Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10:15 – 13:15 on Wednesday, 3 April 2019

Hesketh 1, Ramada Plaza Hotel, Marine Lake, Southport, PR9 0DZ

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				**10:15**
TB065/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**10:15**
TB066/19 (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**		
TB067/19 (D)	**Minutes of the Meeting held on 6 March 2019** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB068/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB069/19 (D) **(V)** **(P)**	**Patients and Engagement Issues including:** • **Summary of Complaints & Compliments** • **NEDs & Executive Visits/Walkabouts** • **Patient/Staff Story: 'The Elective Orthopaedic Service – Improvement Story'** To **receive** the presentation and **note** lessons learnt	**DoN** **NEDs/EDs** **Sally Shorrock/ Joanne Kenyon**	**30**	**10:25**
STRATEGIC CONTEXT				**10:55**
TB070/19 (D)	**Chief Executive's Report** To **receive** key issues and update from the CEO	**CEO**	**30**	**10:55**
QUALITY & SAFETY				**11:25**
TB071/19 (D)	**Monthly Mortality Report** To **receive** the report	**MD**	**10**	**11:25**

PERFORMANCE & GOVERNANCE				**11:35**
TB072/19 (D)	**Assurance and Performance Reports:** **1. Alert, Advise and Assure (AAAs) Reports from:** • Finance, Performance & Investment Committee • Workforce Committee **2. Executive Summaries from Executive Directors:** • Leadership & Well Led • Quality • Workforce • Operational **3. 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 summaries and assurance updates on the performance indicators.	**Committee Chairs** **Executives** **DoN/MD** **COO** **DoF** **DoHR**	**30**	**11:35**
TB073/19 (D)	**The Annual Governance Statement** To **review** the AGS and **make recommendations** for improvement if necessary.	**CoSec**	**10**	**12:05**
TB074/19 (D)	**Financial Position at Month 11** To **receive** the report	**DoF**	**10**	**12:15**
TB075/19 (D)	**Risk Management:** **Corporate Risk Register** To **review** the monthly risk register and make recommendations as required	**DoN**	**10**	**12:25**
OTHER REPORTS FOR NOTING				**12:35**
TB076/19 (D)	**Quality Improvement Plan and CQC Progress Report** To **receive** the monthly report	**DoN**	**5**	**12:35**
TB077/19 (D)	**Monthly Safe Nursing & Midwifery Staffing Report** To **receive** assurance of actions taken to	**DoN**	**5**	**12:40**

	maintain safe nurse staffing			
TB078/19 (D)	**Healthcare Workers Flu Vaccination Report** To **receive** the report	**DoN**	**5**	**12:45**
APPROVAL & RATIFICATION				**12:50**
TB079/19 (V)	**Items for approval/ratification** • To **ratify** the decision taken to apply for an unsupported revenue loan.	**CoSec**	**5**	**12:50**
CONCLUDING BUSINESS				**12:55**
TB080/19 (V)	**Questions from Members of the Public**	**Public**	**5**	**12:55**
TB081/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**5**	**13:00**
TB082/18 (V)	**Items for Forward Agenda – 1 May 2019** • Board Development Programme • Board Assurance Framework • Risk Management & Risk Appetite	**Chair**	**2**	**13:05**
TB083/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	**3**	**13:07**
TB084/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**	**5**	**13:10**
TB085/19 (V)	**Date and time of next meeting** **Wednesday 1 May 2019, 09.30am** Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN	**Chair**		**13:15** **CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting
Wednesday, 6 March 2019
Ruffwood Suite, Clinical Education Centre, Ormskirk, L39 2AZ

(Subject to the approval of the Board on 3 April 2019)

Members Present

Jim Birrell, Non-Executive Director
David Bricknell, Non-Executive Director
Ged Clarke, Non-Executive Director
Juliette Cosgrove, Executive Director of Nursing, Midwifery & Therapies
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
Jitka Roberts, Turnaround Director
Jane Royds, Director of Human Resources & Organisational Development
Audley Charles, Company Secretary
Samantha Scholes, Interim PA to the Company Secretary

Apologies:

Neil Masom, Chair

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB044/19	**Chair's Welcome and Note of Apologies**	
	Dr Bricknell, as Chair in Mr Masom's absence, opened the meeting by welcoming the Board members and attendees. He also welcomed Mrs Michelle Kitson - Matron, Patient Experience who attended to present the Patient and Staff Story. Apologies were received from Mr Masom (Chair).	
TB045/19	**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.	
TB046/19	**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. One amendment was made : **TB029/19 Winter Plan Update** *Paragraph seven, add 'the current building' to the sentence regarding reference to the closure of Royal Liverpool Hospital.* **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendment.	
TB047/19	**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 had continued and the process should be completed by 1 April 2019. **TB005/19: Patient/Staff Story: Waiting Times – In/Out Patient Areas** A Communications process was in place, including whiteboards and that would be completed by April 2019. **TB015/19: Charitable Funds Committee** Plum Marketing commenced the re-brand of the Trust's Charitable Fund on 1 March 2019 and were engaged for a maximum of three months with a proposal that that could yield £0.5m in 2019/20. **TB028/19: Monthly Mortality Report, including External Mortality Review** Dr Hankin had received a number of pro-formas from wards relating to Standard Operating Procedures and he was reviewing their content to provide a single, efficient, standard format. It was acknowledged that incorrect coding of patients might result in unreliable data, including mortality, income, planning and performance which would be addressed by training. A clinical coding manager was now in post to improve the quality of coding.	
TB048/19	**Summary of Complaints & Compliments** **NEDs & Executive Visits/Walkabouts** **Patient/Staff Story: Winter Pressures – The Patient Experience**	
	Summary of Complaints & Compliments Ms Cosgrove presented a summary report which provided themes and figures for the Trust in January. All the complaints received had related to care. It was acknowledged that the Trust was slow in responding to complaints. All complaints were reviewed by the Chief Executive and the Director of Nursing with the relevant Clinical Business Unit accountable for the response. Complaint responses had taken up to 60 days, whilst a standard of 40 days should have been evidenced. There were instances where responses had not been provided six to eight months after receipt, which was unacceptable. Clinical Business Units (CBUs) were aware of the required standards. Ms Cosgrove commented that improvements to Duty of Candour and Being Open had improved the response time, however a Quality	

Assessment process had been included that had impacted on the response time.

The Chair commented that a timely, sincere apology would help and be instrumental in reducing the impact of the experience on complainant/s.

100 compliments had been received, with the Planned Care Business Unit receiving the most compliments with 46 in total and F (Ophthalmology) Ward receiving 25 in the month. Mrs Gorry stated that it was likely that the compliments received were an underestimation and suggested that the Board considered how to assist with that when Board to Ward visits took place.

Dr Hankin added that both complaints and compliments regarding Doctors were referred to the individual's appraisal lead and included in the annual appraisal for reflection.

- **NEDs & Executive Visits/Walkabouts**

The Chair stated that the role of Non-Executive Directors (NEDs) was being reviewed by the Trust Chair and could include a structured programme of walkabouts to provide greater visibility.

Mr Clarke commented that on a recent visit with Ms Patten to Estates & Facilities they were informed that they 'had not seen' an Executive for years.

Mrs Gibson related that her visit to the Urgent Care Business Unit on 5 March had demonstrated amazing work with a culture of accountability and teamwork. She asked how that could be celebrated and commented that if she hadn't seen the work first-hand then she and the Board would have remained unaware of their exemplary work.

- **Patient/Staff Story: Winter Pressures – The Patient Experience**

Mrs Michelle Kitson, Matron – Patient Experience Manager gave the presentation.

On New Year's Day 2019 a patient aged 80+ had arrived at A&E at 11:30 and spent 22 hours there receiving treatment. The patient was seen by nursing staff at 11:55 and by an A&E doctor at midday. They had received corridor care for 15 minutes, which was not the required standard, however, it was noted that that was a significant improvement on the time of corridor care on the same day in 2018. The patient was complimentary in their experience, stating that staff were friendly and caring and they were kept comfortable with effective pain control, food and drink. They had commented that they had been confused regarding all the areas of the department that were visited, which could, in part, be attributed to the analgesia.

Other patients had commented that their experience of the A&E department which reflected a variety of opinions, including the impact of the refurbishment and building work on the A&E department which had temporarily resulted in a lack of drinking water and access to purchasing hot drinks, which had been resolved quickly.

Mrs Kitson, as on-call manager on New Year's Day 2019 had experienced the impact of increased demand and the decision to open an escalation ward that day. Night staff had responded excellently and whilst the escalation ward was not ideal, it had been a good decision.

Mr Christian commented that it was a credit to Mrs Kitson and the teams that the assessment and decision to escalate had been taken.

Mrs Kitson commented that Ward 1 was opened in winter as a 16-bed ward with 11 female bays and 5 male beds. An unanticipated positive result of the lay out of the Nightingale-style ward was that the patients had greater opportunity to speak with one another. In addition, the support of the Pharmacy Technicians within the ward was invaluable and it was recommended that it should be in place in 2019/20. She further added that staff affected felt supported.

The Chair thanked Mrs Kitson and asked if Ward 1 had been a mixed-sex ward and therefore had constituted a breach of regulations. Mrs Kitson responded by stating that the sexes were in separate, closed bays within the ward so had not constituted a breach.

Mrs Gorry questioned when Ward 1 would close, noting that the plan had been for 1 March 2019, which had not occurred. Mr Christian responded that a continuous increase in demand, including norovirus on other wards had impacted on the available capacity within the hospital and it had not been possible to close Ward 1 on that date. Following recovery by all wards, from 6 March 2019, Ward 1 was closed to new admissions; however, the following weekend might have seen a challenge to that. There was a risk that Ward 1 became normalised which was not a tenable position.

Ms Cosgrove stated that the experience of patients and staff had been good and the Trust had done the best it could, whilst recognising that in some areas (i.e. toilet facilities) full compliance had not been met. Mr Nicholls added that therapy staff who had been displaced by Ward 1 and currently occupied a temporary space in the Spinal Unit Gymnasium needed to return to their base as soon as possible as the temporary arrangements were insufficient. He added that lessons learned from the escalation had been:

- Community provision being reviewed by the Clinical Commissioning Group (CCG) for the new financial year
- Continuing pressures to be planned for, including Easter 2019 and next winter.

The Chair asked that Mrs Kitson convey the thanks of the Board to all the teams in recognition of the demands placed on them and the improvement in care from last winter.

RESOLVED:
The Board **received** the presentations and **noted** the lessons learned.

STRATEGIC CONTEXT		
TB049/19	**Chief Executive's Report**	
	Mr Nicholls presented the report. **Trust Strategy 2019/20** The Board had agreed that the Trust's strategy would including becoming a 'general' hospital. **Planning for the Future** The Trust was drawing on the latest expert clinical opinion; NHS planning guidance which focused on a joined-up system approach; and the NHS Long Term Plan as a basis of programme reset work. Dr Hankin was working closely with Aintree Hospitals to enable that to happen. Additionally, a review by CCGs of the community provision was being undertaken as solutions to pressures faced by the health economy were not solely resolvable by the hospital. **Winter Performance** February 2019 had seen an increase in 12-hour Decision to Admit (DTA) breaches. It was important to note that while the Trust had recorded high numbers of that, the actual total numbers of patients managed for longer than 12 hours in the Emergency Department had reduced in comparison to the previous year (30% reduction). That was also partially attributable to patients being seen earlier and the clock starting. The National Team was happy with the performance of the department. It was recognised that the Trust could reduce or eliminate the 12-hour breaches by changing pathways for patients, however, that would not have been the right thing to do. Mr Christian added that Ward 1, which had been opened as an escalation ward, was due to close and thereby maintain safety. **Investing in Our Hospitals** The Trust had now developed a core ward equipment list which matrons checked against for shortfalls and replacement needs. The Therapies team was doing a similar exercise. The Trust planned to spend £1.3m on new medical equipment in 2018/19 and almost £6m over the next five years. Orders in progress included replacement of all 30 anaesthetic machines with newer models; replacement of all hydraulic couches in Outpatients at both hospitals and new drills for Maxillofacial. **Discharge** The Trust was working with CCGs and the community to address the requirements for discharge, which could take 3-4 days to arrange via a bid process required by Sefton & Formby CCG, which could result in delays. Real time information was available to all partners so transparency of the process and its deficiencies were available. **RESOLVED:** The Board **received** the report	
QUALITY & SAFETY		
TB050/19	**Monthly Mortality Report**	
	Dr Hankin presented the report.	

	Hospital Standardised Mortality Ratios (HSMR) & Summary Hospital-level Mortality Indicators (SHMI) The Trust was actively working to reduce both HSMR and SHMI values to bring them within acceptable parameters by 2020. The rolling HSMR showed a modest increase from 91.8 (August 2018) to 93.5 for September 2018. SHMI reduced to 113.2 (September 2018) from 115.5 (June 2018) to and improvements were demonstrated both in hospital deaths and crude death rates for the reporting period September to November 2018. **Structured Judgement Reviews (SJR)** The methodology for learning from deaths was now being used across Clinical Business Units (CBUs). Work on diagnosing and assessing Pneumonia, Lower Respiratory Tract Infections (LRTI) and Bronchitis, which were more complex, was ongoing. A pathway had been devised previously and was recently re-disseminated and delivered to wards by Dr Hankin in person, to embed best practice. Advancing Quality Alliance (AQuA) had analysed the Trust's data for Community Acquired Pneumonia (CAP) patients (January 2018 to October 2018) which showed that patients were receiving NICE recommended care the majority of the time. They had recommended, however, that the Trust looked further at clinical coding, recording of diagnosis and End of Life decisions to understand why patients were dying. It was agreed that it required further training for system users to correctly identify the causes of deaths. Mr Nicholls commented that mortality remained high, however a 7% reduction had been seen in the past six months. Flu rates were currently less than the mean and the hospital was safer than previously. At the February 2019 Board, the Guardian of Safe Working had commented that more concerns were being formally reported within a robust system. It was acknowledged that the improvements were fragile and there was no guarantee the trend would continue, so further work would be undertaken on specific clinical pathways. The Reducing Avoidable Mortality (RAM) project Phase 1 had been completed and Phase 2 had been defined. *The External Mortality Review Action Plan would be reconciled with SMART objectives, then revised and reported to the May Board when completed.* Mr Birrell commented that it was pleasing to see reference to the 'Ward Boards' sub-group and the potential alignment with IT functionality. Dr Hankin stated that the End of Life Policy could be confusing and discussion on how that was delivered on the wards took place. A bid for funding for a single End of Life Team had been submitted, the result of which would be known at the end of April 2019. It was agreed that the implementation of the End of Life Policy could be challenging with some clinicians reluctant to have conversations relating to it. Mrs Gorry concurred that these conversations were	**MD**

	difficult, however, training would support those staff. She added that the challenge was for good diagnostics and information to provide objective information for patients and families to make decisions. **RESOLVED:** The Board **received** the monthly report.	
TB051/19	**Equality & Diversity Annual Report and Objectives**	
	Mrs Royds presented the report. The Workforce Committee had discussed and considered the Equality & Diversity (E&D) Annual Report 2017-2018 and Objectives. The report and previous action plans had also been reviewed alongside the 2016-2017 report by CCGs, Staff Side and Networking Groups and the objectives developed. Mr Singh congratulated Mrs Royds and her Team for the great work which had been undertaken and achieved in the past few years. It was a good, strong piece and very important to all staff. *Mrs Gorry noted that the current E&D objectives on the Trust's website related to 2012-2015 which did not demonstrate the seriousness the Trust placed on them. Mrs Royds agreed, stating that the objectives approved by the Board on 6 March 2019 would replace those on the website.* *In response to Mr Birrell's question regarding what had occurred in the 11 months since the conclusion of the Annual Report Mrs Royds stated that further detail would be brought to the May Board.* *Ms Cosgrove asked what key indicators had been examined to produce the objectives and Mrs Royds responded that the Trust's Equality & Diversity Lead would be examining that prior to the CQC visit.* **RESOLVED:** The Board **received** the report and **approved** the objectives.	**DoHR** **DoHR** **DoHR**
PERFORMANCE & GOVERNANCE		
TB052/19		
	Alert, Advise and Assure (AAAs) Reports from: **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: • Concern was expressed that the Information Management & Technology (IM&T) Committee was not quorate for the third consecutive month. Executive Directors were asked to reinforce the importance of the Committee. **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: • There had been further deterioration in meeting the Fractured	

Neck of Femur target. The Medical Director was personally overseeing the Action Plan and would take a progress report to the April Quality & Safety Committee.

