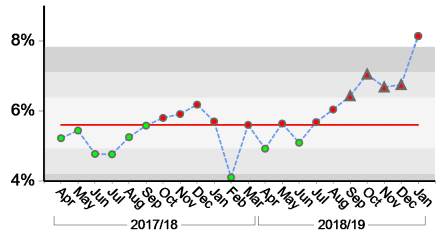
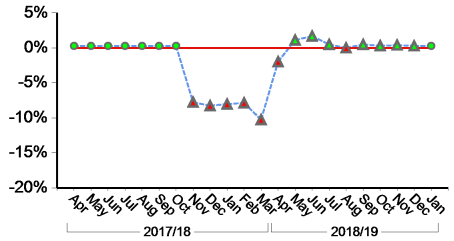
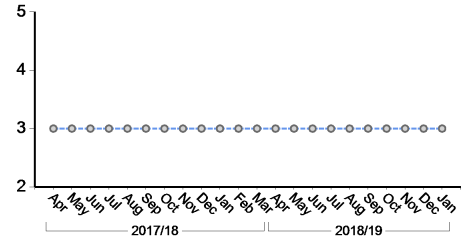
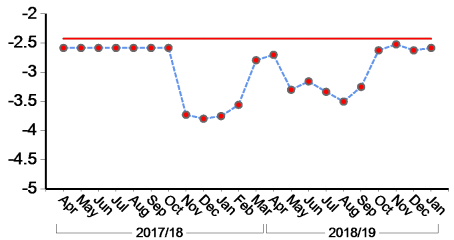
NHS
Southport and Ormskirk Hospital
NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	There has been a significant increase in cost in January - Agency spend in nursing staff rose significantly in January to mitigate higher sickness absence levels and provide additional resource to cope with the higher levels of demand resulting in additional escalation beds across the hospital.	
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 (-17.5%) than plan (-17.8%). Although the actual deficit is £385k worse than plan this is over a higher turnover (plan £135.2m; actual £140.3m).	
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 improvement on this metric - Metric now very close to plan. Plan for January was -2.57 with an actual of -2.58.	

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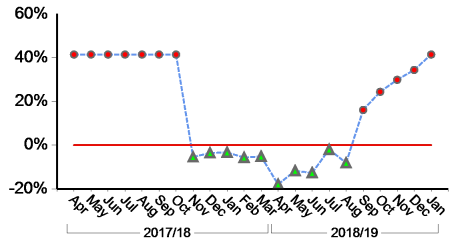
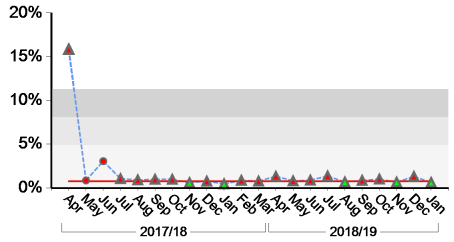
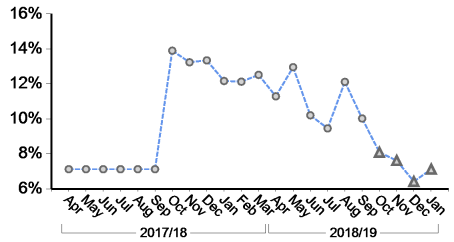
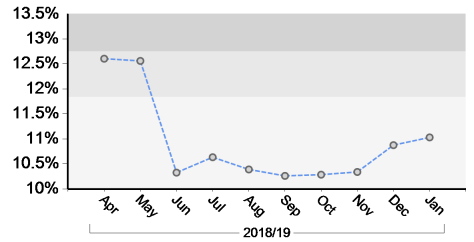
Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Performance declined in January due to increased reliance on agency staff in light of the requirement for safe staffing across an extremely busy January. -	
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month.	Staff turnover has decreased significantly in month and remains on target at 0.61% - New Nursing & Midwifery Recruitment & Retention Steering Group (NMRRSG) to be established by the nursing team to supersede the NHSi Nursing and Retention Pilot Task and Finish Group	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The vacancy rate increased slightly in January due to the retirement of longstanding consultants - Recruitment activity continues to source candidate to fill vacancies, with alternative arrangements being considered as appropriate.	
Staff Turnover (Rolling)	Staff Turnover (Rolling) is calculated by taking the number of leavers over the past 12 months divided by the average headcount from the last 12 months.	New metric - The rolling 12 month figure has increased from 10.88% (Jan-Dec 2018) to 11.03% (Feb 2018-Jan 2019) -	

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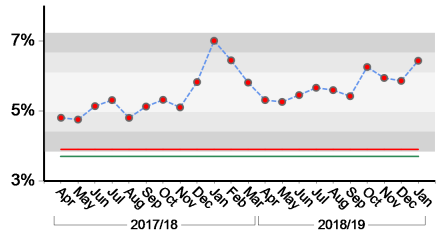
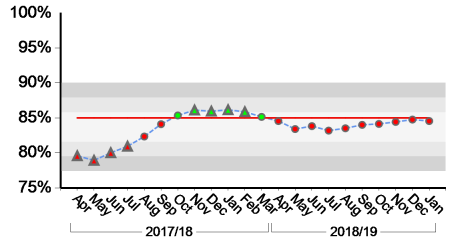
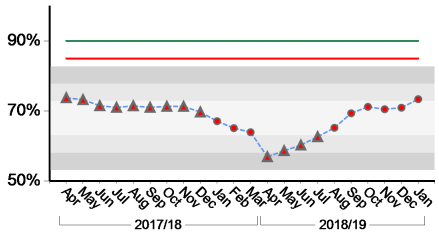
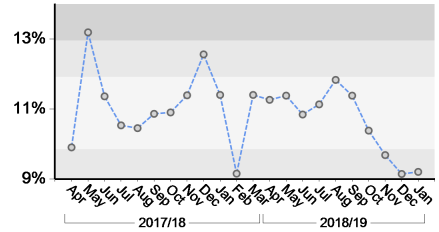
Well-Led

Indicator Name	Description	Narrative	Month Trend
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence has significantly increased in month to 6.43% and 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 December 2018 which was promising however there has been a significant spike in January 2019 which is disappointing. 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 was 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.	There was a slight 0.21% decrease (0.21%) in mandatory training compliance - Staff were unable to successfully complete eLearning modules online due to a national issue with ESR for a period of 2 weeks over Dec/Jan 2018/19, this may have impacted on the overall compliance this month. Action: The training department is reviewing all online activity to update this manually. An Induction & Mandatory Training Action Plan is under development to be monitored via the Risk & Compliance Group to include a review of position mapping, TNA's, time & cost of training, leaver process and the development of a Management of Core & Role Specific Training Requirements. This action plan will commence 01.03.2019.	
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance increased by nearly 3% in month to 73.5% - PDR compliance is now at 73.48% for January 2019 which is nearly a 3% increase from December 2019. This is the third month of consecutive improvement however improvement is slow. All CBU's have revised their PDR improvement plans report to meet 85% improvement target by February 2019. This would require the CBU's to make a 12% improvement in month which would be unprecedented based on historical trends.	
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Slight 'negative' increase in the vacancy factor for nurses & HCA - We have seen a monthly 'positive' decrease in the number of RN vacancies since the summer 2018. There were no recruitment events in December 2018 or January 2019 however, the Trust held an Open Day and attended an external recruitment event in February2019.	

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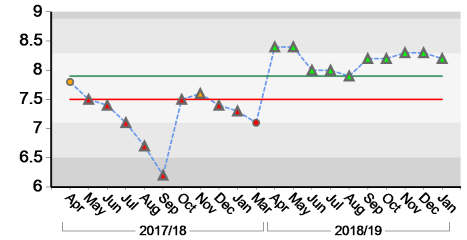
NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	CHPPD remains above national average - Model Hospital data for ward areas demonstrates below average for CHPPD however, as a Trust we are above national average. Therefore extensive data cleansing is required with support form Model Hospital Team.	

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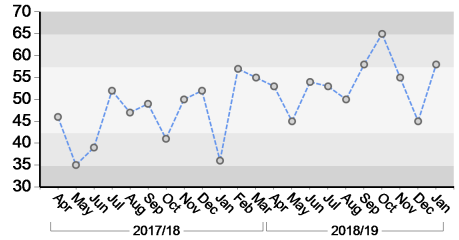
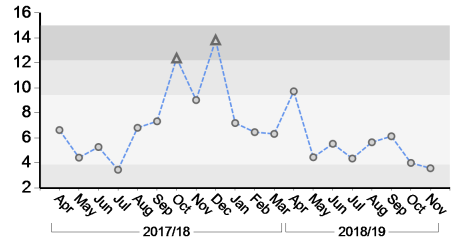
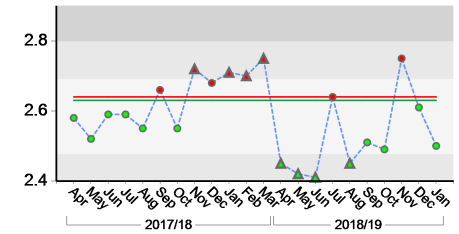
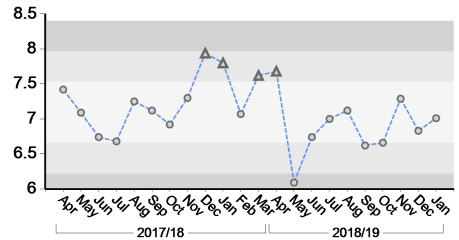
NHS Trust

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.	There was an increase in January (58 patients) due to acuity of patients, and closed wards due to infection - Ongoing management - Implementation of #longstaytuesday with system partners, new review of patients with LOS 20+ days commenced weekly. introduction of daily discharge huddle with LCFT and LA to support cross system working; trusted assessment document developed by community following PDSA with all parties continues. red2green on all in-patient wards at SDGH; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements throughout January due to infection led to delays in discharge of MOFD patients to alternative care facilities	
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).	steady improvement continues - continued improvements within DTOC supported by developing models for both collection and ratifying of data; re-launch of red2green data collection with the completed rollout on all inpatient wards at SDGH. review of working patterns for discharge facilitators due to vacancies, ensuring support to all inpatient areas on a daily basis; improved staffing on Saturdays to support weekend activity	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	The Trust is compliant. - The New:FU Rate reduced again in January 2019 to 2.5%	
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 the normal range for the Trust at 7.01 days. - red2green and discharge reviews are ongoing in all in-patient areas. Implementation of #longstaytuesday with system partners, new review of patients with LOS 20+ days commenced weekly. introduction of daily discharge huddle with LCFT and LA to support cross system working; trusted assessment document developed by community following PDSA with all parties continues. red2green on all in-patient wards at SDGH; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements throughout January due to infection led to delays in discharge of MOFD patients to alternative care facilities and increased LoS	