Workforce Committee

Dr Bricknell, Chair on the day of the Workforce Committee, presented the AAAs report.

The Committee alerted on:
Certain HR policies were out of date but were being reviewed as matter of urgency. Scheduled to be resolved by mid-year. To meet the target HR would need the necessary amount of Executive support.

The Executive Team presented the following summary reports relating to the indicators in the Integrated Performance Report (IPR):

Director of Nursing
Quality & performance and safe staffing would be considered in papers later at the Board. A Ward Co-ordinator/Manager Quality & Safety Governance checklist had been developed and implemented in February 2019. Evidence of the quality of care was demonstrated in the performance in Harm Free care which was 98.25%.

Medical Director
The Fractured Neck of Femur target was receiving Dr Hankin's personal oversight, with an action plan being rewritten and disseminated. The recruitment of a new consultant was anticipated to contribute to the improvement of that matter along with 'Get it Right First Time' (GIRFT). Dr Hankin was pleased to observe a Consultant Orthopaedic Surgeon and Anaesthetist at 8am dealing with a patient who had had a 10 hour wait. Historically patients would not undergo surgery until a post-operative ward bed had been identified, however, the process was being actively managed so that the patient would be kept and monitored at Recovery until a bed was found.

High SHMI and HSMR remained a risk for the Trust with action plans in place to improve care and reduce these. The actions were being monitored at Board level via the Quality & Safety Committee and the Monthly Mortality report to the Board. Improvements had been made in Sepsis management with reduction in Sepsis related deaths.

Ms Cosgrove added that medical workforce engagement continued with weekly meetings with four consultants who understand they were being heard.

Chief Operating Officer
Cancer 62-day performance for December 2018 was below the 85% target at 71.6%. Despite October 2018 showing great improvement, this had not been sustained and performance had dropped to a similar level as seen in September 2018. The Board was asked to note that delivery of the trajectory will not be delivered for Q4. The Trust had challenges in workforce across a number of Tumour Groups and Mr Christian and Dr Hankin met with Tumour Group Leads to determine the issues and critical interventions.

	18 Week Referral to Treatment (RTT) for January 2019 performance was 94.8% which, although a drop from December remained above target however that was the third consecutive drop. The ongoing waiting list was 10,400 – with a target to reduce down to 9,000 by the end of March 2019. In response to the Chair's question regarding comparison with peer groups, Mr Christian responded that for two of five months, the Trust had been in the top 20 for performance and three of five months had been at the bottom of the same group. **Director of Human Resources and Organisational Development** Personal Development Reviews (PDR) had increased by 3% to 73.48% with work ongoing to achieve the 85% target. The data for mandatory training was being interrogated nationally as it might have been inaccurate and resulted in incorrect reporting. The volume of temporary staff, including those from NHS Professionals and other agencies, was being monitored on a daily basis to reduce agency spend and ensure the maximum utilisation of bank fill. Sickness Absence had significantly increased in month to 6.43% and work continued with the Health & Wellbeing Team to manage and reduce it including focusing on potential misuse. **Director of Strategy** The Strategic Work Plan would be taken to the Sefton Transformation Board on 13 March 2019. It sets out a six month programme of work to further our journey towards a sustainable solution for the Trust. **Director of Finance** The Trust was one of 80, of the 90 NHS Trusts in the North of England, which had signed up to the control total for 2019/20. **RESOLVED:** The Board **received** the highlight reports from the assurance committees, the Executive performance summaries and assurance from the Executives and reports on the performance indicators.	
TB053/19	**Financial Position at Month 10 including Forecast Outturn 2018/19**	
	Mr Shanahan presented the report and key highlights. Agency spend had increased by £200k in the month, which reflected the increased medical and nursing costs required to resource additional bed capacity due to winter pressures. The forecast remained on course to deliver the year end deficit of £28.8 million, however, risks to that remained despite recommendations from NHS Improvement (NHSI)/NHS England (NHSE) which supported the Trust's income for Clinical Decision Unit (CDU) tariffs. The outcome had not been fully accepted by commissioners. Whilst both the Trust and the CCGs were open and honest about the challenge, a degree of pressure was being exerted to resolve it. Mr Clarke commented that he was very concerned that the Trust	

	would be technically insolvent to which Mr Shanahan agreed and stated that a number of other trusts were in the same position with negative equity and that the external auditors had commented similarly and the view was supported by NHSI. Ms Roberts added that in 2019/20 activity would be linked to job plans/clinic bookings. The Chair commended the Finance Team for the continued forecast of £28.8m deficit which was likely to be delivered, despite pressures and challenges. **RESOLVED:** The Board **received** the report.	
TB054/19	**Segmental Reporting & Charitable Funds**	
	Mr Shanahan presented the report which reviewed 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. **RESOLVED** The Board **approved** the recommendations that the Trust report one operating segment in 2018/19 accounts, that the Charitable Fund results should not be consolidated and that an annual review of both segmental reporting and charitable fund consolidation be undertaken.	
TB055/19	**Risk Management:** **Risk Register**	
	Ms Cosgrove presented the report. Little movement had taken place relating to risks had taken place in the month to date, with the exception of the removal of risk 1367 - *Failure to have a motivated and engaged workforce (culture).* Dr Hankin commented that progress had been seen relating to risk 1688 - *Inadequate Staffing Levels in Anaesthetic Department*, with the recruitment of three substantive anaesthetic roles to which Ms Patten added that that would positively impact on GIRFT initiative/workstream. Dr Hankin went on to state that the recruitment of an Emergency Medicine Consultant had been completed and the appointee would be in place by the summer time. The Chair and Director of HR both commented that the appointee had specifically chosen to apply to the Trust as they were of the opinion that they could make the most difference here with speedier results. It was agreed that those appointments were a good foundation on which to build and Ms Patten commented that that was part of the three-year Workforce Plan. Mr Singh asked if other specialities, including geriatrics were part of the planned recruitment. Dr Hankin replied that in the longer term the model would be to use Physician Associates to support the senior medical workforce, so that services were not dependent solely on consultants. Mr Christian added that the success of the recruitment was due to the co-design work of vision, ambition and engagement with the clinical teams. Mr Birrell asked from the bids received, what had happened and	

	when would the outcomes be reported? Ms Patten responded that the final list would be signed off by the Executive Management Team and *Mr Nicholls added that in 2019/20, £3m of investment were planned following the approval of business cases and would be signed off on 8 March 2019 and would be shared to the Board of Directors*. Mr Nicholls commented that a Unique Selling Point (USP) of the Trust for active choice by staff was that it was a great place to work and live in, including good work/life balance. **RESOLVED:** The Board **received** the report.	**DCEO**
OTHER REPORTS FOR RECEIVING		
TB056/19	**Quality Improvement Plan and CQC Progress Report**	
	Ms Cosgrove presented the report. All 'should dos/must dos' were continually being reviewed and would be fulfilled by CBUs, Corporate Services, Estates & Facilities. A Provider Information Return (PIR) dummy run in November 2018 provided some good quality evidence and by April 2019 full information as evidence would be completed. Ms Cosgrove stated that the Care Quality Commission (CQC) would be observing the Board, Audit Committee, and the Quality & Safety Committee in April 2019. A Well Led Review would evidence progress made against the Quality Improvement Plan and would be reviewed at the Executive Team Meeting. The challenge would be to provide comprehensive integrated information and any feedback from Board members would be welcomed. Ms Cosgrove confirmed that resources were in place to manage the process. Ms Patten commented on the February 2019 notification regarding a concern which had been raised anonymously with the CQC in relation to the availability and maintenance of equipment in clinical areas (Regulation 15). Following the core service review in December 2018, the Trust had undertaken an exercise and developed a core ward equipment list. Matrons were currently self-assessing against that list to identify any equipment shortfalls and replacement requirements. Ms Cosgrove added that staff were ready and willing to respond to CQC and honestly state what their experience was of working in the Trust including how their appraisals were scheduled and conducted. Ms Roberts commented that the CBUs governance framework would be in place by the end of March 2109 and partially implemented in April 2019. Mr Christian stated that some CBUs Governance meetings were not taking place which was a risk. Ms Roberts responded that the Accountability Framework would be used, refined and simplified and would be presented to the Finance, Performance & Investment Committee. **RESOLVED:** The Board **received** the report.	

TB057/19	**Monthly Safe Nursing & Midwifery Staffing Report**	

Ms Cosgrove presented the report.

The overall fill rate for January 2019 was 90.52% compared to December 2018 which was 93.61% and November 2018 which was 95.76%.

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

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

	Funded WTE	**Contracted WTE**	**Nov Total 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 had reduced by 4wte. Non-registered vacancy had increased in month by 4wte.

Mr Nicholls commented that the impact of 40 extra beds within the hospital was evident, however, with the closure of the escalation ward, Ward 1, staff would be re-distributed and the use of agency staff reduced.

Ms Cosgrove added that a request for £1.5m investment in nurse staffing had been considered by BDISC. Ms Roberts commented that based on the E-Roster some of this spend was already included in the run rate.

Mr Nicholls added that releasing Ward Managers from providing care, back to their substantive roles would identify areas with real issues which would be targeted.

Mrs Gorry commented that the increased use of Volunteers would see significant improvement for Ward Managers. Ms Cosgrove added that recruitment of nursing staff, including training, orientation etc took 12-18 months to impact on the baseline of staffing.

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

APPROVAL & RATIFICATION

TB058/19	**Items for approval/ratification**	

The Board:

- **Approved** the drawdown of Public Dividend Capital (PDC)
- **Ratified** the decision taken under Emergency Powers Section 4.3 of the Standing Orders to apply for an Uncommitted Revenue Support Loan of £2.19m for March 2019.
- **Ratified** the decision taken at the Quality & Safety Committee to approve the Seven Day Services (7DS) Self-Assessment.

CONCLUDING BUSINESS		
TB059/19	**Questions from Members of the Public**	
	None	
TB060/19	**Any Other Business**	
	To **receive/discuss** any other business not on the agenda. Mr Nicholls thanked Ms Roberts for her work with the Trust in the past seven months and stated that it was now in a better place thanks to her input. Ms Roberts thanked the Board and stated that a formal report on the work undertaken and the outcomes would be presented by Kim McNaught at the April 2019 Board. Mr Charles reminded the Board that to facilitate an annual refresh of the Fit & Proper Persons Declaration and the Code of Conduct, copies would be circulated for completion and return.	
TB061/19	**Items for Forward Agenda – 3 April 2019** • Board Assurance Framework 2019/20 • Board Development Programme • Board Annual Business Cycle	
TB062/19	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • *Thank staff for improved year-on-year performance despite increase in patient numbers* • *Financial performance maintained despite pressures, giving confidence for the year ahead* • *Medical recruitment successes (Emergency Department and anaesthetics)* • *Mortality still higher than expected but most indicators now on downward trajectory* •	**Communications**
TB063/19	**Meeting Evaluation**	
	To give members the opportunity to evaluate the performance of the Board meeting	
TB064/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 3 April 2019, **10.00** Hesketh 1, Ramada Plaza Hotel, Marine Lake, Southport, PR9 0DZ	

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)										✓	✓	A
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 3 April 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 TUPEd and appointed as Director of HR in November 2018.A six month secondment agreed to enable the recruitment of the functional HR Team. **January 2019** Work and recruitment continues to transfer services back by end March 2019. **March 2019** Individual consultation meetings almost completed. Recruitment to vacant posts ongoing. Planning for team location. Weekly update to Executive Team on progress **April 2019** Final preparations underway for 1st April transfer. Accommodation at Ormskirk DGH has been secured and is being prepared for staff to commence moving 29th March – including Recruitment; HR Business Team & Medical HR. Communications have been sent Trust wide advising of changes. Work is ongoing over the next month to ensure any outstanding issues are addressed and concluded.	**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	**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. **April 2019** The BAF will be brought to the May Board and will be circulated as requested before then.	**GREEN**
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	Apr 2019	**February 2019** This will take into account the subject of claims, damages and liability expectations and reputational risk. **March 2019 Update** A revised protocol is being written to identify how and where these are managed, monitored and reported and will be reported to the Board and Audit Committee in April 2019 **April 2019** This being discussed at April Audit Committee and at the Board in May	**GREEN**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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. **April 2019** On the April Board Agenda	**GREEN**
TB028/19	Feb 2019	**Monthly Mortality Report, including a summary report of the External Mortality Review**	Standard Operating Procedures (SOP) 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 SOP pro-formas to support daily activity. **April 2019** Dr Hankin to meet with AMD/CD to agree action plan.	**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**	May 2019	May 2019	**March 2019** Dr Hankin and Dr Goddard to review timeline and update Trust Board **April 2019** To be reported to May Board.	**GREEN**
TB031/19	Jan 2019	**Integrated Performance Report**	The report to incorporate a target or forecast line	**DoF**	May 2019	May 2019	**March 2019 Update** This is being progressed and will appear in the April report **April 2019** The IPR currently includes a Target Line (in red), Forecasting (trajectories) are being developed and will be included in the May IPR report.	**AMBER**
TB050/19	Mar 2019	**Monthly Mortality Report**	The External Mortality Review Action Plan would be reconciled with SMART objectives, then revised and reported to the Board when completed.	**MD**	May 2019	May 2019		**AMBER**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB055/19	Mar 2019	**Risk Management**	In 2019/20, £3m investment was planned following the approval of support cases and would be signed off on 8 March 2019 and would be shared to the Board of Directors.	**DCEO/DoS**	Apr 2019	Apr 2019	**April 2019** On the April Board Agenda	**GREEN**

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COMPLETED 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	Apr 2019	**February 2019** The COO would work with a member of staff to consider solutions **March 2019** Trust-wide communications issued regarding required processes and actions. An Outpatient Improvement Programme for 2019/20 would be introduced. The project team were requested to review the potential of adopting custom-fitted white boards in clinics to improve communication to patients such as waiting times to see a clinician with a deadline of April 2019. **April 2019** Boards are fitted and in use in clinics.	**BLUE**

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COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB015/19	Jan 2019	**Charitable Funds Committee**	The Charitable Funds Committee had previously considered a proposal from a marketing company which had previously re-branded St Helen's & Knowsley Trust Charity. 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.	**BLUE**
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.	**BLUE**

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COMPLETED 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**	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	Apr 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 be shared by11 March. **April 2019** Reports shared with families	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	**TB069/19**	**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. The Board is asked to note the report

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

Previously Presented at:

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

Complaints and Compliments

February 2019

1.0 Introduction

This report provides a break down on the number of compliments, complaints, concerns received in the month of February, it does not relate to care or experience received in month.

Across The Trust			
Month	**Compliments**	**Complaints**	**Concerns/Information Requests**
Feb - 19	**123**	**23**	**22**

2.0 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.

We are pleased to report the Planned Care Business Unit received the most compliments with 78 in total and F (Day case) ward receiving 33 compliments in the month.

The Urgent Care Business Unit received 28 compliments with the Physiotherapy department receiving the highest number (12).

The Women and Children's Business Unit received 22, 16 compliments were related to Paediatric / Neonatal care.

2.1 Complaints

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

The Urgent Care Business Unit received the most complaints (12) followed by the Women's & Children's Business Unit who received 6. The Planned Care Business Unit received 5.

The following themes were identified

- Complaints about staff attitude, 5 complaints mixed across all Clinical Business Units.
- Clinical treatment featured in 14 complaints received, these included alleged wrong treatment/diagnosis, coordination of medical treatment, poor nursing care and lack

of continuity. A&E accounted for 5 of these complaints and Eye Clinic accounted for 2.

- Communications featured in 5 complaints regarding lack of clear explanations to both patients and families.
- Admissions/transfers/discharge procedure featured in 4 complaints received in February, all alleging patients were discharged when not fit for discharge.
- Basic care was a feature in 2 of the complaints received, relating to mobilising and washing and dressing.
- Staff competence featured in 2 of the complaints, including staff not observing patients and being unaware of patient's diagnosis.

2.2 Concerns

The concerns received featured a number of areas, staff attitude featured in 6 and clinical treatment featured in 4. Appointment dates accounted for 3 and car parking featured in 2 of the concerns.

3.0 Conclusion

The Planned Care Business Unit received the most compliments this demonstrates that patients consider this a quality service.

Overall clinical treatment featured in 14 complaints across the trust, this needs to be analysed, broken down into location so we can further understand why this is and can look to further improve the care we deliver to our patients.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	TB070/19	Report Title	Chief Executive's Report
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This month's report looks back at key themes in 2018/19 and looks forward to 2019/20 by looking at highlights including the following:

- Service developments
- Performance improvements
- Staff achievements and awards
- Looking ahead to the rest of 2019

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

Strategic Objective	Principal Risk
✓ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
✓ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
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✓ **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 – APRIL 2019

Review of the Year
It's been a challenging few years for the Trust as we all know. But I believe that 2018/19 was the year we started to turn the corner. As I reach the end of my first year here, I am delighted by how ready colleagues are to rise to the challenge of making this Trust the best it can be for patients.

So where have we invested?
£2.8m was invested during 2018/19 for additional clinical staff, including four more SAS doctors and eight clinical fellows. An additional £300,000 has been allocated to fund a Critical Care Outreach Team to provide a 24/7 service, starting this month. The team will be an additional pair of hands to respond to raised Early Warning Scores, ensuring pathways of care are followed and provide consistency in the engagement of parent teams and critical care for our sickest patients

A capital investment of £1.25m allowed the refurbishment and improvement of Southport emergency department. This included an improved waiting room, six new ambulatory care bays, an eight bed clinical decision unit, and new reception area. In addition, £280,000 was spent on the surgical assessment unit.

The discharge and transfer lounge opened in the summer, helping with patient flow and creating a better patient experience. Finally, we opened a new day surgery unit at Ormskirk, a quiet room also at Ormskirk named the 'chillaxation room' for young patients needing a calming environment, a new-look café at Southport and opening this month, a new sexual health clinic in Bootle.

Workforce Developments
During the period we continued to recognise the contribution of our workforce and to develop staff as future leaders illustrated by the initiatives below:

- Having in place a Workforce and Organisational Development Strategy
- Workforce & Organisational Development Action Plan 2018-2020
- Conversations commenced with AQuA to co-design a Quality Improvement Strategy and training programme for all staff
- Commenced a quality appraisal conversations training programme
- Staff Survey Action Plan
- Senior Leaders' Development Programme
- Started Shadow Board Programme geared at Aspiring Directors
- Recruitment of a dedicated apprenticeship lead to deliver an extensive range of apprenticeship programmes to recruit and develop clinical and non-clinical staff
- Designing new job roles such as Nursing Associates
- Launched eLearning to deliver core mandatory training, clinical knowledge and management skills

- Conversations commenced with NHS Elect to design and deliver our staff engagement approach “Big Conversations” with a focus in year one on culture, values & behaviour

Quality, Patient Safety and Clinical Outcomes
Quality continued to be a key focus for the Trust and during the period we have given particular focus to the following:

- A Quality Improvement Assurance programme being developed and led by AQuA
- The Quality Improvement Action Plan with monthly reports to the Quality & Safety Committee and the Board
- Monthly Safe Staffing Report to Board and Quality & Safety Committee
- Commissioned External Reviews including:
    - Mortality,
    - Emergency Care Performance including Patient Flow Pathway
    - Acute Services Transformation plus CIP Reporting/CIP Governance/PMO Review

Service Developments
We have been working on improved depth of coding with support from the Clinical Engagement Manager to ensure the complexity of patients’ illnesses is appropriately reflected. This has led to a sustained improvement in the accuracy of our information and will reflect in future mortality scores.

Better clinical engagement with IT – the current Wi-Fi upgrade, for example, will improve and stabilise access to mobile clinical systems.

Red2Green - getting patients home who no longer need hospital care is key to having beds available for people who urgently do. Whether that’s preventing admissions or accelerating discharge of medically fit patients, we need to work closer than ever with our local NHS partners to achieve this

The Trust has spent over £1m on new medical equipment in 2018/19 and plans to spend an additional £6m over the next five years. This year's purchases include:

- Gastroscope £162,000
- Orthopaedic saws/drills £131,000
- Cardiology cart £57,000
- 40 volumetric pumps and battery packs £70,000
- IOL ophthalmology machine £37,000
- 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.

The management and administration of recruitment has now moved back to the Trust from St Helens & Knowsley. From Monday 25 March, all recruiting activity will take place within the Trust and this should create a more efficient process.

Getting It Right First Time (GIRFT) is now underway for orthopaedics and ophthalmology. The aim of GIRFT is to deliver improvements in clinical quality and process by reducing variation in practice and making sure patients get the best care. We want to do this at pace but be sure it's sustainable in the long-term. GIRFT is a key plank of creating a regional hub for routine planned care at Ormskirk hospital, one of the four themes of the Trust's Vision 2020 corporate strategy.

Congratulations to Rahul Mistry's team for being the first hospital in Lancashire to use a new steam treatment for men with benign prostate enlargement. The Rezum procedure is minimally invasive treatment and can be done under local anaesthetic without the need for an overnight hospital stay. Treatment is completed in less 10 minutes, compared to up to two hours and a one or two-night stay in hospital previously. Their symptoms are expected to improve more quickly than with standard treatment.

Lastly we launched a new menopause clinic with Dr Paula Briggs. To help promote this service, two pop up menopause café events for the public have been held and both were very well attended.

Performance Improvements

We have some good news to report on performance management with some of the key highlights listed below:

- Diagnostics – there is targeted improvement work within x-ray focusing on specific modalities e.g. CT, MRI, non-obs ultrasound and ECG

- We have seen month-on-month improvements in our staff undertaking their mandatory training and have achieved the Trust's target
- Outpatients – a focus on increasing activity has seen improved clinic utilisation as we have been able to see more patients
- In Ophthalmology we have increased the numbers of patients on each list to six
- Our 'Did Not Attend' rate has reduced to 6.5%, so we have fewer patients missing appointments. The national average is 8%
- 14 Day Cancer target – our "What a Difference A Day Makes" initiative is seeing continued improvements in the tumour groups for our 14 day performance by focusing on a seven day pathway for patients. We aim to ensure that patients wait no long than seven days between each stage in their pathway
- Our Reducing Avoidable Mortality Project can demonstrate month-on-month improvements
- We have been rated as the top performing Emergency Department in the region

Staff Engagement

Ongoing executive team visibility has been a focus. We launched a 'Straight to Silas' email inbox for staff to confidentially raise issues, an executive 'breakfast forum' which is open to all staff, and monthly 'back to the floor' shifts. This creates various mechanisms for staff to get to know the executive team and feel confident to speak up at all times

To recognise and reward staff, we launched Thanks a Bunch monthly staff awards in September. Individuals or teams can be nominated by their peers, across both sites. A thank you card and gift is delivered by a member of the executive team to each winner, each month.

New look Time to Shine staff awards were held in October, in Formby Hall for the first time. The event continues to be a popular way to recognise hard work from staff and teams who consistently go the extra mile. We will hold the awards again this year on 18 October.

A staff Facebook group, The Meeting Place, now has over 1,100 members after launching just over one year ago. The group is a lively ground for debate, with staff seeing it as a safe place to air their views. It is also very supportive with people across all levels sharing good news**.**

Lastly, we appointed a Freedom to Speak Up Guardian as part of our work to create cultural change. We want to create a more open, honest and inclusive atmosphere.

In brief…
Last September saw our first **open day** in seven years, which was well received by staff and visitors. One hundred staff have started **apprenticeships**, far out-performing other local Trusts. We signed up for 'working with' status with the **Cavell Trust**, to provide better support for nurses, midwives and HCAs who might be struggling financially due to unforeseeable life events.

SOProud Week in January saw staff invited to talk about their work with pride. During the week we hosted a visit from Roy Lilley. Roy toured both sites and was very well received by all.

Lastly an increased focus on wellbeing saw the launch of free, **weekly staff yoga sessions**. Staff are being asked to suggest other ideas to support their wellbeing, in a way that works around their shift patterns. Other ideas in the pipeline are quick hand and head massages during break times for ward staff.

Staff Achievements and Awards
In September we introduced the monthly Thanks a Bunch award. This has proved extremely popular with over 80 nominations made and 11 winners already including:

- Spinal therapies team who moved out of their space to make way for Ward One during winter escalation
- Mandy Williams and Suzanne Clarke who arranged the Christmas craft fair, also from the spinal unit
- Richard Boydell and Jason Burge – information and IT respectively at Southport
- The entire team on ward 15b
- Ann McMaster and Laura Price from the children's department
- Sharon Wynne from Southport theatres
- Elaine Lloyd at Ormskirk
- Albie Houghton who recently retired after a long service on EAU

Also Helen Hurst and Paul Jebb have been recognised by the Cavell Trust for going above

and beyond. In March our hospitality and medical admin teams won Apprenticeship Star Awards at Southport College.

Tony Carson has been shortlisted in the Student Nursing Times Awards in the trainee nursing associate category – good luck Tony! And our Paediatric diabetes team has been shortlisted in the prestigious HSJ Value Awards 2019 for Diabetes Care Initiative of the Year - good luck team.

Looking ahead to the rest of 2019

Workforce

Workforce remains a priority to deliver Vision 2020. The next year has a number of priorities.

Resource Utilisation

Effective Recruitment Pathways

- On-boarding
- Clear Roles & Responsibilities
- Values based recruitment
- Recruitment Strategy

Temporary Staffing Utilisation

- Bank Growth
- Temporary Staffing Processes
- Managed agency spend

Rostering levels of attainment

- Nursing Rostering
- Medical Rostering

MDT Activity Management & utilisation

- Activity Manager Deployment
- Robust Job Planning (Medical, AHP and Clinical Nurse Specialists)
- Waiting List Utilisation and Processes

Clinical Workforce Strategy

- Succession planning
- Talent pipeline
- Future workforce
- Workforce planning
- Development of new roles

Engagement

Culture Change

- Values & Behaviours
- Board Development & Visibility
- Meaningful Induction Processes
- "Healthy, Happy & Here"
- Shared Clarity, Capability & Commitment

Organisation Development

- Coaching & Development
- QI development plan (AQuA)
- Leadership & Management development

Retention Priorities

Staff Survey
- Friends & Family Test
- Pulse Check

Service Delivery

Emergency Care
The Trust will enhance the model of Same Day Emergency Care (SDEC). This will increase the proportion of acute admissions discharged on the day of attendance. We would not expect the proportion of non-SDEC zero-day length of stay admissions to rise. Hospitals should also specifically reduce avoidable admissions through the establishment of acute frailty services, so that such patients can be assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving units. The SDEC model should be embedded in both medical and surgical specialities, expected to deliver SDEC at least 12 hours per day, seven days a week, by September 2019.

Long stay patients (those in hospital for 21 days or more) account for 7.3% of admissions and 20.4% of bed-days (as at October 2018). In 2018/19, we set the goal to reduce bed occupancy by long stay patients by 20%. We will continue the aim to reduce the proportion of beds occupied by long stay patients by 40% against the original 2017/18 baseline.

Delays in handover of patients from ambulance services to ED result in increased risks to patients, both on site and in the community. The Trust will adopt a zero tolerance approach to delays of over 60 minutes, ensuring that the ED can accept timely handover of all patients arriving by ambulance, with the aim that no one waits more than 60 minutes and that no patient is cared for in a hospital corridor.

RTT
Following good progress in 2018/19, we expect no patient to be waiting more than 52 weeks for treatment. We will work with commissioners and embrace the non-face-to-face redesign of many interactions in outpatients. The Trust will target reductions in cancellations and non-attendance at appointments by improving processes. Furthermore, the Trust will look to release capacity by reducing unnecessary frequent attenders and improving clinic utilisation where it is below the average of Model Hospital peers.

RTT plans will be realistic, making best use of available capacity, informed by rigorous forecasting of demand and activity to ensure that capacity is utilised as effectively and efficiently as possible. This will include working towards a standard of no more than 1% of patients waiting six weeks or more for a diagnostic test.

Cancer Treatment
The Trust will work with the Alliances to ensure that any support or interventions are supported in our local health system. We will commence collecting the 28-day Faster Diagnosis Standard data items in 2019/20, in preparation for the introduction of the Standard in 2020. The key deliverables for cancer are:

- At least 93% of patients who receive an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should have their first outpatient attendance within a maximum of two weeks
- At least 93% of patients with breast symptoms who receive an urgent GP referral for suspected cancer should have their first hospital assessment within a maximum of two weeks

- At least 96% of patients should wait no more than one month (31 days) for their first definitive treatment, from the date a decision to treat is made, for all cancers
- At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is surgery
- At least 98% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is drug treatment
- At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is radiotherapy
- At least 85% of patients receiving an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should wait no more than two months (62 days) for their first definitive treatment, for all cancers
- At least 90% of patients with an urgent referral from an NHS cancer screening programme should wait no more than two months (62 days) for their first definitive treatment
- Implement human papillomavirus (HPV) primary screening for cervical cancer across England by 2020

Patient Safety

Mortality reduction remains the principal organisational clinical challenge going forward. As an overriding 'Quality Indicator' the reduction of our headline SHMI, and disease specific mortality figures is our number one priority. Specifically three work streams have been chosen to have maximum impact not just on mortality, but the overall care of patients and in particular care of the elderly.

Following completion of the external mortality review, the individual root cause analysis of the seven cases where failure of care may have contributed to death have been completed and shared with the bereaved families and the CCG. In only one case was it found that failings in care contributed significantly to death. An action plan and lessons learned have been generated by the reviews for sharing with the clinical workforce.

The medical workforce and its ability to deliver quality care 24/7 remains a national area of concern. A review of the medical workforce and its ability to deliver the range of current services at the level of quality patients require is being undertaken. The Trust has some unique challenges in relation to geography and estates that need to be factored in in developing a flexible and robust medical workforce to deliver the quality goals we aspire to. Considerable investment in the medical workforce (7.5% increase) has demonstrably improved patient flow and quality of ward care. The Trust remains committed to investment in the workforce needed to achieve the '2020 Vision'.

Nursing, Midwifery & Therapies

Workforce – implementation of the business case regarding recruitment, retention, new roles, new ways of working

- Clinical Education – development programmes across all roles including implementing new NMC Educational standards
- Quality Improvement – Focus on Fundamentals inc. Observations of Care
- Professional Standards – NMC process, NMP governance, Roles & Responsibilities for Matrons & Ward Managers
- Ensure Trust is prepared for forthcoming CQC inspection
- Review complaints processes
- Review risk management processes
- Patient experience – enhance feedback, develop volunteers, improve care within frail older peoples care.
- Make Every Contact Count – develop strategy, roll out training, take part in regional engagement strategy
- Lead on the delivery of the Trust Quality Priorities

Finance

The Trust is planning to deliver its deficit Control Total next year. This will require the deficit to be reduced from £28.8 million in 2018/19 to £26.6 million in 2019/20. The Trust will then benefit from non-recurrent funding of £18.271 million (Provider Sustainability Fund £3.464 million; Financial Recovery Fund £14.807 million) which will give a final control total deficit of £8.296 million.

This will mean the Trust has to deliver a minimum CIP of £3.2 million (1.6%) but the Trust is also investing in new business cases at a cost of £3.1.million and therefore the total CIP requirement will be £6.3 million.

The Trust is also planning on a capital investment programme of £5.5 million, £2.1 million for IT, £1.0 million for new medical equipment and £2.0 million on the estate, which will include improvements to the ward environments.