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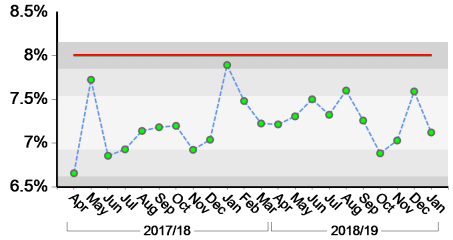
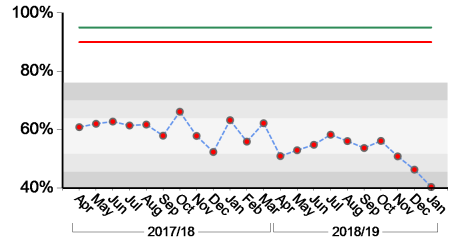
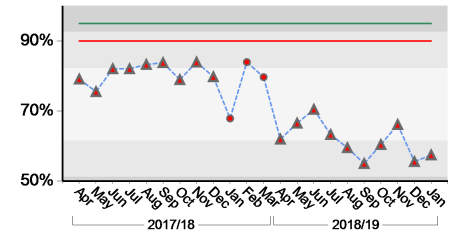
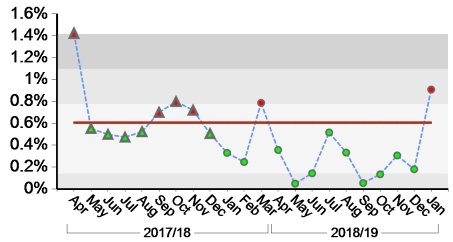
NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	The trust remains compliant. The DNA Rate has reduced in January to 7.12% - 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. The anticipated improvement occurred in January.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Performance continues to show deterioration in utilisation due to winter pressures - Only urgent and target patients were booked at SDGH for the first 3 weeks in January. 58 procedures, 14 cancellations - 13 of which were cancelled due to no ward / HDU beds available.	
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Performance shows some improvement over the previous month at 57.41% but this still represents a decline in performance over the last 21 months. - Urology had a number of cancellations due to beds Several potential opportunities have been identified for investigation, and the data is also being checked for accuracy and timeliness of recording. A working party has been established to ensure accurate recording. Once data is verified, consideration will be given to demand and capacity	
Cancelled Ops	Percentage of Operations Cancelled.	20 out of 2201 elective operations were cancelled in January some of which were due to winter pressures - 14 were cancelled on the day due to beds.	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	TB053/19	Report Title	Financial Position at Month 10 including: Forecast Outturn 2018/19
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 deficit after Provider Sustainability funding (PSF)), and set a deficit plan of £28.8 million.

At month 10 year to date (YTD) the Trust's financial performance is a deficit of £24.502 million; this is £409,000 worse than plan. Income and activity continues to be above plan for A&E attendances and non- elective admissions. This includes income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity. Elective activity balanced to plan in month.

Expenditure run rate increased due to the need to safely staff areas due to higher levels of non elective activity and sickness. The cumulative pay budgets overspend increased by £490,000 to £1.835 million (month 10 YTD). Non-pay expenditure in January is marginally higher than December. CIP programme is forecast to be £0.6 million lower than the £7.5 million plan.

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

- Total sanctions were forecast to be £2.1 million for the year; January performance has increased this by a further £124,000.
- Despite recommendations from NHSI/E that support the Trust's income for CDU tariffs this issue has not been fully accepted by commissioners.
- Non elective income – NHSI/E also advised that the CCG should pay for all the non-elective activity undertaken by the Trust.
- There is a risk to income of £3.5 million for CDU and non-elective.
- Income received for additional activity does not mitigate the cost of resourcing additional staff for escalation in February and March.

The FOT for 2018/19 remains unchanged at £28.8m deficit.

Recommendation:
The Board is asked to **receive** the Month 10 Director of Finance report

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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 – January 2019

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 10 (the financial period ending 31st January 2019).

2. Executive Summary

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

2.2. The Trust was £64,000 ahead of the plan for January, resulting in a year to date deficit of £24.502 million which overall is £409,000 worse than plan.

2.3. Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity; Income has been accounted for based on correspondence received by the Trust and CCGs from NHSI and NHSE. However, this income is at risk which is explained further in the report.

2.4. Significant increase in A&E attendances in January resulting in additional YTD income of £549,000 (6.5%).

2.5. Non elective activity over-performance, including ACU and CDU and adjusted for MRET (Marginal Rate Emergency Tariff) has generated to date additional income of £4.973 million above the Trust's initial plan.

2.6. Elective activity is balanced in month but year to date is down by 11.72%; which is worth £1.103 million in income.

2.7. Outpatient activity is down in month but remains higher than plan YTD.

2.8. A provision of £388,000 has been made for non-achievement of CQUIN. The year-end forecast shortfall is now expected to be £430,000.

2.9. The CIP programme is forecast to be £0.6 million lower than the £7.5 million.

2.10. Expenditure run rate has increased from the consistent level seen over the previous three months. This is mainly related to the additional emergency activity seen in January which resulted in higher levels of premium rate expenditure for nursing and medical staff. The cumulative pay budget overspend increased from £1.346 million (month 9 YTD) to £1.835 million (month 10 YTD).

2.11. Non-pay expenditure in January is marginally higher than December.

2.12. Agency spend significantly higher this month (£921,000 in month; YTD £6.9 million).

2.13. The table below is the I&E statement for January:

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	124,378	127,048	2,670	12,821	13,680	859
PP, Overseas & RTA	1,387	1,156	845	(311)	116	44	(72)
Other Income	14,502	12,060	12,531	472	1,213	1,245	32
Total Income	**164,810**	**137,593**	**140,424**	**2,831**	**14,150**	**14,969**	**819**
Operating Expenditure							
Pay	(129,278)	(108,021)	(109,856)	(1,835)	(10,811)	(11,301)	(490)
Non-Pay	(53,165)	(44,367)	(45,660)	(1,293)	(4,365)	(4,628)	(263)
Total Expenditure	**(182,443)**	**(152,388)**	**(155,516)**	**(3,128)**	**(15,176)**	**(15,929)**	**(753)**
EBITDA	**(17,633)**	**(14,795)**	**(15,092)**	**(297)**	**(1,026)**	**(960)**	**66**
Non-Operating Expenditure	(11,217)	(9,347)	(9,356)	(9)	(935)	(935)	(1)
Retained Surplus/(Deficit)	**(28,850)**	**(24,142)**	**(24,447)**	**(306)**	**(1,960)**	**(1,895)**	**65**
Technical Adjustments	63	48	(55)	(103)	6	5	(1)
Break Even Surplus/(Deficit)	**(28,787)**	**(24,094)**	**(24,502)**	**(409)**	**(1,954)**	**(1,890)**	**64**

2.14. Capital expenditure is within the plan and continues to be managed through the Trust's Capital Investment Group (CIG).

2.15. The Trust continues to require revenue support loans as cash support. To support this process a monthly rolling 13 week cash forecast is provided to NHSI.

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

2.16.1. Income received for additional activity does not mitigate the cost of resourcing additional beds in February and March. Total sanctions were forecast to be £2.1 million for the year; January performance has increased this by a further £124,000.

2.16.2. Despite recommendations from NHSI/E that support the Trust's income for CDU tariffs this issue has not been fully accepted by commissioners.

2.16.3. Non elective income – NHSI/E also advised that the CCG should pay for all the non-elective activity undertaken by the Trust.

2.16.4. There is a risk to income of £3.5 million for the issues in 2.16.2 and 2.16.3

2.16.5. Income received for additional activity does not mitigate the cost of resourcing additional staff for escalation in February and March.

2.17. The Trust's FOT remains at £28.8 million deficit but this is dependent on a satisfactory contract settlement.

3. Income Performance

Elective

3.1. Elective activity has balanced to plan this month which is an improvement on the YTD performance. However, the YTD adverse variance is £1.103 million (7%) and the elective shortfall will not be brought back to plan.

3.2. Outpatient performance underperformed in month which reflects the deployment of medical and nursing staff to emergency work during January.

A&E

3.3. A & E attendances exceeded plan significantly in January. Income overperformance is £549,000 YTD.

Non Elective

3.4. Non elective activity continues to overperform 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 £1.665 million. Note that this has increased this month and reflects the unprecedented demand through January as well as the application of MRET to assessment ward activity.

3.5. CCG's have accepted the local tariffs for ACU; £769 for 1st attendance including A&E; £100 for follow up.

3.6. A joint letter was received from NHSI/NHSE on 10th January which recommended that the CDU tariff should be paid following findings of the MIAA report. It also recommended that other activity overperformance should be paid for. Commissioners did not agree with the regulators view.

3.7. Despite the NHSI/NHSE letter commissioners are refusing to agree CDU and continue to challenge the non-elective activity over performance. The current gap is £3.5 million. The Trust is waiting on the outcome of further discussions between NHSE/NHSI

3.8. Income of £2.123 million was accrued at month 10 YTD for both ACU and CDU activity. It is now likely that the full year value could be in the region of £2.8 million and this figure has been built into the forecast outturn.

3.9. Overall non elective activity (including ACU and CDU activity) is generating to date £4.973 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. Following further analysis of CQUIN performance an additional £62,000 for CQUIN has been deducted in month 10 (YTD £388,000).

3.13. It is now anticipated that total deductions will be £439,000 for the full year (see appendix). Discussions with commissioners are ongoing to minimise this.

Sanctions

3.14. The Trust has been informed CCG's will impose sanctions in 2018/19 for non-compliance with operational and national performance standards.

3.15. The Trust anticipates that sanctions will be applied on breaches of the national 95% A&E target. The Trust will utilise reserves to cover the additional sanction of £708,000 YTD when applied but this would leave less available to mitigate expenditure pressures in Quarter 4.