Investment in IT will include new additions to support the development of our electronic patient record strategy. Careflow Connect will enable VitalPac users to have encrypted mobile and web-based messaging between teams and individuals while Careflow Clinical Narrative/Noting; will enable pathways and care plans to be used to support clinical processes. Careflow Clinical Workspace will provide clinicians with a clinically optimised, consolidated view of patient information The Patient Demographic Service will provide real time interaction with the national Personal Demographics Service (PDS) and the Child Protection Information Sharing system. Bluespier Theatres will integrate with the existing waiting list, TCI lists and home screens in the Medway EPR. The Trust will also be upgrading to Windows 10 and making further improvements to the infrastructure to support the use of these new Medway products.

Strategy

The Trust continues to work on developing a sustainable model for acute care working with partners across Sefton and West Lancashire. The aim is to completely transform the way future health, care and wellbeing services are provided. This work has an ambitious programme during 2019/20, to build a single system that brings together services from

across the health, care and voluntary sectors to help residents manage their own health and wellbeing.

The following design principles have been set to drive the work - this is important as these principles will ensure that future services are clinically safe and sustainable. Services will:

- see and treat enough patients to operate a safe and efficient service
- have an appropriate workforce to meet staffing needs
- have interdependent clinical services in place and in reach to operate core services safely and effectively
- be deliverable within the resource envelope that is available
- meet national standards to ensure the best possible outcomes
- maximise the opportunity to network services with partner organisation to ensure access to the sustainability of the services
- provide services as local to the populations as is clinically and financially viable

By October we have agreed to have developed a comprehensive Programme Definition Document which describes the blueprint, project portfolio, timescales and benefits realisation plan. We will also have developed a strategic partnership framework, financial framework and enabling strategies and plans. All of this work will sit within an aligned and agreed commissioner approach.

Corporate Governance and Information Governance

A number of initiatives were undertaken to improve our governance arrangements. Shortly after joining the Trust I commissioned a Rapid Review of Governance undertaken by EY; this resulted in:

- A robust integrated governance structure
- A Hospital Management Board
- A Hospital Improvement Board
- Performance Review Groups where the Clinical Business Units are held to account

In addition to this review a number of systems and processes were put in place which have strengthened our financial governance arrangements and have aided in our achieving our control total for the year

Our Information Governance has coped well with the introduction of General Data Protection Regulations in May 2018 and our staff are compliant with regards to Information Governance Training. We will build on these positive achievements during 2019/20 year.

Southport and Ormskirk Hospital NHS Trust

TRUST PUBLIC BOARD

3 April 2019

Agenda Item	TB071/19	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 Committee 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.

Measuring Mortality

Summary Hospital-level Mortality Indicator (SHMI) – 12 month rolling published up to September 2018

Hospital Standardised Mortality Ratio (HSMR) – Rolling 12 month and in month for October 2018

Disease-Specific Mortality Ratios – October 2018

Reducing Avoidable Mortality (RAM) Project

An overview of the first phase of the RAM project is given which details levels of completion against the original project scope for all six work streams. An overview of second phase of the project is provided with details of the scope of work for the four main work streams.

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*
✓ **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)*

An amalgamated status update on the progress of activity for both the External Mortality Review Action Plan and the Action Plan for cases identified as having received very poor care will be incorporated into the Mortality Report from May 2019 onwards.

Previously Presented at:

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

1.0 Mortality Report – March 2019

Executive Summary

- Headline indicators show statistically improving position, most likely driven by improved data collection, completeness and accuracy coupled with improved patient flow and capacity-demand matching.
- Clear area of focus is respiratory infective death. A new pneumonia pathway is now available and in use. This should improve the diagnostic accuracy and escalation if used appropriately. Investigation now focuses on Lower Respiratory Tract Infection (LRTI) /Bronchitis as a cohort while other aspects of pneumonia care are scoped (nutrition / mobility).
- Sepsis and AKI have been subject to standardisation of process of care and these areas are no longer showing as alerts for mortality rates, but further work is needed to embed quality of care
- Other areas that are under surveillance or evaluation are deaths within 30 days of discharge, deaths within 24 hours of admission and the in-month rise in crude death rate within the urgent care CBU which is likely due to seasonal illness, demographics and challenges to flow.
- In this report patients that died waited 50% longer in the Emergency department than those who survived, while the wait from decision to admit was similar. This suggests overall responsiveness and capacity is the dominant factor

Key national and local mortality indicators

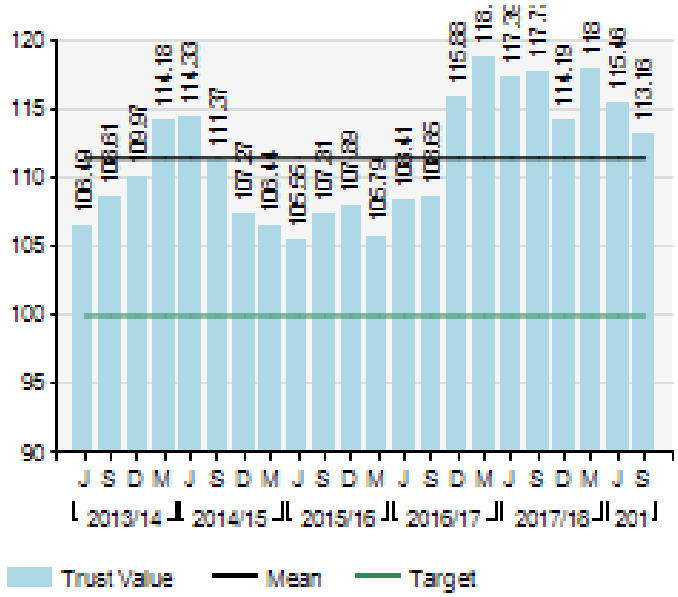
	2017/18		2018/19										Target
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Rolling 12 Month HSMR	123.1	123.4	121.2	120.6	118.3	117.5	116.0	114.4	111.7				*100.0*
Monthly HSMR	136.0	124.7	105.0	125.6	98.9	123.5	96.1	95.0	72.6				*100.0*
SHMI		118.0			115.5			113.2					*100.0*
Local HSMR Bronchitis	126.1	165.9	154.5	161.6	154.5	169.7	157.8	151.4	134.2				*100.0*
Local HSMR LRTI	127.2	167.4	155.9	163.0	155.9	171.2	159.1	152.6	135.2				*100.0*
Local HSMR Pneumonia	145.0	144.5	142.5	135.9	133.0	135.8	126.2	128.1	120.6				*100.0*
Local HSMR Septicemia	94.3	88.4	93.8	92.5	90.1	87.1	87.3	87.0	89.1				*100.0*
Local HSMR Stroke	139.0	139.1	135.4	136.6	127.7	123.5	126.1	115.9	107.4				*100.0*
Local HSMR UTI	108.3	131.2	131.6	127.5	126.1	125.0	112.6	116.9	114.4				*100.0*
Local HSMR Acute Renal Failure	106.4	124.2	121.5	109.0	108.0	108.6	104.2	97.7	96.4				*100.0*
Mortality Screens - %	91.01%	102.83%	106.76%	88.24%	90.77%	92.21%	72.73%	58.90%	53.45%	58.82%	50.62%	62.37%	*90.00%*
SJRs								33	21	13	7	12	*0*
2nd Review								0	2	1	0	1	*0*
In Hospital Deaths	89	106	74	85	65	77	66	72	59	69	81	94	*77*
In Hospital Deaths Crude Rate	39.3	41.4	30.4	29.0	22.2	26.6	21.1	22.2	17.4	20.6	24.4	27.4	*31.0*
LD Deaths	0	1	0	1	1	0	1	0	0	0	0	0	*1*
Steis Incidents	8	3	7	5	9	4	8	1	10	2	3	4	*5*

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

Individual indicators are discussed in the narrative below. The table itself shows a gradually improving reporting position, with the caveat that in-hospital deaths have increased in the past two months. This is to an extent expected as the winter months progress with seasonal illness that affects our demographic in a dis-proportionate fashion. In-month standardized indicators are likely to reflect this in time.

The clear areas of work are respiratory infective illnesses with improvements in diagnostic accuracy and access to diagnostics. Further improvement work is being scoped as a result of the coalescence of the External Mortality Review Action Plan, The Root Cause Analysis of 7 cases of very poor care action plan, and the Reducing Avoidable Mortality Project action plan into a single project.

SHMI – Summary Hospital Level Mortality Indicator

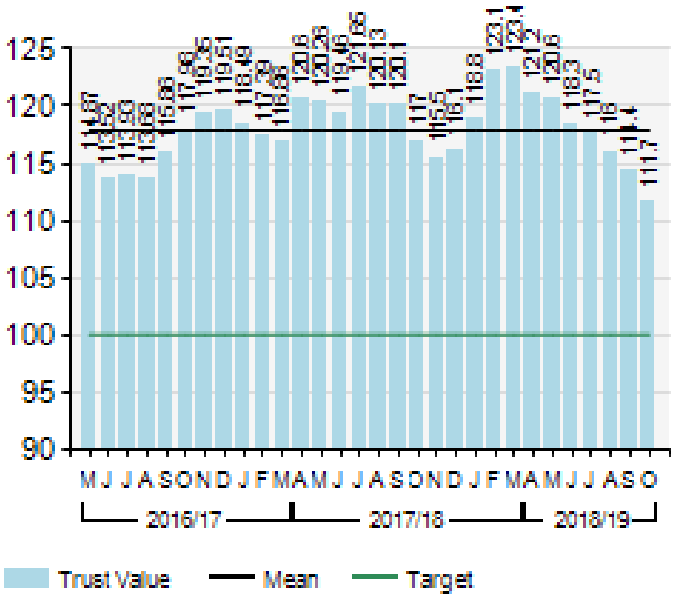


The SHMI indicator for the trust remains high and above the target of 100(1.0). The Current release however is at its lowest since 2016 and shows an improving position. This is being driven by multiple factors:

- Improvements in the depth of clinical coding identifying the co-morbidity burden within our population gives a more accurate representation of risk.
- As reported previously, The SHMI includes deaths within 30 days of discharge. This is periodically evaluated by palliative care services as most of these deaths (88%) are known to them. A review of deaths post-discharge not registered on the Gold Standard Framework will be presented to the April Mortality Operational Group.

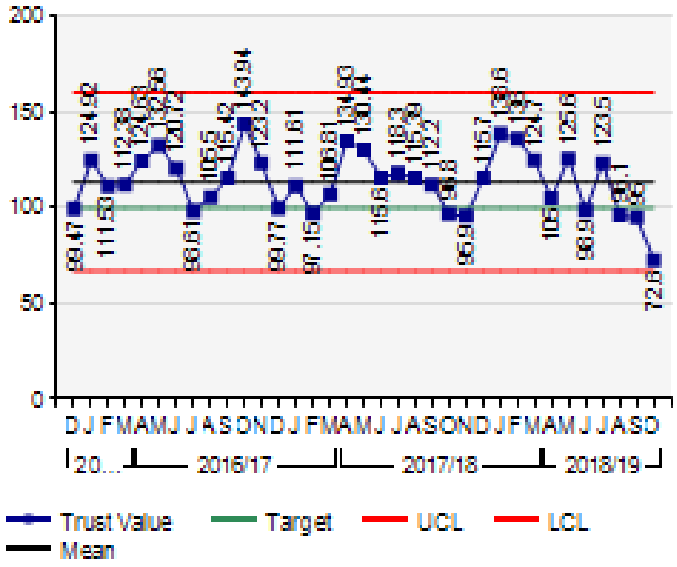
The current SHMI is at its lowest since 2016, but is elevated above the target level (113 / 1.13 vs 100 / 1.0). Improvement in this is linked to better collection of clinical data on co-morbidity in our population, leading to a more accurate reflection of the mortality risk. The trust has a large proportion of deaths that occur within 30 days of discharge (which forms part of SHMI) and a presumed large number of frailty syndrome patients (a condition which is not a diagnosis for statistical purposes and therefore not collected, but impacts clinically on mortality risk). Evaluation of and improvements in quality of care delivered in hospital, prior to admission and post-admission are ongoing and likely to impact SHMI as a result.

HSMR - Hospital Standardised Mortality Ratio (Rolling 12 month)



Again the HSMR is above target at 111.7. (target 100) The trusts current position is the lowest HSMR that we have on our report and shows a steady and stepwise decline. HSMR excludes those patients receiving palliative care, the trust has dramatically improved its recognition of patients receiving specialist palliative care input, and this has likely contributed to the improved HSMR position. The demographics of our population, the high risk conditions for mortality identified and the increasing GSF registrations only re-inforce that this is a key area for ongoing work to improve quality of care and patient experience, which will be reflected in mortality data.

HSMR - Hospital Standardised Mortality Ratio (Monthly)

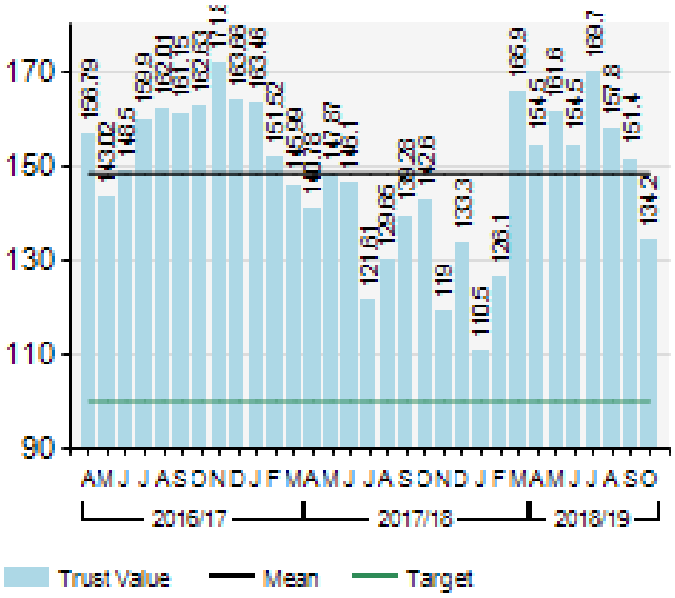


The in-month SMR of 72.6 is the lowest we have reported and is approaching the lower control limit. This is reported for the month of October, which in previous years has been a month with a high HSMR.

In month SMR is subject to a high degree of seasonal variation. Looking ahead to the winter months it is likely that this position will deteriorate due to the increased number of deaths recorded and the worsened (though still below 12 months average) crude mortality rate.

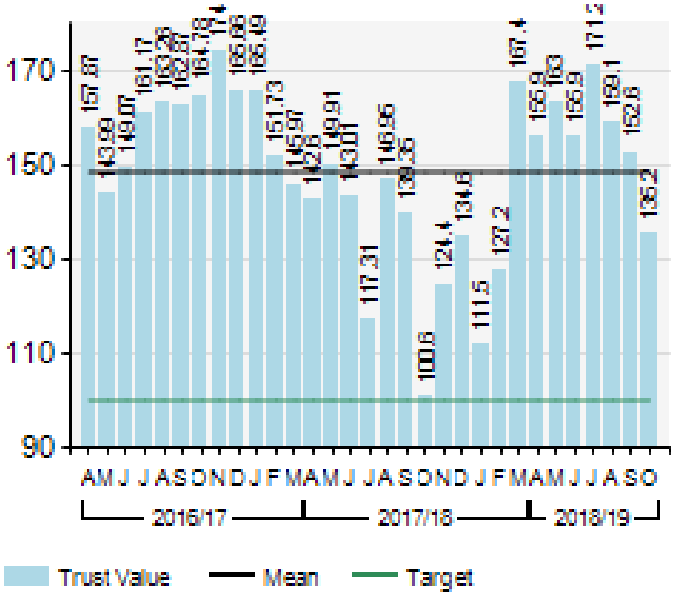
This is largely being driven by urgent care deaths (crude rate 41.3/1000 in the week and 52.2/1000 at the weekend from January data). That said the actual number of deaths in January 2019 is significantly less than January 2018, with the year as a whole recording less deaths in the 80-89 age bracket in particular to January 2019.

Local HSMR Bronchitis



Bronchitis and LRTI remains a diagnostic category of concern. It is likely that this represents either a mis-diagnosis or a mechanism of decompensation of frailty syndromes or significant chronic co-morbidity. A review of patients coded as Bronchitis or LRTI is required to evaluate this further.

Local HSMR Lower Respiratory Tract Infection



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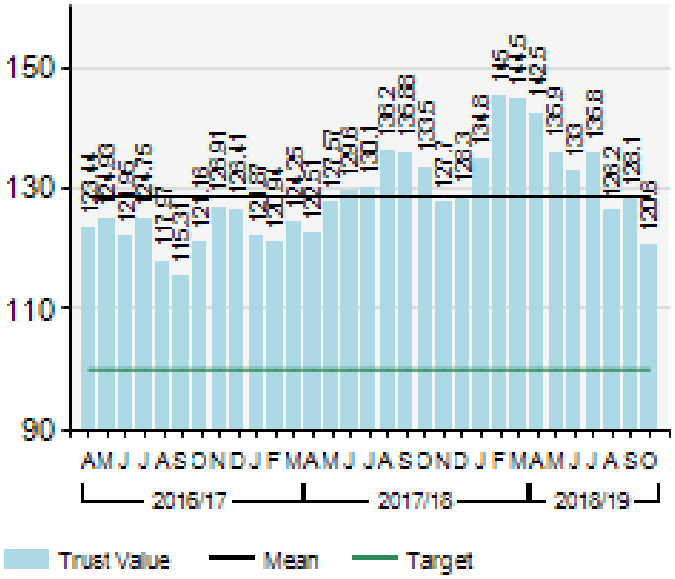
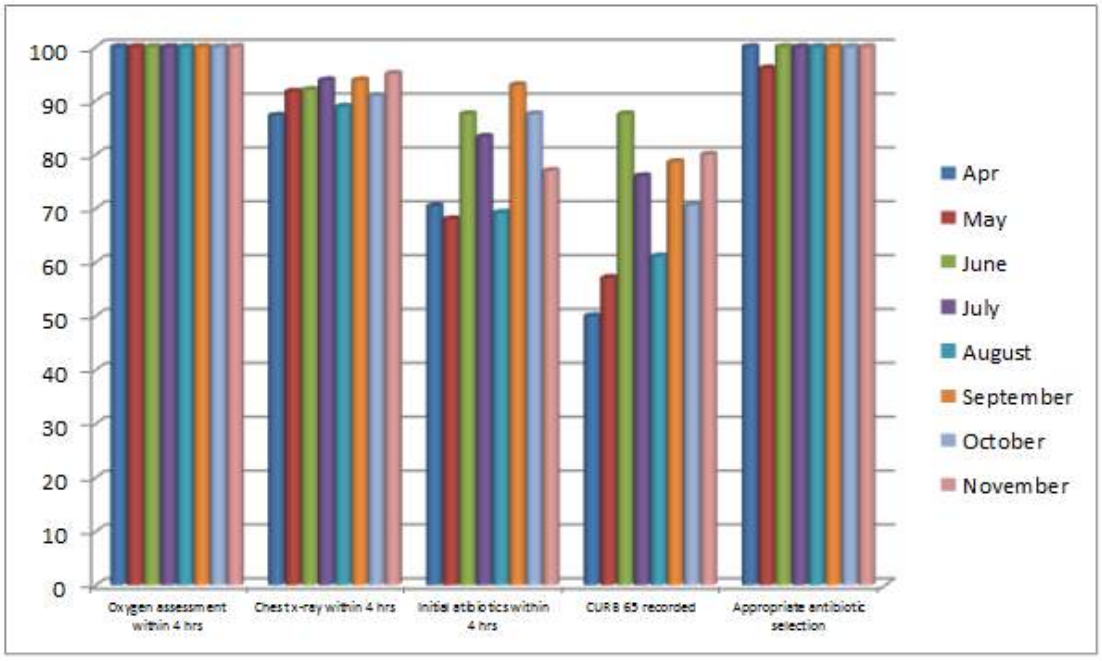
Local HSMR Pneumonia



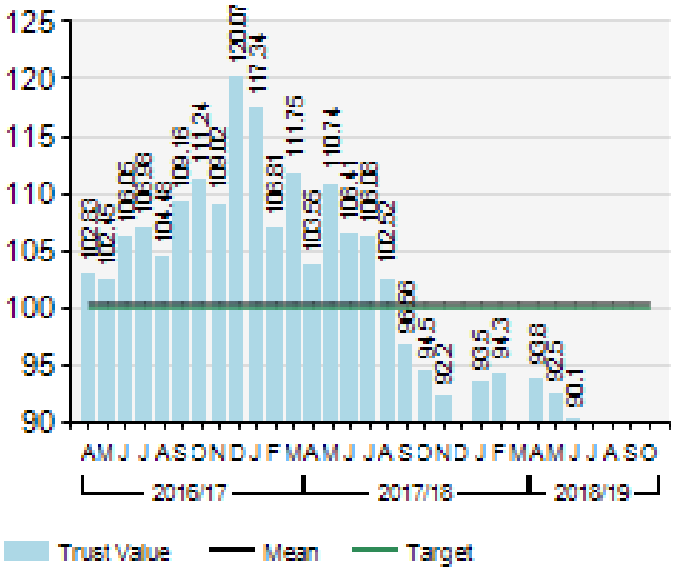
The trusts position on Pneumonia in October 2018 is that the SMR has reduced to under the trusts average for the previous three years. However, the condition remains the most concerning diagnostic grouping related to mortality. The causes of this are multi factorial including the demographics of our local population and their predisposition to respiratory disease. The trust has updated and produced guidance on investigation and medical management of pneumonia patients – mainly to improve diagnostic accuracy and access to diagnostics. Moving beyond this, work to prevent the development of pneumonia by reducing immobility, providing safe nutrition and hydration and improving patient flow through the system are key areas of development.

We are working with AQ on audits of pneumonia care and a new project on hospital acquired pneumonia to identify processes of care for improvement.

The table below demonstrates the most up to date process scores for the Advancing Quality Pneumonia data (November 2018. CURB 65 score on admission is showing improvement, work continues to improve the access to diagnostics within the earliest possible timeframe in order to allow early delivery of appropriate antimicrobials.

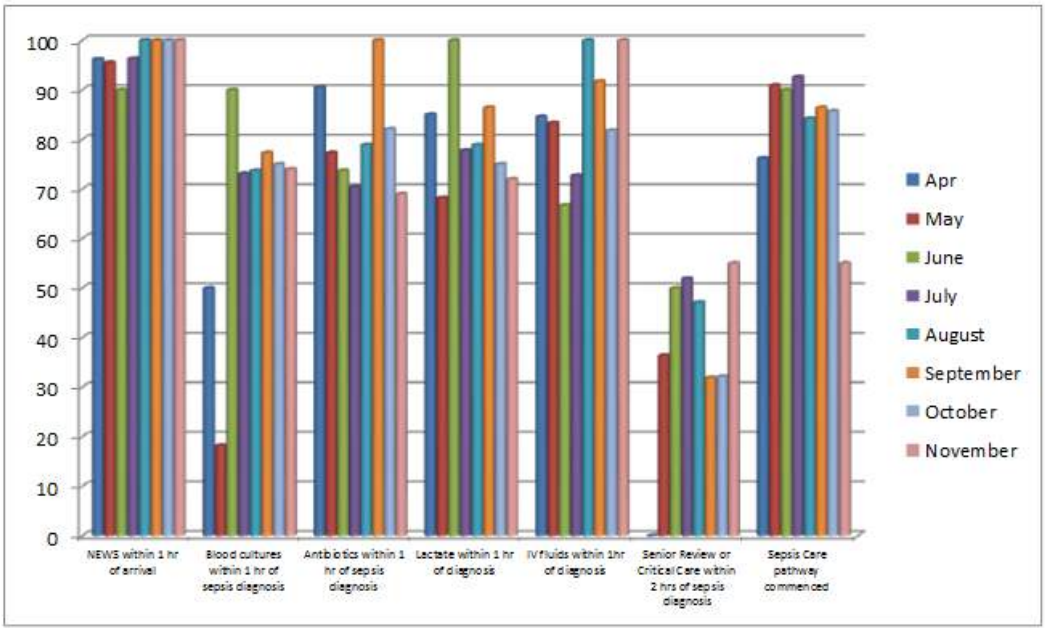


Local HSMR Septicemia

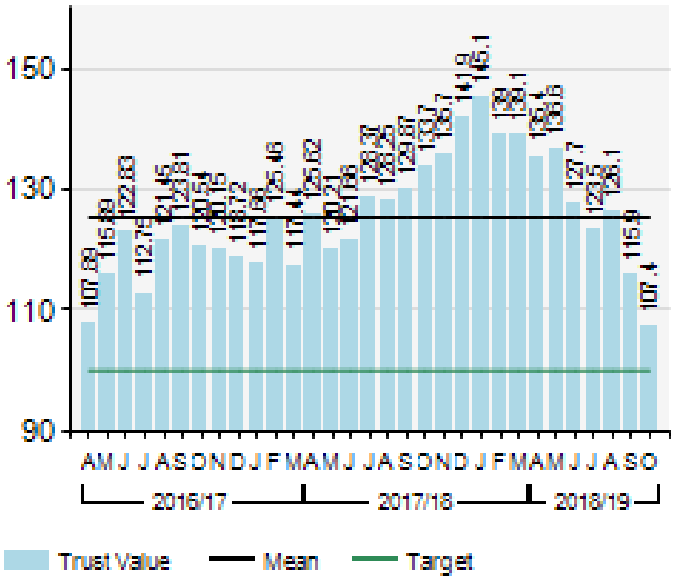


The SMR record for septicaemia remains historically improved. While encouraging, we have to remain mindful that sepsis can be underdiagnosed and therefore over-represented in other diagnostic groups such as pneumonia, LRTI, Bronchitis and UTI. This will be subject to ongoing periodic audit.
The diagnostic criteria for sepsis is now well recognized, consistent and embedded and forms part of teaching programs in all specialisms.

Regarding process of care the chart below describes AQ data up to November 2018. While the delivery of IV fluids has improved, as has the performance of a 2 hour senior review, there has been a deterioration in performance regarding antibiotics, lactate and blood cultures in the first hour. This likely represents a combination of system pressures and the work on patient flow to improve senior responsiveness at the front door. Improvements to the pathway to make it more user-friendly are to come on stream soon. Further evaluation of the mechanism of this audit to ensure reliability of the data is also being pursued. Performance in this area is continuously monitored and improved by clinical teams.



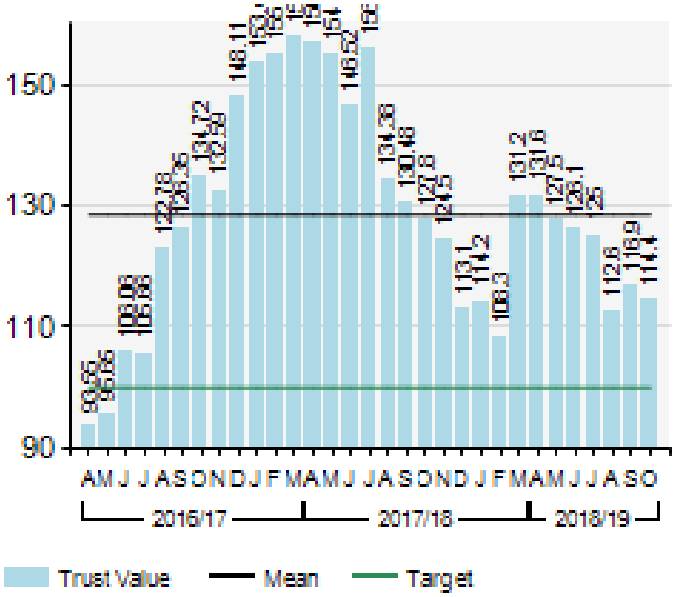
Local HSMR Stroke



The HSMR for the diagnostic category of stroke shows a continuous improvement, this is likely due to the better recording of co-morbidity and palliative care given the high risk population for debilitating and high mortality stroke.

Improvement work on assisted nutrition and prevention of aspiration pneumonia that is currently ongoing is likely to assist improvement further. As the stoke service has access to a dedicated specialist nursing service that are trained in the placement of nasogastric feeding devices they are likely to be benefitting from a robust and consistent approach to assisted feeding.

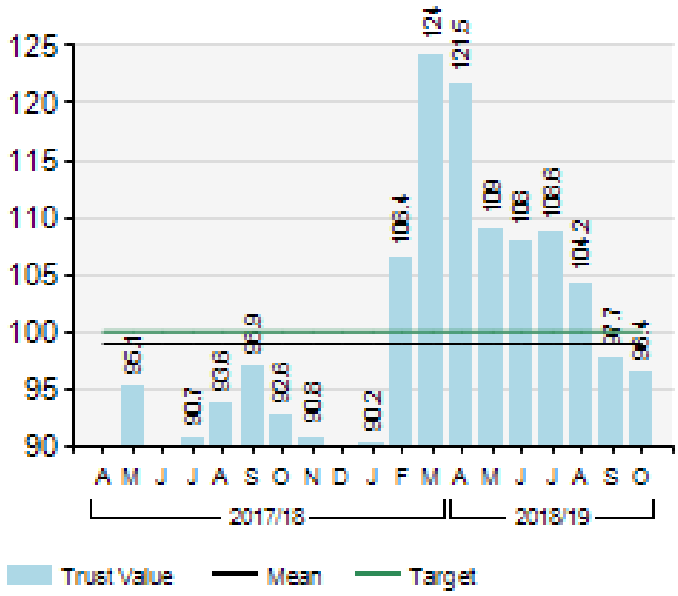
Local HSMR Urinary Tract Infection



In a similar way to LRTI and Bronchitis, UTI is a low risk medical problem that carries a low risk of death. Death due solely to a UTI is unlikely so therefore this elevation above the average mortality rate suggests decompensation of undocumented chronic significant co-morbidity, death on the background of a significant frailty syndrome or a missed diagnosis of sepsis secondary to urinary infection. The records will be evaluated to determine this in due course.

Work around reducing urinary infection by improving mobility, reducing deconditioning, and reducing unnecessary catheter usage are ongoing.