3.16. Based on performance for the first ten months sanctions of £1.908 million (now £2.2 million forecast for full year) will be levied by commissioners.

4. Expenditure

4.1. Underlying expenditure levels have increased in January for both pay and non-pay in comparison to December.

4.2. The increase in consultant pay is due to the Clinical Excellence Award (CEA) for both 2017 and 2018 being paid this month. The 2017 award is backdated to April 2017 and is an addition to basic salary paid on a permanent basis. This has changed with the recent pay award and from 2018 the award is now a one off payment non-consolidated and paid annually at the end of each year.

4.3. Non consultant medical staff and nursing staff continue to overspend which is a reflection of the increased escalation beds and additional ward opened in January along with the high level of vacancies and the necessity to fill shifts at premium rates.

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

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

4.6. Non pay spend has increased in month with an increase in drug expenditure on the Medical Day Unit £43,000 and medical and surgical supplies in paediatrics has increased by £16,000, although this has been offset by equivalent income for the expenditure. The cumulative overspend has increased to 2.8% from 2.6% previously (before reserves and CIP).

5. Agency spend

5.1. The Trust has spent £921,000 on agency staff in January (9.7% 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 £6.9 million, £1 million above the NHSI agency cap with another two months of the financial year remaining.

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

5.4. Due to the volume of non-elective activity through A&E in January and the number of patients being admitted, escalation beds have been put up in most wards along with an additional ward (Ward 1) being opened on 4th January. This has resulted in an additional requirement of both medical and nursing staff.

5.5. Although Ward 1 has been mainly staffed by the Trust's substantive nurses, they have been backfilled on the other wards with agency staff resulting in an increase of £165,000 nurse agency spend in month.

5.6. Additional agency medical staff have also been used to cover the additional ward with an extra £36,000 expenditure compared to December on other medical staff.

5.7. Overall nurse vacancy levels have reduced by 0.2% to 8.7%, the reduction is in registered nurses.

5.8. Bank fill has increased in month; the focus continues to be recruiting to substantive posts.

5.9. The cost of providing cover for nurse sickness in January was £205,000 (bank £143,000; agency £62,000) based on the information provided by NHSP.

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

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

5.12. 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.

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

5.14. The cost of providing cover for medical sickness in January was £5,000 (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	5,536	5,172	(364)	731	2,000	1,269	6,414
17/18 Balance to FYE	535	446	446	0	44	44	0	535
Total	7,541	5,982	5,618	(364)	775	2,044	1,269	6,949

6.4. The forecast CIP shortfall at the year end remains at £0.6 million.

7. Cash

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

7.2. A rolling 13 week cash forecast is updated monthly and sent to NHSI, usually in the second working week of the month; this forms the basis of any cash draw downs in the future month. (January's cash flow was sent on 5th December).

7.3. The Trust borrowed £2.437 million in January 2019 at an interest rate charge of 3.5% as it did not agree the control total for 2018/19.

7.4. Performance against the cash target in January 2019 was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,121	Brought forward balance.
Cash inflows	16,659	17,292	Majority of difference (£500,000) relates to November's VAT return which was not submitted until early January. December's VAT return was also submitted and received in January. In effect cash inflows include 2 VAT returns as opposed to one.
Cash outflows	-16,659	-17,338	Additional monies required to fund increased capital spending.
Closing balance	**1,000**	**1,075**	

7.5. 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 million bank balance at the end of the month.

7.6. February's loan was £2.64 million and March's request is £2.19 million.

7.7. The Board is asked to note that there is a potential cash risk if activity overperformance is not paid for by CCG's over the next two months.

7.8. Capital expenditure in Quarter 4 is forecast to be £2.4 million which is putting further strain on cashflow (see section 8.3)

8. Capital

8.1. The capital report has been re-designed to provide assurance to the Board that the projected forecast plan is in line with the Trust's statutory Capital Resource Limit (CRL).

8.2. To aid this donated equipment spend and radiology equipment (under the GE managed service contract) has been removed as these do not count against the CRL.

8.3. Whilst there is a clear plan in place the Board should note that spend in the next two months is forecast to be £1.926 million (see capital appendix-columns "orders not yet received, verbally agreed and additional spend"). This represents a significant amount of expenditure in two months.

8.4. The Board should note that the remaining 2018/19 plan includes the following items agreed at Capital Investment Group on 25th January 2019:

- 30 anaesthetic machines £647,000.
- Reverse osmosis plant at Southport, £100,000.
- Wards 11A & 14A alterations, £30,000.
- Y Block Office & new entrance, £16,000.
- SDGH Main Entrance Toilets, £18,000.
- Maternity Theatre ODGH Light Replacement, £12,000.
- Maxillo Facial Drill, £24,000.
- 40 volumetric pumps, £70,000.
- Pharmacy Fridge Alarms/Monitors, £7,000.
- Printers in outpatient consulting rooms, £6,000.
- Infusion Devices ODGH, £5,000.
- 28 hydraulic examination couches for outpatients (both sites), £20,000.

- Medisoft ophthalmic software, £21,000.
- Lift for EBME/Boiler House, £20,000.

9. Risks

9.1.1. Income received for additional activity does not mitigate the cost of resourcing additional beds in February and March. Total sanctions were forecast to be £2.1 million for the year; January performance has increased this by a further £124,000.

9.1.2. Despite recommendations from NHSI/E that support the Trust's income for CDU tariffs this issue has not been fully accepted by commissioners.

9.1.3. Non elective income – NHSI/E also advised that the CCG should pay for all the non-elective activity undertaken by the Trust.

9.1.4. There is a risk to income of £3.5 million for the issues in 9.1.2 and 9.1.3

9.1.5. Income received for additional activity does not mitigate the cost of resourcing additional beds in February and March.

10. Forecast Outturn 2018/19

10.1. The forecast outturn position remains at £28.8 million deficit.

11. Recommendations

11.1. The Board is asked to **receive** the Month 10 Director of Finance report.

List of Appendices

1. Activity
2. Statement of Financial Position (Balance Sheet)
3. Statement of Cashflows
4. Capital

NHS
Southport and
Ormskirk Hospital
NHS Trust

	In Month Position			Year to Date		
	Trust	ODGH	SDGH	Trust	SDGH	ODGH
GP Referrals	3,284			34,026		
Consultant Referrals	3,224			30,217		
Other Referrals	3,255			30,572		
A&E Attendances	7,330	2,408	4,922	71,226	47,707	23,519
NEL Full Admissions	1,445	269	1,176	12,836	10,258	2,578
NEL Ass. Ward Admissions	1,334	172	1,162	11,436	10,028	1,408
Daycases	2,013	1,201	812	18,709	7,172	11,537
Electives	198	142	56	2,075	731	1,344
Maternity	208	208		2,136		2,136
Births	173	173		1,758		1,758
Outpatients First Att.	8,445	4,192	4,253	81,885	41,617	40,268
Outpatients Follow Up Att.	24,535	12,883	11,652	232,250	109,029	123,221
Scopes	559	386	173	5,611	312	5,299
Radiology Exams A & E Attender	4,118	1,046	3,072	39,372	27,858	11,514
Radiology Exams GP Direct Access Patient	3,462	1,917	1,545	31,639	14,504	17,135
Radiology Exams In Patient	2,165	281	1,884	18,327	16,051	2,276
Radiology Exams Out Patient	5,406	3,066	2,340	48,016	21,079	26,937
Radiology Exams Other	57	42	15	371	90	281

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/01/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
3. Statement of Cashflows	126,790	126,031	(759)	(44)
Other assets	1,382	1,122	(260)	(45)
TOTAL NON CURRENT ASSETS	**128,172**	**127,153**	**(1,019)**	**(89)**
CURRENT ASSETS				
Inventories	2,454	2,435	(19)	(16)
Trade and other receivables	9,591	14,447	4,856	844
Cash and cash equivalents	1,079	1,075	(4)	(45)
Non current assets held for sale	0		0	
TOTAL CURRENT ASSETS	**13,124**	**17,957**	**4,833**	**783**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(25,830)	(599)	272
Provisions	(131)	(201)	(70)	(39)
PFI/Finance lease liabilities	(1,746)	(1,746)	0	0
DH revenue loans	(4,220)	(14,218)	(9,998)	(9,998)
DH Capital loan	(400)	(400)	0	0
Other liabilities	(471)	(672)	(201)	(508)
TOTAL CURRENT LIABILITIES	**(32,199)**	**(43,067)**	**(10,868)**	**(10,273)**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(25,110)	(6,035)	**(9,490)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**102,043**	**(7,054)**	**(9,579)**
NON CURRENT LIABILITIES				
Provisions	(278)	(214)	64	52
DH revenue loans	(66,615)	(83,787)	(17,172)	7,561
PFI/Finance lease liabilities	(13,807)	(13,628)	179	71
DH Capital loan	(1,400)	(1,000)	400	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(98,629)**	**(16,529)**	**7,684**
TOTAL ASSETS EMPLOYED	**26,997**	**3,414**	**(23,583)**	**(1,895)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	98,104	863	0
Retained earnings	(83,484)	(107,930)	(24,446)	(1,895)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**3,414**	**(23,583)**	**(1,895)**

In month material movements are as follows:

There's been a reclassification of DH loans in month with current loans (due for repayment within 12 months) rising by almost £10m and a fall in the non-current loans of £7.6m. The actual loan taken out in January was £2.437m which reconciles to the 2 movements.

Receivables have increased mostly on NHS as this reflects the current over-performance.

Other liabilites is also a re-classification and reflects R&D monies to fund projects over multiple financial years.

Movement in retained earnings matches the in month deficit.

Statement of cash flows

NHS
Southport and Ormskirk Hospital
NHS Trust

3. Statement of Cashflows	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Actual Nov-18	Actual Dec-18	Actual Jan-19	Plan Feb-19	Plan Mar-19	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,217)	(2,330)	(2,192)	(2,274)	(2,376)	(1,792)	(1,669)	(1,507)	(2,471)	(1,484)	(2,085)	(1,459)	(23,856)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)	(20)	0	(6)	(12)	(7)		(10)	(180)
Depreciation and Amortisation	523	524	523	524	523	524	518	522	522	524	496	496	6,219
Impairments and Reversals	0	0	0	0	0	0	0	0	0	0			0
(Increase) in Inventories	(50)	59	(83)	0	(39)	19	95	62	(60)	16		(19)	0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818	(805)	(540)	(4,585)	100	(803)	(220)	4,816	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	(144)	492	472	1,324	(1,172)	1,898	(2,939)	(1,417)
Increase in Provisions	(3)	(3)	(61)	82	0	(3)	7	0	(7)	(7)		(45)	(40)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(1,465)	(2,221)	(1,097)	(5,042)	(604)	(2,933)	89	840	(19,274)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	5	4	4	5	4	4	4	42
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(8)	0	(2)	(35)	(36)	(298)	(414)	(1,002)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(214)	(114)	(114)	(1,515)	780	(1,500)	(1,493)	(5,889)
Receipts from disposal of fixed assets	0	0	1	2	0	0	37	31	1	0			72
Receipt of cash donations to purchase capital assets	5	52	30	18	20	20	0	6	12	7		10	180
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(197)	(73)	(75)	(1,532)	755	(1,794)	(1,893)	(6,597)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	127	0	280	456	0			863
Public dividend capital repaid	0	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	0			(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(554)	(122)	13	(29)	(243)	(8)	(991)
Capital element of PFI, LIFT	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(16)	(162)	(14)	(14)	(162)	(760)
Interest Paid	(99)	(103)	(148)	(104)	(136)	(484)	(145)	(150)	(165)	(181)	(190)	(1,052)	(2,957)
Interest element of finance lease	0	0	0	0	0	0	(262)	(5)	0	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	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	2,133	1,630	1,053	25,792
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**(1,076)**	**194**	**(9)**	**(98)**	**(45)**	**(75)**	**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	1,075	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**	**1,075**	**1,000**	**1,000**	**1,000**

NHS
Southport and
Ormskirk Hospital
NHS Trust

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2018/19 £'000	YTD to M10 £'000			Orders not yet received	Verbally agreed / letter of intent	Additional Planned Spend before Y/E	Forecast outturn
			Original Plan	Plan	Actual	Variance				
MEDICAL DEVICES	Medical Equipment fund	G0072	870	635	372	263	201	647	147	1,367
	Beds / Trolleys	G0060	50	50	51	(1)				51
	Sub total MEDICAL DEVICES		**920**	**685**	**423**	**262**	**201**	**647**	**147**	**1,418**
IM&T	Electronic Patient Record	F6409	190	180	70	110	67			137
	Patient Service Signposting	G0081	0	456	149	307				149
	Vitalpac	G0007	30	27	14	13				14
	eDMS	F6447	160	134	25	109				25
	Wireless network upgrade	G0073	150	302	259	43	70			329
	Server warehouse infrastructure incl. storage	G0078	75	75	272	(197)	1			273
	Telephony system replacement	G0059	120	95	0	95				0
	Cyber security	G0071	50	42	10	32	7			17
	Fixed network infrastructure	F6498	100	84	21	63	12			33
	Datacentre	G0075	50	50	184	(134)				184
	Virtual desktop infrastructure	G0076	25	23	2	21				2
	Equipment refresh	G0077	50	42	5	37			6	11
	Sub total IM&T		**1,000**	**1,510**	**1,011**	**499**	**157**	**0**	**6**	**1,174**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	400	200	224	(24)	7			231
	Southport A&E Redesign	G0068	350	753	794	(41)	6	72	17	889
	Ward reconfigurations	G0064	140	140	134	6				134
	Medical gasses	G0067	30	30	43	(13)				43
	UPS Theatre	G0053	50	140	35	105		99		134
	Waste management storage facilities	G0080	100	100	8	92			48	56
	Theatre airplant controls		45	45	0	45			7	7
	Generator connectors		65	65	0	65				0
	Fire compartmentation	G0052	165	12	12	0				12
	Fire Precautions - Fire Doors	G0019	45	7	7	0				7
	Discharge lounge	G0074	70	134	134	0				134
	Spinal isolation works	G0070	200	200		200			50	50
	Additional Car Parking	G0083	0	50	9	41			25	34
	Sexual Health Accomodation	G0079	0	260	51	209	43	153	13	260
	Doctor's Mess Facilities	G0082	0	40	26	14	3			29
	Capital team	F6305	155	86	147	(61)		24		171
	Aseptic isolator	G0084	30	75		75			30	30
	Ward(s 11A &)14A Alterations								16	16
	Y Block Office & new entrance								18	18
	SDGH Main Entrance Toilets								25	25
	Maternity Theatre ODGH Light Replacement								12	12
	Reverse Osmosis Plant SDGH								100	100
	Sub total ESTATE IMPROVEMENT SCHEMES		**1,845**	**2,337**	**1,624**	**713**	**59**	**348**	**361**	**2,392**
FACILITIES	Catering equipment	G0026	100	100	24	76				24
	Sub total FACILITIES		**100**	**100**	**24**	**76**	**0**	**0**	**0**	**24**
	CONTINGENCY	**F6301**	**319**	**241**	**111**	**130**				**111**
	Capital plan excluding donations and IFRIC 12		**4,184**	**4,873**	**3,193**	**1,680**	**417**	**995**	**514**	**5,119**

Required capital spend to achieve Capital Resource Limit is £5,119k.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	TB054/19	Report Title	Segmental Reporting and Charitable Funds
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper reviews the number of operating segments required to be reported in the 2018/19 annual accounts and whether to consolidate the charitable funds into the main Trust's accounts.

Recommendations:

The Board is asked to **approve** the following:

- That the Trust report one operating segment in 2018/19 accounts.
- Charitable fund results should not be consolidated.
- An annual review of both segmental reporting and charitable fund consolidation

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)*

In the preparation of the statutory accounts, the Trust will ensure that only one operating segment is reported and that the charitable fund results are not consolidated into the Trust's accounts.

Previously Presented at:

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

1. Introduction

1.1 International Financial reporting standards (IFRS) requires the amount reported for each operating segment item to be the measure reported to the chief operating decision maker for the purposes of allocating resources to the segment and assessing its performance.

1.2 In 2017/18 the Trust reported only one segment in the final accounts. This brief report will review this approach and provide a recommendation to the Board for approval.

2 Segmental reporting

2.1 The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Trust Board.

2.2 The Trust Board reviews the financial position of the whole organisation in their decision making process, rather than individual Business Units.

2.3 All contractual income for the Trust is held in the Corporate Business Unit and this accounts for more than 90% of total revenue. Therefore only one Business Unit exceeds the 10% revenue threshold.

2.4 If the Trust implements full Service Line Management (SLM) including utilising it to allocate resources at a Clinical Business Unit (CBU) level then the Trust would be likely to have to report at that CBU level in its statutory annual accounts.

3 Charitable Fund consolidation

3.1 In determining whether to consolidate the charity accounts there are two tests

- Control and
- Materiality.

3.2 The Trust has the power to govern the financial and operational policies of the charity so as to obtain benefits from its activities and therefore under IFRS 10 (International Financial Reporting Standard on consolidated financial statement) the Trust is deemed to have control.

3.3 Materiality has both a quantitative aspect and a qualitative one.

3.4 Firstly on the quantitative side the value of the charity's income, expenditure, assets and liabilities all fall below 1% the value of the Trust's.

3.5 Secondly on the qualitative side omission of the charity figures in the Trust accounts would not affect a user's understanding of the accounts.

3.6 The Trust's position is that although the control criteria is met, the value is not material. As such it is not necessary to consolidate the charity's accounts into the Trust's annual accounts. A disclosure to this effect though will be included in the accounting policies note.

3.7 These matters have been discussed with the external auditors, and, consistent with prior years, are not minded to challenge the Trust's approach.

4 Conclusion

4.1 Only one segment has revenue above the threshold level and therefore the Trust should continue to report one operating segment in 2018/19 accounts. It is likely that if Service Line Management (SLM) is fully implemented the Trust would need to report operating segments at a divisional level.

4.2 The Trust should not consolidate the results of the charity into the Trust's accounts as these are not material.

5 Recommendation

5.1 The Board is asked to approve the following:

- That the Trust report one operating segment in 2018/19 accounts.
- Charitable fund results should not be consolidated.
- An annual review of both segmental reporting and charitable fund consolidation.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	TB055/19	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, no new risks have been escalated onto this risk register.

One risk has been removed from the risk register:

- **1367** – Failure to have a motivated and engaged workforce (culture). This risk has been closed and a replacement risk is in draft, awaiting the publication of the staff survey results (expected end of February 2019).

There are currently 6 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
- **1942** - Eradicating the Trust's deficit by 2023/24

The Committee is asked to:

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

Recommendation:

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

Strategic Objective(s) and Principal Risks(s)

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

Strategic Objective	Principal Risk

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

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

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

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

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

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

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

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

Previously Presented at:

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

FEBRUARY 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 25/02/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-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	Risk Closed - replacement risk in draft - awaiting publication of staff survey results
1329	SO3 - Provide care within agreed financial limit	Returning to financial balance by 2021	Director of Finance	=16	=16	=16	=16	Risk Closed - replaced with Risk 1942	
1132	SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services	AED Staffing	Executive Medical Director	=16	12	=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	15	=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	=16
1917	SO2 - Improve clinical outcomes and patient safety	Quality of Older Peoples Care	Director of Nursing & Quality		!16	=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	=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	16	=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	=16
1942	SO3 - Provide care within agreed financial limit	Eradicating the Trust's deficit by 2023/24	Director of Finance					!16	=16