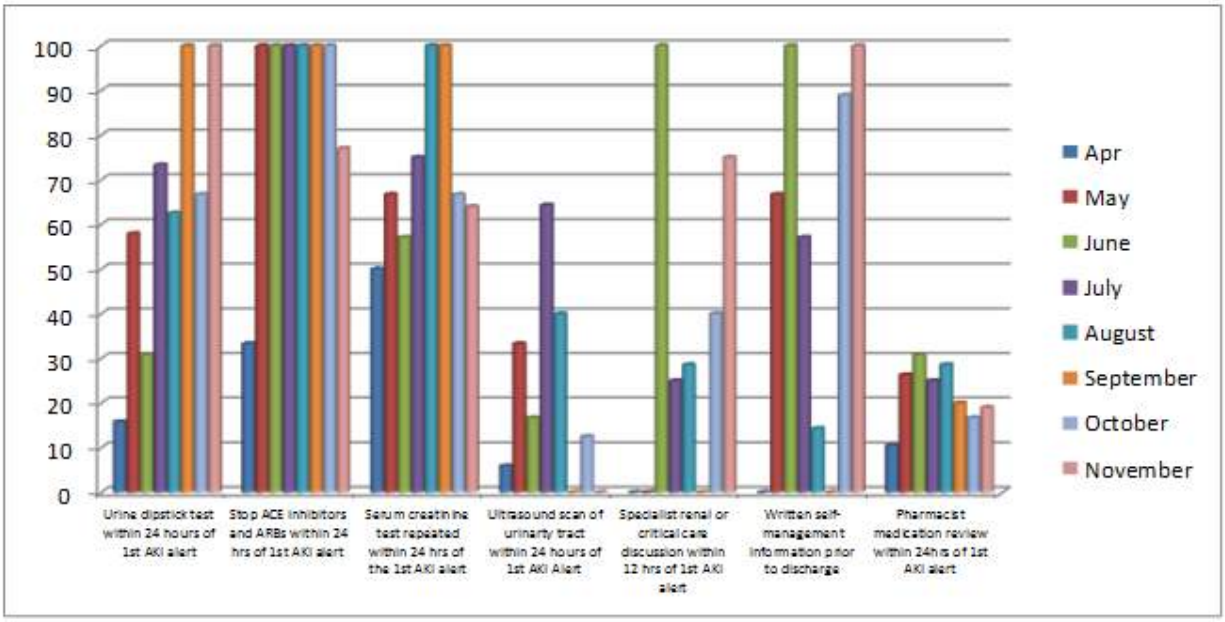
Local HSMR Acute Renal Failure



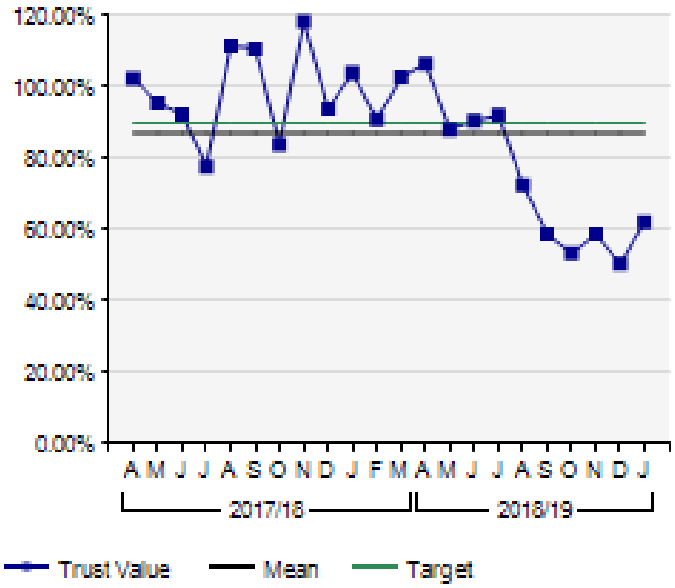
This report describes the second consecutive month that the SMR for renal failure has returned to within tolerance. Guidance on the appropriate management and referral processes for this condition are available and are becoming embedded. The work of the AKI steering group on improving process and

alerting of AKI to relevant staff is ongoing. Electronic alerting of AKI into the VitalPAC system is to be implemented following the launch of NEWS2 on the 26th of March.

Regarding process of care; data up to November 2018 demonstrates improved performance of urine dipstick on admission which is a key investigation in AKI. Areas of work, in common with other areas are the availability and responsiveness of diagnostics. Renal ultrasound within 24 hours of an AKI stage 3 is a key area that needs improvement. The upcoming alerting system should improve the timeliness of pharmacy review.



Mortality Screens – Percentage of Deaths Screened

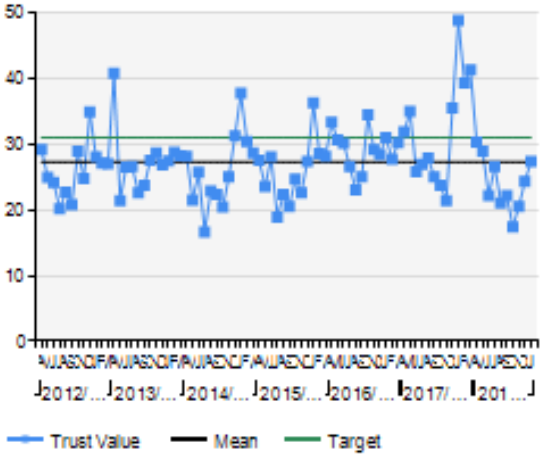


Communication has gone out via the February medical induction as to the importance and process of mortality screening. Prior to this the rate of screening has improved to over 60%. Re-enforcement of good practice from senior clinicians and the bereavement office will encourage further improvement. The

process of mortality screening has been added to the trust medical induction booklet for the August intake.

The cases being referred through for Structured Judgement Review, based on the results of reviews performed so far demonstrate that the process is identifying cases where there is scope for learning and improvement.

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



The crude mortality rate in this report as a trust is at the historical average for the reporting month of January. Crude rate is affected by seasonal variation and is not standardized for case mix or risk. The in-month raw number of deaths is also seasonally affected, this is higher than average for the year while the rate is lower, demonstrating the increase in demand.

This rate is mainly from urgent care, demonstrating the pressures within the system. Patients who died in January waited 50% longer (2.5 hours) in A&E than patient who survived. Deaths of ward outliers have remained below the yearly average.

Deaths within a day of admission have stabilized below the 15% average; these are being evaluated and will be presented at a subsequent Mortality Operational Group.

The average number of days to death post discharge has reduced dramatically to around a week, the length of stay has also reduced to 10 days in this group – further review is needed to ensure the care was appropriate in these cases.

2.0 Reducing Avoidable Mortality Project Update – March 2019

2.1 Conclusion of RAM Phase One

At the time of reporting, the 'RAM' project activity has been running for less than one year. Final BRAG rating has been provided ahead of the official end date of the project of 31st March 2019 at which point RAM Phase 2 will commence.

Final Report on Progress for RAM Phase 1

Work Stream	Overview of progress against scope	Deliverables	Benefits	Overall Completion %	Overall BRAG
1. Care Pathways	All activity scoped for this work stream has been completed despite the original timeline being unrealistic. Work will continue to drive quality improvement for care pathways under RAM Phase 2, 'Correct Pathways of Care', with particular focus on the management of pneumonia (as identified in the External Mortality Review).	1. New Sepsis, AKI and Pneumonia Pathways 2. Deteriorating Patient Trolleys on wards 3. AQ reporting on care pathway compliance 4. External Mortality Review (EMR) has accelerated learning from deaths activity and understanding of our management of pneumonia and stroke 5. External Mortality Action Plan created in collaboration with key stakeholders across Trust *Supporting projects have delivered: IV Fluid Therapy Drugs Charts, VitalPac 3.5 and 3.6 Upgrades to support upcoming NEWS2 and AKI modules, the opening of the Surgical Assessment Unit*	1. Continuous improvement in the management of Sepsis, AKI and Pneumonia to reduce the likelihood of mortality in our patients. 2. A toolkit based on best practice and national guidelines to support the staff in the treatment of the deteriorating patient. 3. Clear action plan to reduce deterioration in patients with pneumonia	**100%**	**B**
2. Effective Escalation	The Effective Escalation Pathway has harnessed technology to deliver enhanced reporting to the Safety Hub from the Wards. Key meetings are being run through the Hub which is home to the Resus and Critical Care Outreach Teams. A subgroup is on target to deliver a prototype Board Round data capture tool which will feed into a Clinical Reporting Module in the Safety Hub (this April, ahead of the May 2019 deadline). Further development will continue as an 'IT and Equipment' cross cutting enabler under RAM2. *This work stream is BRAG rated green because there is*	1. Purpose built Safety Hub for Bed Management and Discharge Planning Meetings supported by bespoke reporting. 2. Installation of the Critical Care Outreach Team and Resus Team 3. Pathways for effective escalation are being delivered on the back of Board Round Capture / Clinical Reporting Module, the introduction of NEWS2 and the revised Track and Trigger Policy.	1. Improved handover and cross team working. 2. Improved communications for the most appropriate management of patients. 3. Clear pathways for escalation of the deteriorating patient. 4. Standardisation of Ward Rounds and data capture to: ensure documented senior input / junior doctor support, ensure capture of essential information, save time, drive best practice & remove unwarranted variation	**90%**	**G**
3. Learning Culture	The successful roll out of the SJR method has embedded learning from death activity which has been further expedited by the EMR. Quarterly Learning from Death reporting to the Quality & Safety Committee and the Trust Public Board. *This workstream has a BRAG status of green because work is still outstanding to cascade lessons learned throughout the Trust through meetings and technology.*	1. Roll out of the Structured Judgement Review (SJR) 2. Development and roll out of in-house screening tool to review all deaths & support the SJR process 3. Triangulation of serious incidents, SJR and mortality data through the Mortality Operational Group.	1. Clarity of issues and cases where we could have provided better care as learnings 2. Assurance that we are triangulating all information available to us relating the patient safety for resolution and learning 3. Assurance that we are following Royal College of Physicians process to review deaths	**90%**	**G**

Work Stream	Overview of progress against scope	Deliverables	Benefits	Overall Completion %	Overall BRAG
4. Future Care Planning	All work which was scoped under 'Future Care Planning' has been undertaken; further embedding is required in RAM 2 to deliver on-going training requirements. The ongoing challenge is to embed a cultural change to: drive the right conversations with patients and their families / carers, to ensure that patients are supported with the most appropriate care plans and that anticipatory clinical management planning is instigated where required. This work stream has a green BRAG rating because key deliverables will require a much longer timeframe to realistically deliever than was originally administratively scoped. Future Care Planning is one of the four main work streams of RAM 2 which will be measured against realistic timeframes and a suite of KPIs to drive activity.	1. The Anticipatory Clinical Management Planning model was introduced on the Frail and Elderly Short Stay Unit in 2018 by the Trust's Lead Geriatrician who was designing a training course. Changes in personnel mean that a new champion is now required to drive training and cultural buy-in. 2. 11 training days of training for frontline staff in Advanced Care Planning (run by the North West Learning Collaborative at Queenscourt Hospice) ran over the second half of 2018 attended by 55 hospital, 14 community staff, 26 primary care staff and 102 care home staff. 3. Strong relations with North West Ambulance Service Community Paramedics attending the weekly Specialist Palliative Care Service Multi Disciplinary Team Meetings. 4. Change of ambulance transfers from category 4 to category 3 has made a difference in reducing delays in Rapid End of Life Transfers 5. The Transform Palliative Care Team are working with the Critical Care Outreach Team providing in-reach into wards.	1. Clearer long term care management for patients with long term conditions which can prevent uneccessary re-admissions 2. Confidence and skills for staff to have the right conversations with patients/ families/ carers. 3. Transfers for patients to die at home if this is their wish	**80%**	**G**
5. Information	Mortality Reporting has undergone a number of revisions over the last year, greatly improving the quality of data and the insights available to deliver change. Indepth coding reviews have increased the accuracy of data for reporting and a more robust platform for the analysis of information to drive improvement.	1. Mortality reporting of: clear trajectories of national and local mortality ratios, factual and anecdotal evidence of issues and progress against project activity. 2. Meetings with data suppliers; Dr Foster, The Advancing Quality Alliance and Model Hospital to discuss the most appropriate methods and focuses for mortality reporting in line with our local population profile. 3. Investment in coding reviews has delivered more accurate and complete data as well as substantial financial savings. 4. Coding reviews have revealed issues for example with recording and documentation of diagnosis (and revision of diagnosis) particularly for LRTI/ Pneumonia / Acute Bronchitis which has revealed where quality improvement activity is required.	1. More realiable, accurate and complete data. 2. Bespoke reporting pertinent to our local population profile to be more responsive to population needs. 3. Identification of improvements required in recording and documentation to be delivered in RAM2.	**100%**	**B**
6. Workforce	Essential Executive backing and guidance from our NHSI Improvement Director secured the enhancement of the Critical Care Outreach Team to become a 24/7 service. The team will ensure that there is a consistent support service to the wards in the cases of escalation of the deteriorating patient.	1. The establishment of an enhanced Critical Care Outreach Team to provide 24/7 cover. 2. Team provide training on wards for example in the roll out of the revised care pathways. 3. Team to support the full utilisation of safe staffing tools.	1. Safer care for patients who deteriorate outside of daytime hours during the week based on 24/7 support from the CCOT 2. Safer care for patients attributable to highly trained staff in the use of safe staffing tools.	**100%**	**B**