TRUST RISK PROFILE AS AT 25/02/2019

	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** **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	13/02/2019	13/03/2019	
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. 12.02.19 - Business Case presented at BDISC, for HMB next week. If approved, recruitment drive to advertise/appoint to posts - forecast 6 months to recruit - full qualification of some staff in post will be 2 years.Await outcome of HMB next week.						**Action Plan Due Date**	18/12/2017 01/04/2019	**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 96 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	14/02/2019 / 18/03/2019
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 Establish confirm and challenge sessions for each action and core service to expedite progress against action Plan To deliver against the 96 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.						**Action Plan Due Date**	31/03/2019 31/03/2019 29/03/2019 31/03/2019 / **Action Plan Rating**: Moderate Progress Made Moderate Progress Made Little or No Progress Made Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety					Link to BAF		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
19/10/2018	1917	Director of Nursing & Quality	Megan Langley	Quality of Older Peoples Care					
Description	If the limited care of Older People in Southport & Ormskirk NHS Trust continues then harm may be caused to our older patients. The areas of concern relate to specific practices: •Deconditioning of patients •Poor falls assessment and management of bed rails •Poor mouth care •Poor nutrition & hydration management •Poor continence management •Lack of interaction and social/cognitive stimulation increasing confusion and delirium •Limited availability of Geriatricians to provide holistic comprehensive assessment and advanced care management plans for patients •Inability to discharge patients home due to lack of resource to support at home								
Controls	Commenced education and roll out of Red2Green Board Rounds to value and consider patients time Falls assessment in nursing notes Care plans and policies in place. Additional care needs bay on one ward.						**Gaps in Controls**	Care plans not always used appropriately and not all care plans are appropriate Red2Green Board Round not fully rolled out - 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 e.g. 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	14/02/2019	14/03/2019	
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 patients who remain in the acute setting. Develop a nutrition, hydration and mouth care quality improvement group to deliver identified changes to						**Action Plan Due Date**	07/03/2019 07/03/2019 07/03/2019	**Action Plan Rating**	Moderate Progress Made Moderate

	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 patient's 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		07/03/2019 07/03/2019 29/03/2019		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 liaison shared learning to be carried out with Mersey care re: patient observation (awaiting publication of ECIST metal health deep dive) Full system engagement involving Mersey Care & Lancs Care both CCG, acute trust (regular meeting carried out) news ops manager based onsite for Mersey Care						**Gaps in Controls**	Mersey Care staff not present in the department 24hours 7days a week No RMN's employed within the current Trust nursing establishment Staffing levels can prove challenging. There is already a significant shortfall in the medical and nursing staff establishment and the intensity of input and observations for a single patient can detract from the service's capacity to see all the patients within the 4hour standard Limited availability of AMP to carry out assessments which often leads to delay	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	12	16	Extreme risk	8	High Risk	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 Mersey care on site Mental Health Sub-Group of the A&E Delivery Board has been established to review and agree appropriate actions to support mental health patients An audit has been completed into the 12 hour breaches which is being reviewed at SIRG with a retrospective trend analysis to be completed by 20/12 to be shared with partners and NHSI. The actions associated with this audit will be monitored within our internal governance arrangements for our CBU and shared with the A&E Delivery Board. Documentation audits are to be scheduled to identify deficits in record keeping Emergency Care Improvement Support Team (ECIS) undertaking full review of mental health pathway Nov 2018						**Action Plan Due Date**	29/01/2018 30/04/2019 31/03/2019 02/04/2018 23/11/2018	**Action Plan Rating** Completed Little or No Progress Made Little or No Progress Made Completed Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services						Link to BAF	SO2
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
20/06/2018	1862	Director of Nursing & Quality	Fiona Barnes	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	12/02/2019	15/03/2019
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		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 and invest in its infrastructure then it will not make significant financial improvements against the current deficit. It will then be unable to comply with NHS Operational Planning and Contracting Guidance 2019/20 which states that all Trust deficits should be eradicated by 2023/24.								
Controls	Monthly run rate reports, Trust and CBU Turnaround Director review of financial governance PMO in place to assist the drive for internal efficiencies identified through Model Hospital GIRFT programme commenced with future roll out to other specialties proposed						**Gaps in Controls**	Future clinical model still to be finalised and costed Accuracy of PLICS and Model Hospital data Uncertainty around future funding of CCG's and proposed restructure of tariff could lead to unrealistic financial assumptions Five year financial recovery plan (NHSI to publish guidance) not in place No Wave 4 Capital funding West Lancs CCG member of Healthier Lancashire and S Cumbria STP		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	18/02/2019	18/03/2019
Assurance	Acute Sustainability Programme Board-currently fortnightly Finance Performance & Investment Committee and Trust Board-monthly Hospital Management Board-monthly Performance Review Board-monthly						**Gaps in Assurance**	Agency spend/vacancy rates	
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 31/03/2019 31/03/2019	**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 March 2019

Agenda Item	**TB056/19**	**Report Title**	**Quality Improvement Plan Progress Update**
Executive Lead	Juliette Cosgrove, Director of 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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on the development of the Quality Improvement Action Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November/December 2017 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018.

2. TRUST PROGRESS

As with December 2019, of the 96 improvement actions, 57 are currently rated amber (on track to deliver), 34 Green (action completed) and five blue (delivered and sustained).

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	3	2	5
Action Completed	18	16	34
On track to deliver	37	20	57
No progress / Not progressing to Plan	0	0	0
TOTAL	58	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	34
On track to deliver	96	95	89	73	73	72	57	57	57
No progress / Not progressing to Plan	0	0	0	0	0	0	0	0	0

3. URGENT & EMERGENCY SERVICES QUALITY IMPROVEMENT PLAN

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

Due to the ongoing work within the department and increasing operational demand there has had an impact on the continued improvement relating to the actions

ED BRAG rating

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

ED BRAG rating monthly reported completion

Rating	Sept 18	Oct 18	Nov 18	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

4. PACE IN IMPROVING PROGRESS

In relation to the accountability framework in regarding the 96 actions a review has been undertaken in order to realign responsibility between operational, nursing and medical management, this will strengthen accountability within CBUs, corporate services, estates and facilities.

In order to escalate pace in improving progress, the Director of Nursing is establishing 'Confirm and Challenge' sessions for Core Services to review their evidence and confirm RAG status of the MUST and SHOULD Do's.

This will enable actions to be identified for review at the Assurance Panels where sign off for final RAG status is given. The next two assurance panels have been confirmed for 27 February to review Regional Spinal Unit actions and 11 March to review Emergency Department Actions.

Individual panels will meet in between to review any identified 'quick wins'.

Our expected trajectory is – Trust wide

Rating	Current Position Jan 19	Forecast Feb 19	Forecast Mar 19	Forecast Apr 19
Delivered and Sustained	5	8	12	20
Action Completed	34	41	47	51
On track to deliver	58	48	38	26
No progress / Not progressing to Plan	0	0	0	0

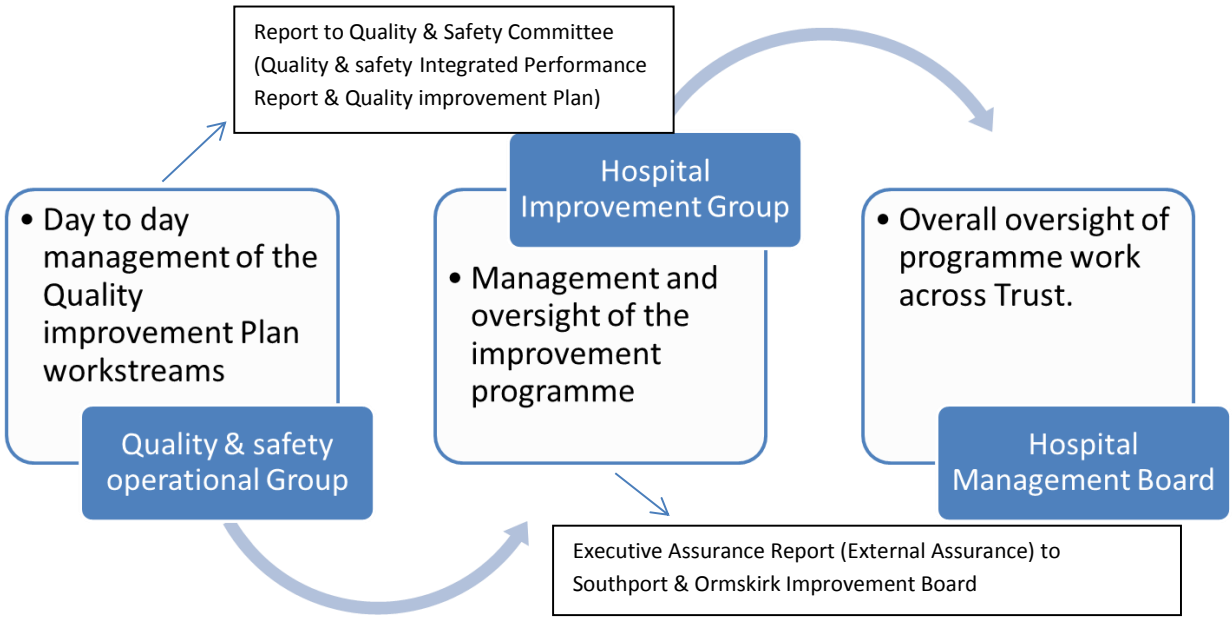
5. MONITORING AND ASSURANCE

The Quality Improvement Plan (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 and Safety Group (QSG) 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 under development.

The first meeting of the Quality & Safety Group took place on 30 January 2019, Terms of Reference (TORs) for the group were established and detailed programme planning is underway with work stream leads.



6. PREPARATION FOR QUALITY VISITS – UPDATE

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

- Provider Information Return (PIR)
- Core Service Review

CBUs were requested to complete core service self-assessments to identify areas of strengths, areas for improvement and gaps against the Key Lines of Enquiry (KLOE) for each core service. Self-assessment returns are currently being reviewed; they will be triangulated with the outcome of the PIR to identify any gaps areas requiring improvement

The Core Service Review took place on 11 and 12 December 2018, over 30 people took part in the review including Trust staff, NHSI, CCGs, local NHS Trusts, and Student Quality

Ambassadors (SQAs) from local universities. The event was chaired by Pete Weller – Senior Clinical Lead, NHSI Greater Manchester and Lancashire. Dr Vince Connolly NHSI Medical Director (North) also attended for one day and led medical engagement with clinical leaders from the Trust. A separate report identifying actions and time scales from the Core Service Review will be presented to a future Quality & Safety Committee.

The Company Secretary is developing a project plan in relation to the Well Led work stream, further sessions with AQUA are planned for February and March 2019.

CQC Engagement January 2019

The last CQC Engagement site visit took place on 31 January 2019. Whilst on site the CQC held focus groups with corporate staff including estates and facilities, finance, PMO, Business Intelligence, IT and HR, this also coincided with the Trust's quality week 'SO Proud – Celebrating Quality Care'.

Feedback from these sessions was on the whole positive, although concerns were raised in relation to storage of drinks on Ward 1, management of air mattresses, access to the observation ward and communications concerns within CBUs.

Bullying was also discussed following the recent newspaper article, however staff felt this was being addressed internally and there was a general feeling that culture is improving with the Freedom to speak up guardian and champions as well as an approachable senior executive team who are visible to staff.

The Director of Nursing described the forthcoming work with NHS Elect which would examine management practices and definitions of bullying. Feedback was also received from two patients from Ward 11a who were very positive about care received there and also on the Medical Day Unit.

CQC Engagement February 2019

In February we were notified that an anonymous concern had been raised with the CQC in relation to the availability and maintenance of equipment in clinical areas (Regulation 15).

As a response the Heads of Nursing and EBME (Electro Biomedical Engineering) Department undertook an immediate review and visited all areas on both sites to reassure staff regarding equipment, enquire as to their views on any shortfalls, assess staff's awareness of reporting mechanisms for maintenance, assessed staff awareness of the ability to reorder equipment, as well as staff awareness of the asset register and how to access this on line. No equipment deficits within clinical areas were identified and staff raised no issues or concerns that would impact on patient safety.

The current EMBE equipment registers were also shared with CQC. In addition, following the core service review in December 2018, the Trust has undertaken an exercise and developed a core ward equipment list. Matrons are currently self-assessing against this list to identify any equipment shortfalls and replacement requirements.

We also developed a Trust communication to reinforce to staff the process relating to raising concerns regarding equipment utilising their line manager, senior teams, risk department and freedom to speak up guardian as well as the guardian of safe working.

We were informed at our weekly CQC telephone call that no further action would be taken in relation to the equipment concern, however we will continue to work with EMBE to review governance and compliance.

7. RECCOMENDATIONS

The Board are asked to note progress identified in this report and to note the establishment of Confirm and Challenge sessions and additional Assurance Panels to increase the pace of progress and assurance processes in place.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	**TB057/19**	**Report Title**	Monthly Safe Nurse & Midwifery Staffing Report
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery &Therapies		
Lead Officer	Fiona Barnes Deputy Director of Nursing 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 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 January 2019.

- **Alert** - Decrease in our overall fill rate for the second month.
- **Advise**- Nurse Staffing risk reports as extreme (Major -4 x Likely – 4 RR =16) via the risk register (ID 1862).
  Risk assessment has also been undertaken in regards to the use of Non-framework nurse agency (Moderate -3 x Possible 3 = RR 9 (ID1941).
  Non – registered vacancy has increased in month by 4. whole time equivalent (wte)
- **Assure** - For the month of January 2019 the Trust reports safe staffing against the national average (90%) at 90.52%.
  Registered nurse vacancy against overall establishment has reduced by 4. wte

Within the report there is a summary of the actions within the workforce improvement plan due in January & February 2019 and the Trust Nursing Recruitment & Retention Improvement plan that has been shared with NHS Improvement.

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

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

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

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

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

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

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

On-going support for the recruitment and retention of N&M staff.

Previously Presented at:

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

1. Introduction

This report provides an overview of the staffing levels in January 2019 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 January 2019 was 90.52% compared to December 2018 that was 93.61% and November 2018 that was 95.76% (Appendix 1).

- 84.42% Registered Nurses on days
- 95.86% Registered Nurses on nights
- 89.48 % Care staff on days
- 98.44% Care staff on nights

There has been a continued slight decrease in our overall fill rate due to sickness, underlying vacancy position and escalated bed numbers.

The overall Care Hours per Patient Day (CHpPD) for the Trust is 8.2hr (appendix 1) and slightly above the national average, there are a number of wards that have a low CHpPD, for example Frail & Elderly c shows 4.9 CHpPD. This means that in a 24hour period a patient would receive 4.9hrs of direct care, which could be registered nurse or HCA, against the national average of 7 CHpPD.

2. January Safe Staffing

Trust whole time equivalent (wte) funded establishment versus contracted for January 2019 below:

	Funded WTE	Contracted WTE	Jan. Vacancy
Registered	842.25	688.64	86.09
Non-registered	376.39	308.11	25.56
Total	1218.64	996.75	111.65

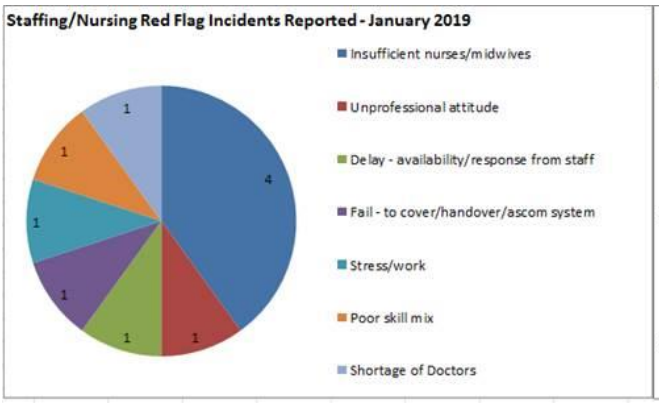
Registered nurse vacancy against overall establishment has reduced by 4 wte. Unfortunately non – registered vacancy has increased in month by 4 wte. There is a plan to scope all HCA candidates in the recruitment process with HR/Recruitment colleagues by the end of Feb 2019 to assure offers move forward against vacancies at pace. The outcomes and actions required going forward will be monitored through the commencement of the trusts recruitment and retention steering group. The inaugural meeting is set for 4th March 2019. This steering group will further support and monitor the delivery of the NHSI Recruitment and Retention action plan and its key deliverables over the next 3-12 months engaging with NHSI regarding outcomes as required (Appendix 2).

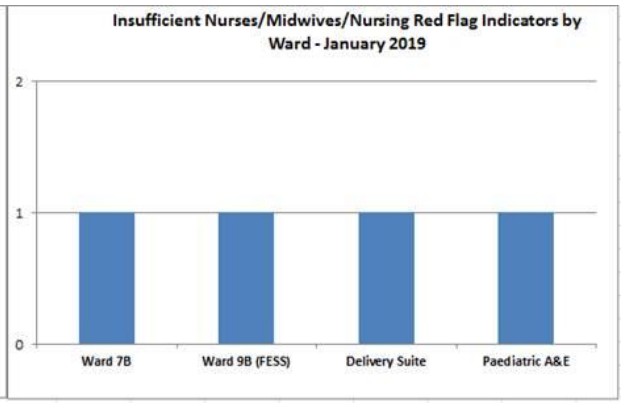
Further to this the Trust remains engaged with local recruitment opportunities and hosted a Registered Nurse recruitment event in early February. The event was well attended with 14 Registered Nurses commencing the recruitment process. The Trust also attended the Royal College of Nursing recruitment event in Manchester during February where a further 3 student nurses have been given conditional offers of employment on completion of training in September 2019. All are invited for informal visits to the trust. A further senior paediatric trained nurse offered employment in the trust and is liaising with the paediatric matron.

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 weekly support and challenge meetings within each Clinical Business Unit will commence in February 2019.

3. Staffing Related Reported Incidents January 2019





There were 10 staffing incidents/nursing red flags were reported in January,18 less than the previous month. 4 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, a quarter of those reported in the previous month.

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 (NICE, 2016)

A combined improvement plan has been developed and is progressing against planned timeframes. The actions below are due in January / February 2019.

Action	Timescale	Progress Update
Development of Standard Operating Procedure for Establishment Review	January 2019	Final draft for NM Group ratification in February 2019
Development of Enhanced Levels of Care guidelines	February 2019	Draft due to go to NM Group in March 2019
Development of Clinical Metrics dashboard	February 2019	Ward Co-ordinator & Ward Manager checklist currently being trialed. Quality Care Indicators being trialed by H of N & DDoN across the Trust
Ward Co-ordinator training & Professional Learning Communities	February 2019	Dates in diary for March 2019
Recruitment & Retention Steering Group	February 2019	Dates in diary for February onward.

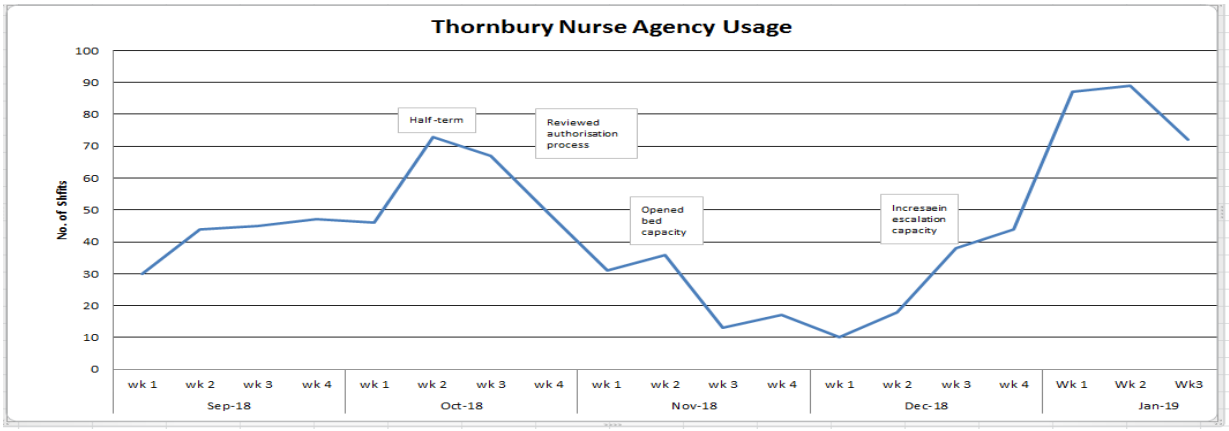
5. Non Framework Nurse Agency Usage

The use of Thornbury Nurse Agency (TNA) during the month of January has been expediential.

During this period the Trust has had up to 40 additional escalation beds open across the organisation, mainly on the Southport site. Although this has not been for the whole month Ward 1 (16 beds) has been open since the New Year.

Based on the current patient case mix and establishment the ward is utilising the equivalent of 22 wte. which equates to 275-300 shifts over a month. On a daily basis the ward is managed by Southport & Ormskirk employees from our medical wards. However, the number of staff required on a daily basis has been too great for the wards to manage within their current establishment and therefore the staffing to support Ward 1 have been sourced from NHS Professionals (NHSP) and TNA, with re-allocation of flexible versus substantive staff across the wards as required to support effective skill mix.