2.2 Reducing Avoidable Mortality - Phase Two

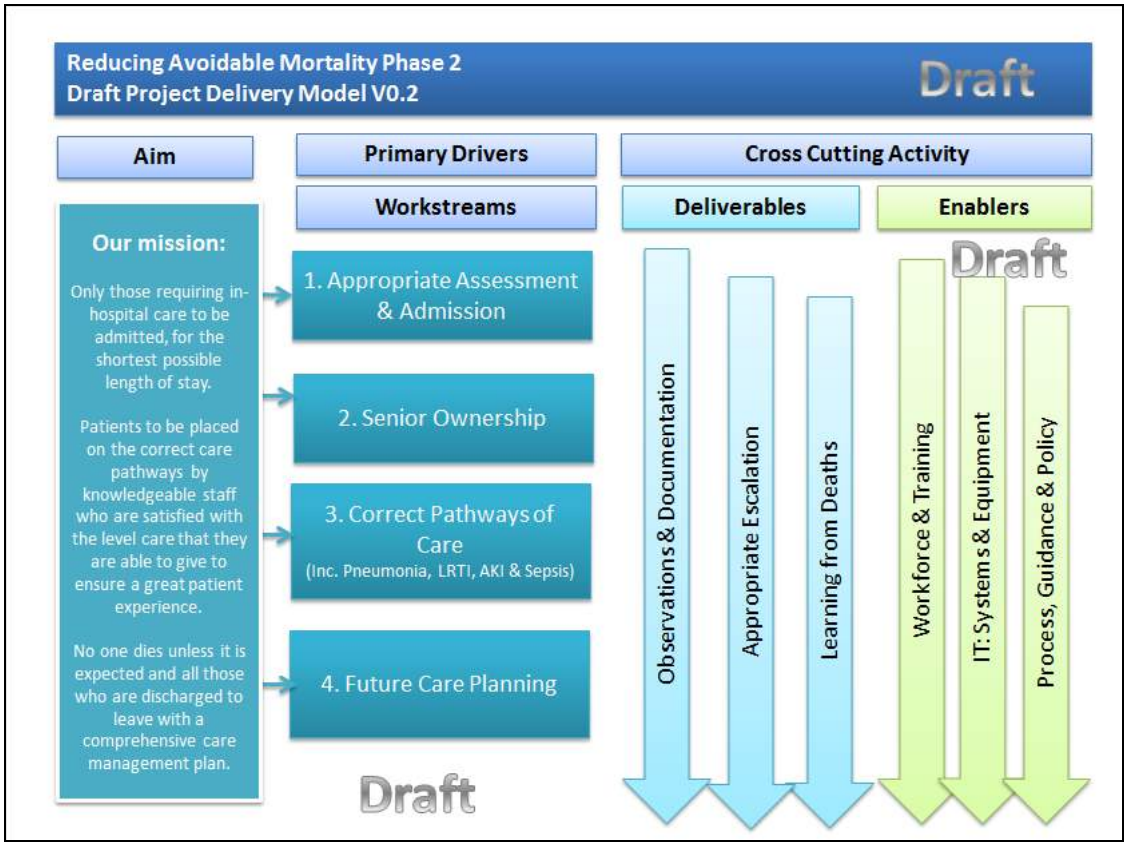
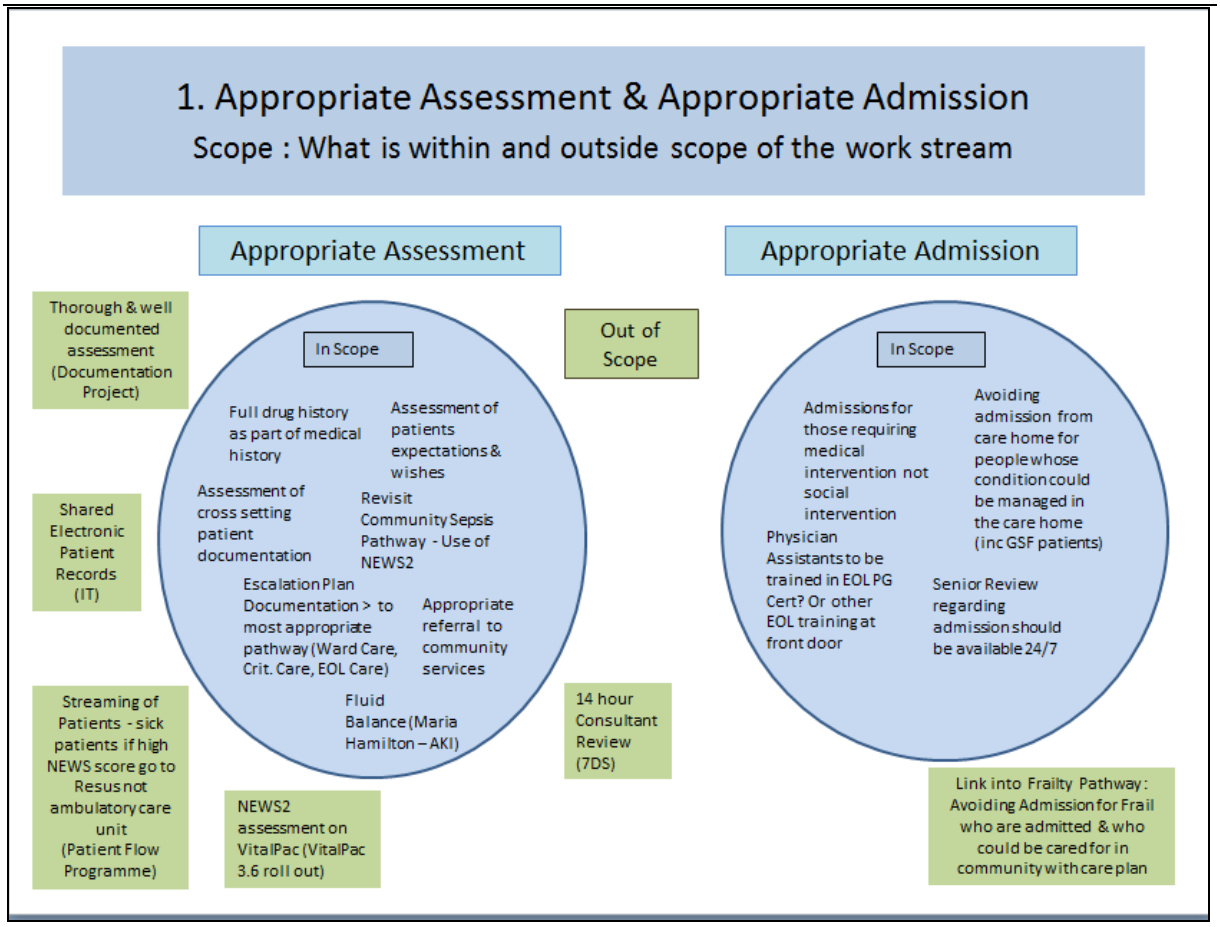
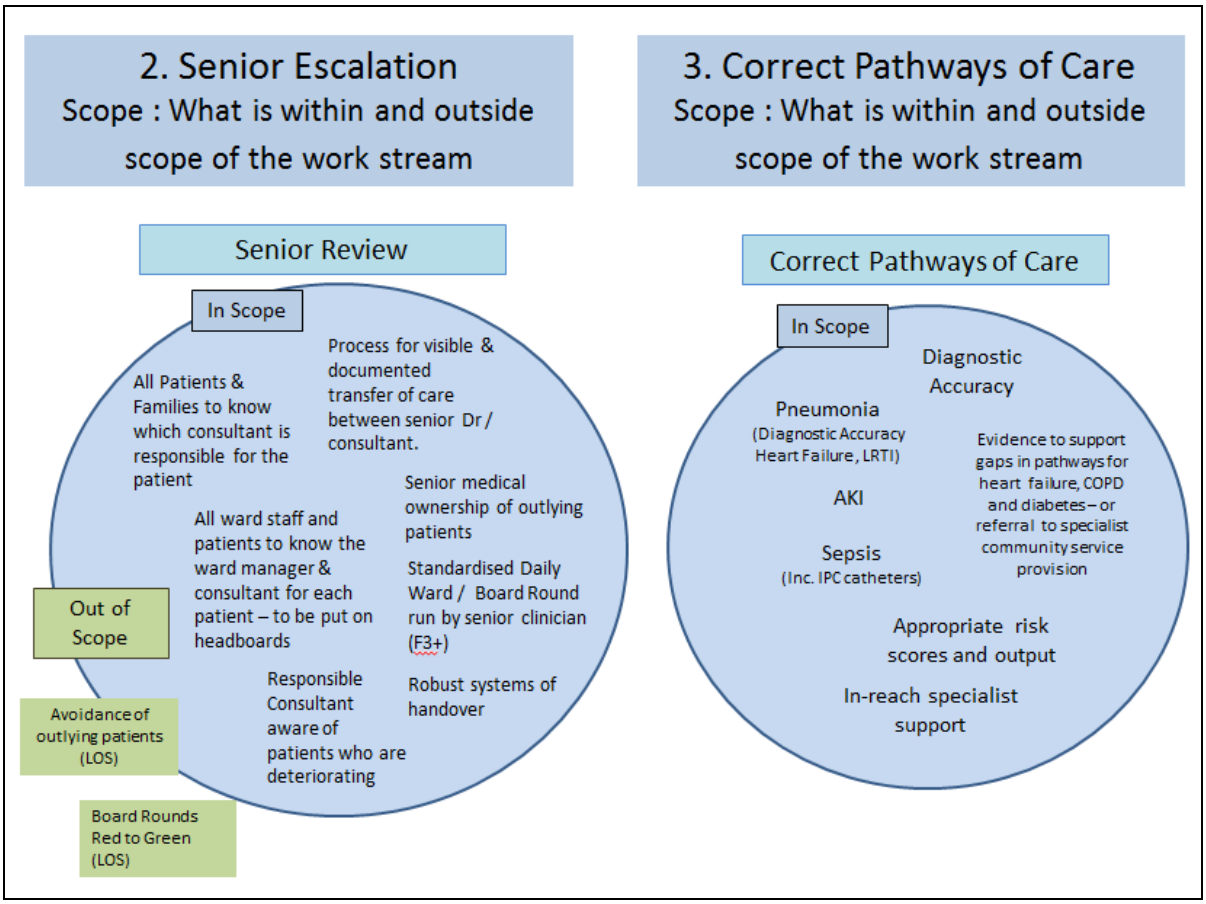


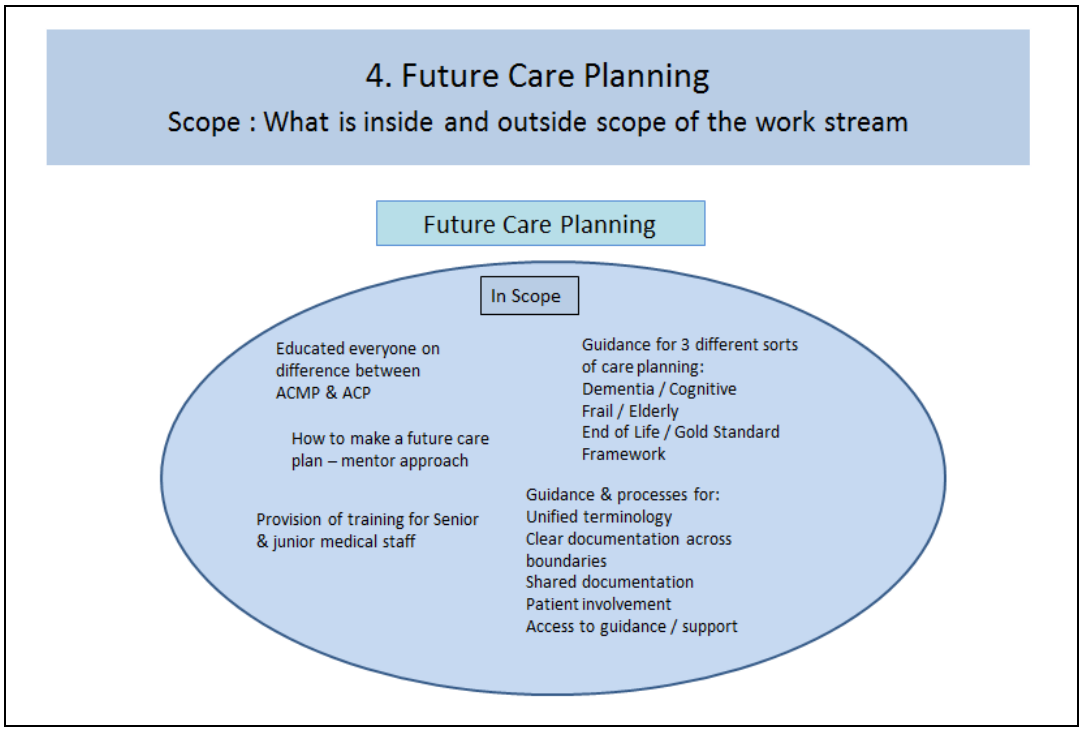
Diagram 3: Reducing Mortality Phase 2 Draft Project Delivery Model V0.2

A second scoping session was held on 11th March 2019 to confirm the detail of scope for the four newly agreed work streams. Work stream owners, timeframes, KPIs and specific required activity are currently being confirmed, all of which will be formalised through the Trust's Programme Office framework.

While there continues to be support for RAM 2 to be delivered through two 'model wards' (one surgical and one medical) there is ongoing discussion as to which are currently most appropriate to accommodate and deliver project activity. Executive sign is off will be sought before activity commences.


1. Appropriate Assessment & Appropriate Admission
Scope : What is within and outside scope of the work stream
Appropriate Assessment
Appropriate Admission
Thorough & well documented assessment (Documentation Project)
In Scope
Full drug history as part of medical history
Assessment of patients expectations & wishes
Assessment of cross setting patient documentation
Revisit Community Sepsis Pathway - Use of NEWS2
Escalation Plan Documentation > to most appropriate pathway (Ward Care, Crit. Care, EOL Care)
Appropriate referral to community services
Fluid Balance (Maria Hamilton – AKI)
Out of Scope
Shared Electronic Patient Records (IT)
Streaming of Patients - sick patients if high NEWS score go to Resus not ambulatory care unit (Patient Flow Programme)
NEWS2 assessment on VitalPac (VitalPac 3.6 roll out)
14 hour Consultant Review (7DS)
In Scope
Admissions for those requiring medical intervention not social intervention
Avoiding admission from care home for people whose condition could be managed in the care home (inc GSF patients)
Physician Assistants to be trained in EOL PG Cert? Or other EOL training at front door
Senior Review regarding admission should be available 24/7
Link into Frailty Pathway: Avoiding Admission for Frail who are admitted & who could be cared for in community with care plan

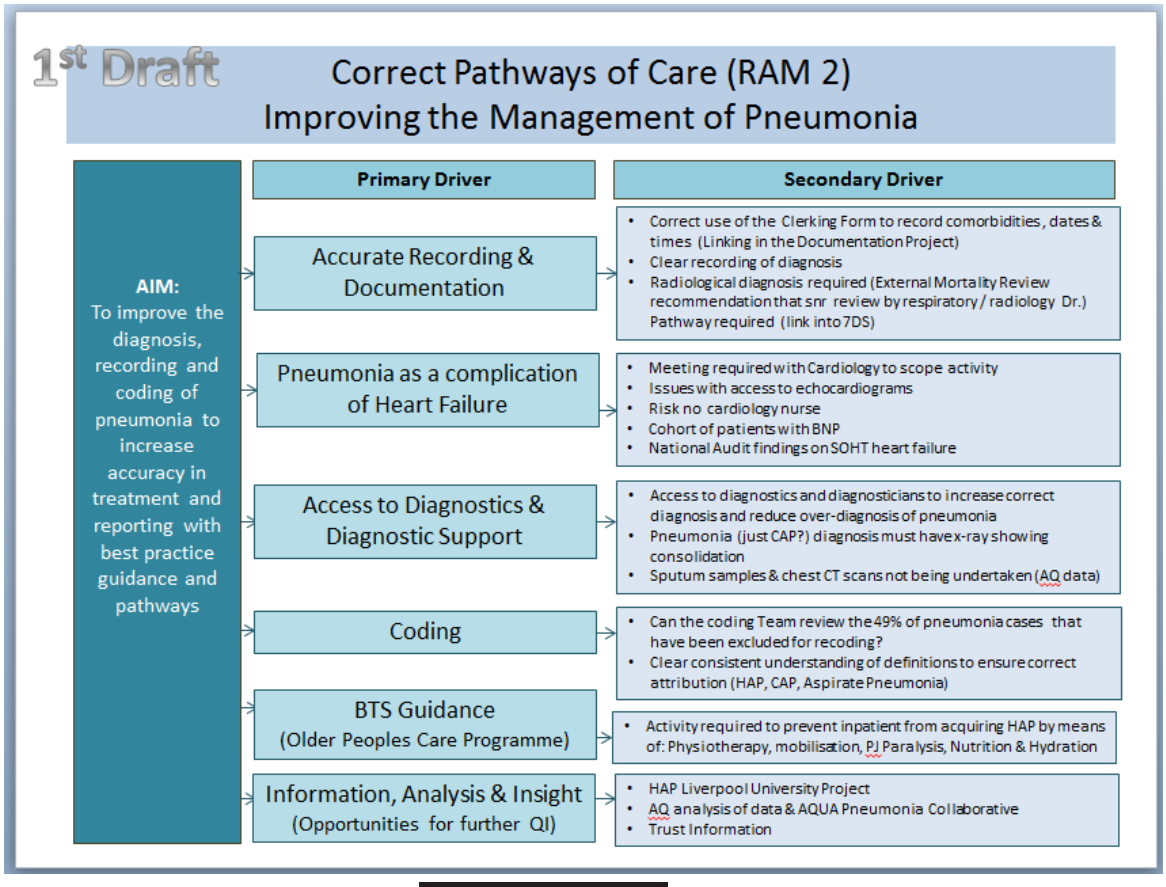

2. Senior Escalation
Scope : What is within and outside scope of the work stream
Senior Review
In Scope
All Patients & Families to know which consultant is responsible for the patient
Process for visible & documented transfer of care between senior Dr / consultant.
Senior medical ownership of outlying patients
All ward staff and patients to know the ward manager & consultant for each patient – to be put on headboards
Standardised Daily Ward / Board Round run by senior clinician (F3+)
Responsible Consultant aware of patients who are deteriorating
Robust systems of handover
Out of Scope
Avoidance of outlying patients (LOS)
Board Rounds Red to Green (LOS)
3. Correct Pathways of Care
Scope : What is within and outside scope of the work stream
Correct Pathways of Care
In Scope
Diagnostic Accuracy
Pneumonia (Diagnostic Accuracy Heart Failure, LRTI)
AKI
Sepsis (Inc. IPC catheters)
Evidence to support gaps in pathways for heart failure, COPD and diabetes – or referral to specialist community service provision
Appropriate risk scores and output
In-reach specialist support



2.3 RAM Activity Currently Underway

Respiratory Failure QI Workshop

The Respiratory Failure QI Workshop took place on 21st March with representation from AQUA, Trust Clinicians, Clinical Audit and Programme Office. The secondary drivers identified, will form the basis of quality improvement activity to support Pneumonia care under the Correct Pathways of Care work stream in RAM 2. An additional session is still required with cardiac specialists to discuss the diagnosis of pneumonia as a complication of heart failure.



Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 25 March 2019
Lead:	Jim Birrell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Concern was expressed at the increased cost of agency staff, even allowing for the extra costs associated with the opening of escalation beds. A report reviewing the current situation and outlining planned action will be presented to the next FP&I meeting.
- The recently received Ernst & Young Costing Assurance Programme report concluded with a "no assurance " classification. An action plan is underway that should ensure that the Trust's 2018/19 reference costs are compliant with the recommended approach.
- 2019/20 contracts with commissioners were due for completion by March 21st but this did not happen. Discussions are ongoing to find a resolution.

ADVISE

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

- A review of storage areas on the Southport Hospital site has highlighted a need for additional space. Early indications suggest that the investment required, which was supported in principle by the Committee, will be in the region of £600k.
- The Committee pack was again very large so it was asked that renewed efforts be made to ensure that reports are an appropriate length.
- Whilst noting improved performance in A&E, the Committee requested further information on the mix of major and minor patients attending the department.
- The Trust remains on course to outturn at our planned deficit of £28.8m although discussions continue on forecast outturn contract values.
- To date £5.8m of 2019/20 CIP schemes have been identified, with a number of other opportunities being explored. The Committee were reasonably assured on the progress to date, albeit conscious that delivering the plans will be taken forward without the oversight of a Turnaround Director.