The remaining additional escalation capacity opened since the New Year has been spread across the wards. During the first two weeks of the year most wards had additional patients above their bed capacity which, if the staffing establishment was low due to vacancies &/or sickness, required additional staff. This was mainly from TNA due to the 'short-notice' requirement of the shifts.



There is considerable effort being made to reduce the escalation capacity and to manage the sickness and vacancy factor for registered nurses (RN) and Health Care Assistants (HCA). However, within the ward teams there has been an increase in sickness rates in January 2019 (RN – 7% & HCA – 10%) and vacancies remain static (see earlier).
There is a review of staff sickness 'patterns' being undertaken by HR and will be fed back to this Committee in due course. HR Business partners are working closely with Ward Managers to review individual sickness and this will be further highlighted as part of the E-roster 'Support and Challenge' meetings.

Draft terms of reference are in circulation to direct the 'Support and Challenge' meetings with finalisation expected through the Nursing and Midwifery Steering group 22nd Feb 2019.

6. Recommendations

The Board is asked to receive 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 – January 2019

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	1,757.50	1,129.48	2,024.50	1,739.50	1,089.00	960.00	851.00	623.00	840	64.27%	85.92%	88.15%	73.21%	2.5	2.8	5.3		Ward Manager & matron reviewed staffing to ensure safe care provided for patients
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	762.75	679.25	371.00	483.75	731.00	658.50	368.00	366.50	261	89.05%	130.39%	90.08%	99.59%	5.1	3.3	8.4		
E A U	300 - GENERAL MEDICINE	1,784.75	1,518.00	1,446.50	1,217.75	1,089.50	1,077.00	733.50	721.00	584	85.05%	84.19%	98.85%	98.30%	4.4	3.3	7.8		
FESS Ward	300 - GENERAL MEDICINE	1,544.50	1,074.58	1,422.58	1,216.81	1,098.50	1,050.00	749.50	677.50	825	69.57%	85.54%	95.58%	90.39%	2.6	2.3	4.9	Y	Night shift short term sickness -Additional NHSp and Nurse Agency to support clinical staff
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,400.50	1,108.42	1,265.25	1,341.33	1,110.50	750.00	807.50	1,056.50	758	79.14%	106.01%	67.54%	130.84%	2.5	3.2	5.6		Short term sickness over a w/end that redcued numbers of staff. No harm to patients
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,556.25	1,522.25	1,462.17	1,370.92	1,106.00	1,140.50	742.00	728.50	911	97.82%	93.76%	103.12%	98.18%	2.9	2.3	5.2		
Short Stay Unit	300 - GENERAL MEDICINE	1,498.25	1,058.13	1,858.75	1,734.00	1,104.50	996.00	1,109.00	920.50	855	70.62%	93.29%	90.18%	83.00%	2.4	3.1	5.5		
Ward 15a General Med	300 - GENERAL MEDICINE	1,171.25	1,053.25	905.50	1,393.23	1,123.50	1,066.50	738.00	1,099.00	737	89.93%	153.86%	94.93%	148.92%	2.9	3.4	6.3		
Stroke Ward	300 - GENERAL MEDICINE	1,428.50	1,225.59	1,182.25	1,052.92	997.83	1,022.33	717.50	693.50	591	85.80%	89.06%	102.46%	96.66%	3.8	3.0	6.8		
Rehab & Discharge Lounge 7b	314 - REHABILITATION	1,442.00	1,168.83	1,556.58	1,586.00	737.50	725.00	748.00	1,025.50	771	81.06%	101.89%	98.31%	137.10%	2.5	3.4	5.8	Y	Reduced RN levels on night shift - esclated to senior nurse on site
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,498.58	1,276.83	2,138.50	1,859.83	1,100.00	1,039.75	1,407.00	1,441.50	908	85.20%	86.97%	94.52%	102.45%	2.6	3.6	6.2		
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,850.00	1,180.00	1,715.75	1,202.25	732.00	746.50	383.50	512.75	512	63.78%	70.07%	101.98%	133.70%	3.8	3.3	7.1		Suported by ACP from Ssurgical assesse=ment unit
Ward H	110 - TRAUMA & ORTHOPAEDICS	754.50	660.00	744.00	365.25	737.50	569.50	371.00	167.00	133	87.48%	49.09%	77.22%	45.01%	9.2	4.0	13.2		Increased demand of bed occuapancy against establishment.
Surgical Ward	100 - GENERAL SURGERY	1,321.25	1,152.75	1,114.50	1,021.25	742.50	731.00	732.00	405.00	528	87.25%	91.63%	98.45%	55.33%	3.6	2.7	6.3		
Spinal Injuries Unit	400 - NEUROLOGY	3,869.57	3,367.82	3,641.00	3,207.75	2,911.00	2,723.00	1,507.75	1,447.25	1103	87.03%	88.10%	93.54%	95.99%	5.5	4.2	9.7		
Ward G	101 - UROLOGY	1,135.00	909.92	744.50	661.25	739.50	844.00	364.00	408.50	407	80.17%	88.82%	114.13%	112.23%	4.3	2.6	6.9		
TOTAL		**24,775.15**	**20,085.10**	**23,593.33**	**21,453.79**	**17,150.33**	**16,099.58**	**12,329.25**	**12,293.50**	**10244**	**81.07%**	**90.93%**	**93.87%**	**99.71%**	**3.53**	**3.29**	**6.83**		

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		4,032.83	3,611.58	1,981.17	1,787.50	3,375.75	3,641.25	741.50	993.00	0	89.55%	90.22%	107.86%	133.92%	N/A	N/A	N/A		
Ambulatory Care Unit		571.50	397.25	661.00	347.75	172.75	305.50	173.25	38.75	92	69.51%	52.61%	176.85%	22.37%	N/A	N/A	N/A		
TOTAL		**4,604.33**	**4,008.83**	**2,642.17**	**2,135.25**	**3,548.50**	**3,946.75**	**914.75**	**1,031.75**	**30**	**87.07%**	**65.91%**	**80.81%**	**112.79%**	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	4,961.65	4,084.27	1,255.75	979.67	4,091.00	3,620.50	1,128.00	888.00	368	82.32%	78.01%	88.50%	78.72%	20.9	5.1	26.0		HCA short term sickness

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	1,824.50	1,823.25	370.50	358.50	1,485.00	1,486.50	371.50	311.00	77	99.93%	96.76%	100.10%	83.71%	43.0	8.7	51.7	Y	Increased workload and lack of ability to overview shift by co-ordinator - Escalated at the time to mitigate the risks.
Maternity Ward	501 - OBSTETRICS	980.50	1,128.92	738.75	621.00	742.00	755.00	580.00	624.50	337	115.14%	84.06%	101.75%	107.67%	5.6	3.7	9.3		
MAU	501 - OBSTETRICS	1,294.00	1,071.83	431.00	427.25	740.00	693.50	370.00	346.50	79	82.83%	99.13%	93.72%	93.65%	22.3	9.8	32.1		
TOTAL		**4,099.00**	**4,024.00**	**1,540.25**	**1,406.75**	**2,967.00**	**2,935.00**	**1,321.50**	**1,282.00**	**493**	**98.17%**	**91.33%**	**98.92%**	**97.01%**	**14.12**	**5.45**	**19.57**		

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	1,137.75	1,144.25	318.00	240.25	1,114.50	1,127.50	84.00	60.00	206	100.57%	75.55%	101.17%	71.43%	11.0	1.5	12.5		HCA short term sickness
Paediatric Unit	420 - PAEDIATRICS	3,873.75	3,335.58	1,182.00	1,104.75	2,226.00	2,082.00	742.00	706.00	315	86.11%	93.46%	93.53%	95.15%	17.2	5.7	22.9	Y	Increased activity in AED - Support from Paeds ward
TOTAL		**5,011.50**	**4,479.83**	**1,500.00**	**1,345.00**	**3,340.50**	**3,209.50**	**826.00**	**766.00**	**521.00**	**89.39%**	**89.67%**	**96.08%**	**92.74%**	**14.76**	**4.05**	**18.81**		

PLANNED		15,390.55	12,631.58	11,354.00	9,297.25	11,053.50	10,274.25	5,893.25	5,270.00	3959	82.07%	81.89%	92.95%	89.42%	5.5	3.5	**9.5**		
URGENT		18,950.58	15,546.61	16,137.25	15,271.46	13,736.33	13,392.58	8,478.75	8,943.25	7225	82.04%	94.63%	97.50%	105.48%	6.9	3.8	**5.9**		
W&C		9,110.50	8,503.83	3,040.25	2,751.75	6,307.50	6,144.50	2,147.50	2,048.00	1014	93.34%	90.51%	97.42%	95.37%	5.3	3.7	**19.2**		
TRUST TOTALS		**43,451.63**	**36,682.03**	**30,531.50**	**27,320.46**	**31,097.33**	**29,811.33**	**16,519.50**	**16,261.25**	**11,650**	**98.16%**	**94.24%**	**101.08%**	**107.82%**	**4.9**	**3.4**	**8.2**		

Appendix 2

Trust Nursing Workforce Retention Action Plan

As part of Southport and Ormskirk NHS Hospital Trusts ongoing commitment to recruit and retain our nursing workforce, through the Trust Retention Task and Finish Group, make the following commitments:

1. To reduce nursing workforce vacancies
2. Undertake a root cause analysis of the Trust's top reasons effecting nurse workforce turnover and identify 4 targeted areas to action
3. To provide CBU's with meaningful business intelligence, i.e. age profile of workforce, turnover, vacancy position thus enabling intensive support to be timely and focussed
4. Close the gap between starters/leavers by reduction of 1.5-2% by end of Q4.

The attached targeted action plan with deliverables within the next 12 months, underpins the above commitments, a more detailed operational action plan has been developed through the Retention Task and Finish Group and underpins this plan.

NHSI Nursing Workforce Retention Action Plan

Objective	Action(s)	Measures of success	Lead	Target Date	Progress Update/Improvement Trajectory	BRAG
Workforce Governance Clear structure and process to support the development of the nursing/midwifery 'Workforce'.	Trust Retention Group in place	Implementation and embedded	ADoN	April 2019	ToR drafted for NMG Jan 2019 Meeting dates to be circulated To include recruitment	Amber
	Recruitment and Retention Plan	Ratified and in place	HR	Feb 2019	Recruitment and Retention Plan board sign off – January 2019	Amber
	Generic Nursing Job descriptions	Generic job descriptions ratified bands 2 – 8	Nursing & HR	Sept 2019	Band 2 & 3 in draft and aligned to the apprenticeship levy	Amber
	To establish the 'USP' for the Trust	USP supported through all Trust communications	Nursing, HR, PR & Comms	Sept 2019	Retention group ToR dates being confirmed Vision 2020	Amber
	Development of new roles	Nursing Associate Assistant Practitioners, ACP in post	Nursing & HR	May 2019	Workforce planning inclusive of establishment review in progress to inform Trust Board during Q4. Band 4 roles continued to be introduced through apprenticeship levy with plan to increase numbers	Amber
	Top 3 wards (lowest vacancy turnover) to be identified. What's good? Why do staff stay?	Presentation by Senior Sister to Retention Group to recognise, share and celebrate achievements	HoN & HR	April 2019	Data available to be reviewed and identify Wd manager	Amber
	Review, identify and progress the training opportunities required to support pathways of development to retain and recruit to our nursing workforce.	Agreed T.N.A. for B2-B8	Nursing & HR	Dec 2019	Apprenticeship roadshow planned for March 2019 Initial diagnostic sessions completed 12 month plan being drafted	Amber

Objective	Action(s)	Measures of success	Lead	Target Date	Progress Update/Improvement Trajectory	BRAG
Staff Engagement Clinical staff to share recruitment & retention ideas for the Trust	Brew and review concept to be developed	Brew and review programme fully developed and implementation plan in place	Nursing leads	Sept 2018	Brew and Review commenced – diagnostics completed and identified key retention drivers: a) Training opportunities b) Development Opportunities c) Career Pathways	Green
	# '3 Good Things'	# '3 Good Things' embedded	Nursing and HR	Sept 2019	Added to agenda of key meetings Adding to ward huddles	Amber
	Employee of the month / 'Thanks a Bunch'	Employee of the month reported across trust media streams	Comm.s	On-going	Commenced and communicated out across the trust media streams	Green
	Tea with the DoN	Afternoon Tea with the Director of Nursing in place and staff % uptake reported to influence changes	Nursing	January 2019	Commenced and communicated out across the trust media streams	Green
	A letter to be sent at 1 year of service to newly qualified staff and new to the organisation (attach a card for them to return) to recognise contribution to organisation and asking what would encourage them to stay, feedback to be collated	Understanding of key issues/themes for newly qualified staff /new to organisation	Education and Training lead Practice Educators	May 2019	Not due to commence until February 2019	
	Understand student nurses experience of working at S&O Trust	Meeting with student nurses on a bi-annual basis	DoN / DDoN	January 2019	Meeting with DoN, DoN & student nurses to understand their experiences	Green
Training Opportunity To understand training needs for key staff groups across the Trust	Review and develop evidenced and updated Preceptorship Programme aligned to the NMC proficiencies.	Renewed Preceptorship programme embedded Band 5 Competency Matrix aligned to new NMC proficiencies	Education and Training lead Practice Educators	April 2019	Task and finish group in place – sharing good practice across organisations supporting reviews of current trust programme	Amber

Objective	Action(s)	Measures of success	Lead	Target Date	Progress Update/Improvement Trajectory	BRAG
	Education & Training for B2 and B3	Core certificate training for those who have not completed	Nursing	Dec 2019	Funding streams to be secured to achieve trusts clinical training programmes	Amber
	Improved engagement with local HEI's and HEE	Regular meetings Home Trust (EH)	Nursing	Dec 2018	First meeting held with Edge Hill regarding 'Home Trust' concept	Green
Development Opportunity Innovative and flexible approaches to delivering staff education, training and key development	Trust Leadership programme for B7 and B8a Development of band 5 programme Development of HCA programme	Trust supported, developed and recognised programme	Nursing	January 2020	Band 6 and above programme implemented and completed	Amber
Career Pathway Establish clear career pathways to identify progression, development, training and education	On boarding survey to be developed to send to staff at 3,6 and 9 months	Survey in place % increase in staff retention	ADoN and HR	Sept 2019	No yet commenced	
	Deliver a Trust Transfer Scheme	Trust transfer scheme in place as a development offering with outcomes measured and reportable to WFC Staff numbers accessing the scheme versus leaving the trust increasing and	Nursing & HR	Sept 2019	Trust Transfer scheme in draft- awaiting ratification early 2019	Amber

Objective	Action(s)	Measures of success	Lead	Target Date	Progress Update/Improvement Trajectory	BRAG
		reflective of decreasing vacancy %				
	Trust Transfer Process	Transfer scheme embedded and reviewed to support change	Nursing and HR	Sept 2019	Trust Transfer scheme in draft- awaiting ratification early 2019 Flexible retirement opportunities and barriers to be reviewed to raise profile to line managers- need to consider returning retirees Staff rotation opportunities to be review Reported and monitored exit questionnaire data	Amber
Overall reduction in vacancies for registered and un-registered nursing staff	Monitor monthly Nurse & HCA vacancies	2% reduction of Nurses and HCA by 5%	Nursing and HR	March 2019	**August**: RN -12.23% vacancy HCA 10.92% vacancy **December:** RN vacancy –10.42% HCA vacancy – 5.43%	A/G
Retain experienced senior staff in the workforce	Review staffing profile Invite all staff due to retire to forum to consider options to retain in the clinical 'workplace'	Identify key themes to retain experienced /senior staff.	Nursing & HR	Sept 2019	Not commenced yet	

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

Carol Fowler, Assistant Director of Nursing-Workforce v5 of Final plan

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

6 March 2019

Agenda Item	**TB058/19**	**Report Title**	**Public Dividend Capital (PDC) Drawdown Approval**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The Trust has been awarded public dividend capital (PDC) for 2 capital projects.

- £11,500 has been awarded to upgrade the pharmacy system to be compliant with the electronic dictionary of medicines and devices.
- £98,000 from the Health Service Lead Investment (HSLI) in Provider Digitisation Programme.

In order to draw down these monies the Trust must sign a memorandum of understanding (MOU), provide a cash flow to the Department of Health & Social Care and sign the utilisation request.

Recommendations:

The Board is asked to **approve** the drawdowns of PDC totalling £109,500, based on Section 18 – External Borrowing of the Scheme of Reservation and Delegation and authorise the Director of Finance to sign the utilisation requests and the Memorandum of Understandings (MOUs).

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	*Failure to attract and retain staff*

open and honest communication	
☐ **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)*

Signed MOUs, utilisation requests and cash flows are sent to NHS Improvement. These are then reviewed and sent to the Department of Health & Social Care (DHSC) with monies paid directly to the Trust.

Previously Presented at:

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

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Peformance was last formally assessed using the 7 day services online survey in the Spring of 2018. The results of this submission were reported by NHS England / NHS Improvement on the 13th August 2018 in the form of a letter to the Chief Executive. This letter confirmed we achieved 74% complaince wih this standard. Looking foward our suggestion is a random audit of 10 sets of notes from each specialty per month to measure compliance with this standard. (Starting in March 2019). The main area for non-compliance sits with Paediatrics where consultant rotas start at 9am impacting on the ability to deliver the required 14 hour review to those who arrive late afternoon and evening the previous day. A review of consultant cover, rotas and care pathways are to be undertaken to drive improvement work in order to meet compliance.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Peformance was last formally assessed using the 7 day services online survey in the Spring of 2018. the results of this submission were reported by NHS England / NHS Improvement on the 13th August 2018 in the form of a letter to the Chief Executive. This letter confirmed we achieved 92% compliance wih this standard.	Echocardiography	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Peformance was last formally assessed using the 7 day services online survey in the Spring of 2018. the results of this submission were reported by NHS England / NHS Improvement on the 13th August 2018 in the form of a letter to the Chief Executive. This letter confirmed we achieved 100% compliance wih this standard.	Emergency Renal Replacement Therapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Urgent Radiotherapy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Percutaneous Coronary Intervention	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Cardiac Pacing	Not applicable to patients in this trust	Not applicable to patients in this trust	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Peformance was last formally assessed using the 7 day services online survey in the Spring of 2018. the results of this submission were reported by NHS England / NHS Improvement on the 13th August 2018 in the form of a letter to the Chief Executive. This letter confirmed we achieved 77% complaince wih this standard. Looking foward our suggestion is a random audit of 10 sets of notes from each specialty per month to measure compliance with this standard. (Starting in March 2019). Twice daily reviews for high dependancy patients are supported by a framework of process and workforce. The requirement for daily review over the weekend falls short for patients on general wards where resource is focused on the 14 hour reviews of new admissions.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
CS1. PATIENT EXPERIENCE. (Shared decision making and informed choices for families and carers 7/7). Project work to standardise Advance Care Planning as part of discharge planning will ensure shared decision making and informed choices for patients, families and carers. The Trust's Patient Charter developed through the Patient Experience Group incorporates pledges to 'Develop and implement systems and processes to involve Carers and Families in decision making' and 'Ensure that access to information is easy and relevant for patients, carers, families and professionals.' CS3. MDT REVIEW. (14 hour assessment by MDT for emergency in-patients. An integrated management plan with EDD and medicines reconciliation within 24 hours). Emergency admissions to the Observation ward have a consultant ward round with Occupational Therapy and Physiotherapy input 7 days a week each morning. CS4. SHIFT HANDOVERS. (Handovers by a senior decision maker at designated time and place. Handover processes including communication & documentation requirements formalised in a policy). A formalised Board Round process and supporting IT functionality is being developed to standardise handovers and documentation, the pilot for which is tabled for June 2019. CS7. MENTAL HEALTH. (Mental health needs identified for acute admissions to be assessed by psychiatric liaison within 1 hour for emergency care and 14 hours for urgent care 7/7). A Mental Health Service is now resident and available within the Trust , auditing to be undertaken for spring 2019 to quantify compliance levels to target. CS9. TRANSFER TO COMMUNITY, PRIMARY & SOCIAL CARE. (Support services to be available 7/7 to ensure next steps for patient care are consultant led whether in hospital, community or mental health setting). The Trust has employed eight Discharge Facilitators to liaise with community, primary and social care. While this has supported the transfer of patients back home, the full handover to community services falls short due to inadequate

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Not applicable