ASSURE

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

- The Model Hospital Team is providing the Trust with significant support in addressing potential key impact areas. However, it was noted that this will be dependent on the organisation responding positively to requests for information, consideration of new approaches, etc.
- Length of stay; information provided from the Model Hospital suggests that the Trust has a lower average length of stay than its peer group for both elective and non-elective elderly patients.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 21 March 2019
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

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 previously been escalated and added to the risk register. Raised as an alert as this impacts on CQC and Well Led. The Director of HR and OD has agreed to liaise with the Company Secretary.

Friends and Family Test (FFT) Completion
The Trust FFT performance in January 2019 has declined compared to the previous two months – the figure decreased by 3.19% for the month of January to 89.09%. FFT response rates have also decreased by 1.84% to 5.09% for January 2019. HR are proactively undertaking walkabouts around the Trust with iPads for staff to complete.

Sickness Absence
Whilst sickness absence within the Trust has reduced to 5.58%, it continues to be a concern as the rate is still higher than the national trend.

Safe Staffing Red Flag Events
There has been an increase in the number of 'red flag events' recorded in February, although no patient harm has been caused due to insufficient staffing levels. Raised level of events could be due to a decrease in staff available or potentially due to raised awareness of red flag event criteria.

NHSP
NHSP performance does not currently meet the KPIs detailed in the contract; 58% of shifts released through the roster were filled by Bank workers, 18% were filled by agency workers and 24% were unfilled in January 2019. KPIs require 67% bank fill and 10% agency fill at this stage of the contract. The NHSP contract performance however is being closely monitored.

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)

PDR
There are currently only 27% of employees who have not had a PDR remaining. A focus review of PDR's will be happening in CBU Performance Review Boards.

Agency Staff
There has been a significant increase in agency staff cost in January 2019. The Executives and Head of Resourcing will be meeting with NHSI at the end of March to discuss improving agency support for Trusts. Leads within the Trust are collaborating with other Trusts in the region to reduce agency spending.

ASSURE

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

Supporting Attendance
70% of managers within the Trust have undertaken the Supporting Attendance policy training.

TUPE Transfer
The TUPE transfer is making good progress. Updates on the transfer are being given to the Executive team on a weekly basis. Communications on the transfer have been relayed to staff affected. The transfer is on track for 1st April 2019.

Mandatory Training
The Trust target of 85% for Core Mandatory Training was surpassed in February 2019 and reached 85.65%. However mandatory training for medics remains an issue, this is alerted through risk committee.

Sickness Absence Health and Wellbeing Action Plan
The top four areas which have been identified to have the highest levels of sickness absence have been identified. The Assistant Director of Health and Wellbeing has met with two areas and due to meet with the others at the end of March. Action plans have been developed with many actions and teams are working hard to decrease levels. Lots of good practice is going on and we need to celebrate and focus on communicating these successes.

Band 1 – Band 2 Transition
Letters to staff affected are being sent out on 21st March 2019 in readiness for transition on 1st April 2019. Meetings have been offered to the staff affected if they require one.

Revalidation on Track
Professional registration is monitored on a monthly basis and processes are in place to ensure that relevant staff groups renew their required registration to be able to continue to practice.

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

3 April 2019

Agenda Item	TB072/19c	Report Title	Integrated Performance Report
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Anita Davenport, Interim Performance Manager		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

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

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

The report contained the following components:

- Performance Dashboard
- Executive Assurance
- KPI Graphs and Narrative

Recommendation:

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

To continue to apprise the Board that controls and assurances are in place

Previously Presented at:

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

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NHS Trust

Integrated Performance Report

Trust Board March 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - February 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	3	11	3			
Never Events	0	0	2	0			
VTE Prophylaxis Assessments	95%	96.7%		146			
Harm Free (Safety Thermometer)	94.99%	98%	97.4%	8			
Falls - Moderate/Severe/Death	1	2	25	2			
Patient Safety Incidents - Low, Near Miss or No Harm		711	6621	711			
Safe Staffing	90%	91.3%		N/A			
Fractured Neck of Femur	90%	75%	70.4%	18			

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%	42.3%	75.1%	15			
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	51	170	51			
Written Complaints	44	23	256	23			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	95.9%		23			

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%	85.9%	88.6%	1365			
Accident & Emergency - 12+ Hour trolley waits	1	27	57	27			
Ambulance Handovers <=15 Mins	99%	49.6%	44.6%	689			
Diagnostic waits	1.01%	1.3%		38			
14 day GP referral to Outpatients	93%	93.2%	94.6%	52			
31 day treatment	96%	98.4%	98.3%	1			
31 day treatment (Surgery)	94%	100%	97.2%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	84.1%	77.7%	7			
62 day GP referral to treatment	85%	79.8%	78.7%	9			
Referral to treatment: on-going	92%	94.5%	94.5%	559			
Bed Occupancy - SDGH	93%	93.1%		N/A			
Bed Occupancy - ODGH		37.7%		N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	100%	84.8%	0			
Duty of Candour - Evidence of Letter	100%	100%	71.7%	0			
I&E surplus or deficit/total revenue	-1%	-17.6%	-19%	N/A			
Liquidity	-23	-60	-60	N/A			
Distance from Control Total	0%	0.4%	-7.9%	N/A			
Capital Service Capacity	-2.423	-2.658	-3.559	N/A			
% Agency Staff (cost)	5.6%	9%		N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	53%	-5.6%	N/A			
Staff Turnover	0.76%	0.7%	6.8%	N/A			
Staff Turnover (Rolling)		11.2%		N/A			
Vacancy Rate - Medical		3.8%	3.8%	N/A			
Vacancy Rate - Nursing		9%	9%	N/A			
Sickness Rate	3.9%	5.8%	5.8%	N/A			
Personal Development Review	85%	76%	76%	N/A			
Mandatory Training	85%	85.7%	85.7%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.1		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		59		59			
DTOC - Number of Beds lost per month		4		3.57			
Length Of Stay		6.6		N/A			
New:Follow Up	2.64	2.6	2.4	N/A			
DNA (Did Not Attend) rate	8%	6.9%	7.2%	1540			
Cancelled Ops	0.61%	0.7%	0.3%	14			
Theatre Utilisation - SDGH	90%	41.4%	50.8%	N/A			
Theatre Utilisation - ODGH	90%	52.6%	60.6%	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

AQuA will lead a discussion on next steps at the 3 April 2019 Board
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
As part of the response to the Well Led Review we will agree and roll out a programme focusing on High Performing Teams

Board Governance

A new BAF model based on new and refreshed strategic objectives and principal risks will be presented to the 3 April 2019 Board for approval
Following this a quarterly review of the Board Assurance Framework takes place. Corporate Risk Registers will be reviewed monthly at the board and assurance committees

[In January and February 2019, 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 terms of reference for the statutory and assurance committees have been reviewed along with annual business cycles and the 3 April 2019 Board will be asked to approve them.
The Trust's statutory instruments are being reviewed as per good practice leading into 2019/20
Reports to the Board have been improved and the agendas revised to enable better communication flow and decision-making.
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; the next meeting is scheduled for 27 March 2019

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 commenced monthly IPC meeting with Matrons in March
Roll-out of MCA & DoLs pathway documentation continues
NEWS2 training programme in progress 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 continues 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. Approval paper to Trust Board in March 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 commenced in February 2019
Draft Quality Care indicators (QCI) developed and tested in March 2019.

Operational Overview:
Safe Staffing is compliant with national average and improved slightly in February 2019 (91.34%).
Performance in Harm Free Care (97.99%)
VTE - 96.7%

Assured/Most Improved

Duty of Candour again reporting 100% in February for documentation of the discussion and letter.

Not Assured/Most Deteriorated

Six incidents were referred to StEISS in February.

One grade 3 patient pressure ulcers have been reported in February, relating to a plaster cast. This was discussed at SIRG

Delivering single sex accommodation breaches have increased to 51 pt. for February 2019, this was due to waits for beds from critical care environments

There have been three C. Diff. infections reported in February 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 in February being graded as moderate or above harm, both have been discussed at SIRG

Friends & Family Test (FFT) response rate continues to be low however the likely to recommend increased to over 96% in February

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 successive fall, down to 111.7 for October 2018.
The SHMI is down to 113.2 for September 2018
Hospital deaths increased Nov-January in line with increased activity, and crude death rates since April 2018 remain below target.
Pneumonia pathway to improve quality of care has been rolled out.
Structured Judgement reviews methodology for Learning from deaths is now being used across CBUs
External Mortality was presented the Public Board on the 6th February 2019
Root cause analysis finished and shared with families and CCG
Work streams under the Reducing Avoidable Mortality project are being progressed.
Critical care outreach team has been appointed to and will go operational 24/7 in April.

Assured/Most Improved

High SHMI and HSMR remains a risk for the trust. Action plans are in place to improve care and reduce SHMI & HSMR . The actions are being monitored at the board level via the Quality Safety Committee and monthly Reducing Avoidable Mortality report to the board.
A full report on Mortality is presented to the board monthly by the Medical Director
The reducing mortality action plan has been reviewed and organized across three principal domains for improvement over the coming year.

Mortality for respiratory diseases continues to improve.

Not Assured/Most Deteriorated

Mortality screening requires improvement.
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 February was 85.9%, February 2018 it was 80.9%.
- This is mainly due to performance at Southport which has improved in the year from 56.6% to 69.5%, despite an increase in attendances of 553 patients in the month.
- This is the sixth consecutive month that performance has been better than last year and March is so far continuing this trend despite further increases in demand as we emerge from the winter period.
- February unfortunately failed to meet the trajectory target agreed with NHSI but only by 0.9%.
- The Trust was ranked 43rd nationally out of 131 acute Trusts and ranked 2nd best performance (out of 10 acute Trusts) in Cheshire & Mersey

Ambulance Handover Times

- The Trust had 56 ambulance handovers greater than 1 hour in February 2019. In February 2018 this was 107 – an improvement of 47%.
- 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

- February 18-week performance was 94.5% which is a slight drop from the January position but is still well above the 92% target.
- The ongoing waiting list is 10,830 – with a target to reduce back down to 9,000 by the end of March 2019 although this looks very unlikely to happen.
- There are 3 patients waiting over 40 weeks, the number of 30+ week waiters has grown marginally, currently 76, but this was planned to help 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 6.49 days in February, with patients on assessment wards staying an average of 8 hours. We continue to see small improvements in length of stay despite the continuing winter pressures 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 February has 16% fewer stranded patients and 33% fewer super stranded patients than February last year

Diagnostics

- Performance for February against the 6-week-wait target was 1.26%, which, whilst still above target is significantly improved on the January position.
- Last year in February 2018 diagnostic performance was worse at 1.95%.

Not Assured/Most Deteriorated

Cancer 62 Day

- Performance for January was below the 85% target at 79.8% but is an improvement from the January position and is also better than the February 2018 position of 75.9%.
- 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

- As a result of the reduction in outpatients activity in January and medical cover escalation Ward 1 during February the number of overdue follow up patients has grown to just over 2200 at the end of February.
- In February 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.

NHS
Southport and Ormskirk Hospital
NHS Trust

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 rigour, grip and control into everyday use of Trust resources to ensure that the Trust meets its 2018/19 plan and reduces deficit in future years.

Month 11

Month 11 financial performance balanced to plan resulting in the YTD adverse variance remaining at £0.4 million. Expenditure levels similar to January excluding non-recurrent issues and once again reflect the higher costs associated with staffing escalation beds. A revised monthly I&E trajectory was agreed with NHSI and this was achieved in February. There are a number of risks that will impact on whether the Trust will deliver the planned deficit of £28.8 million as follows:

- 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. This issue has not been fully accepted by commissioners.
- There is a risk to income of £3.8 million for these two issues.
- Non recurrent assistance of £2 million from NHSE reduces this risk to £1.8 million. Discussions are ongoing regarding the remaining risk and a verbal update will be provided to the Committee.

Assured/Most Improved

- February monthly deficit was in line with forecast discussed with NHSI.
- Elective income balanced to plan in month for second consecutive month.
- Clinical income continues to over perform across all points of delivery (POD) with the exception of electives
- 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 increased again in February.
- Both CDU and Non elective income and activity subject to CCG contract challenge.
- No assurance that the £1.8 shortfall in contract income will be resolved which threatens the £28.8 million deficit forecast.
- CIP forecast year end gap of £0.6 million not yet resolved and a further £439,000 of schemes RAG rated red.

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

Core Mandatory Training

Core mandatory training rates continue to steadily increase and improve each month. In February the overall Trust rate was 85.65%, this is the first time that the Trust has achieved the 85% target for core mandatory training since early 2018. 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, the core mandatory training action plan will be discussed on a quarterly basis at the Risk and Compliance Committee. An MIAA audit undertaken in 2018 provided 'significant assurance' around the Training Department's management of mandatory training processes.

Reducing Agency Spend

The Trust escalation position over winter led to an increased requirement for temporary staffing however reductions in medical temporary staffing spend were achieved in month in February. Temporary staffing requirements within Nursing & Midwifery continue to be monitored on a daily basis. Off framework utilisation through Thornbury Nursing Services remained high during February 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 (within month a number of long term agency workers have transferred successfully to bank contracts and reduction in block booking rates have been achieved). AHP bank recruitment campaigns are underway to support this staffing group.

Health and Wellbeing

Hotspot focused support for absence areas has been provided and identified best practice already being implemented; a communication plan to reinforce and share this best practice will be developed during April.

With the support of NHSI, Representatives from the Trust attended the National Health and Wellbeing event on 5th and 6th March, this was an informative event that will help to shape and develop the Health & Wellbeing Strategy. It will help to focus resources on projects and work that will assist in supporting the organisational priorities, for example, supporting attendance, recruitment and retention.

The Occupational Health & Wellbeing team achieved 82% uptake in this year's flu campaign, exceeding the CQUIN target of 75%.

The first 'Mental Health First Aid Training' for our staff is taking place 25th and 26th March, a second training event will be taking place on 30th May and 1st April. This training will provide support for staff experiencing symptoms of mental health and enable signposting and assistant to appropriate services in a timely manner.

The lead for this service is not in scope to transfer to the Trust as part of the TUPE and recruitment has commenced in advance of transfer to mitigate the associated risks associated to this important work stream.

Organisational Development

The Trust has invested in the recruitment of an OD team; the interviews for these new posts will take place in April 2019. The OD team objectives are set based on the strategic pillars in the Trust's Workforce & OD Plan 2018-2020. In the meantime, focus has been given to establishing the ground work for future OD developments as follows:

- Access for all staff to skills & career development through a suite of apprenticeship qualifications to attract new apprentices and develop our existing staff - this includes Level 2-7 Leadership & Management programmes (up to Master's Degree). This will form the framework for a new Leadership & Management offer 2019/2020. Assurance can be given that the Trust is continuing to maximise its Apprenticeship Levy.
- New roles supported by new apprenticeship programmes include: Nursing Associates, Advanced Care Practitioners
- Delivery of the NHS Leadership Academy Mary Seacole programme to 21 Trust staff since 2018
- 360 degree feedback available for all staff based on the NHS Leadership Academy Healthcare Leadership Model
- Increase in the number of NHS Leadership Academy Healthcare Leadership 360 degree Facilitators from 2 to 10
- Investment in 2 x cohorts of CMI Level 5 trained coaches to establish an in-house Coaching Service for Staff – a coaching strategy is currently under development (due Spring 2019)
- Conversations commenced with AQuA to co-design a Quality Improvement Strategy and QI training programme for all staff 2019
- Ongoing quality appraisal conversations training programme – this along with other management soft skills will be further

developed on appointment of the OD team

- Senior Leaders' Development Programme – next step to develop a business case to commission team coaching 2019
- A Shadow Board Programme geared to develop Aspiring Directors to commence May to Sept 2019 chaired by the Trust Chairman which supports the start of our 'grow' your own' approach to talent management
- The Trust is part of the NHS Leadership Academy Talent Management Readiness Assessment Tool Pilot – this will inform the Trust of its current position to develop a TM Strategy
- Launch of eLearning to deliver core mandatory training, clinical knowledge and management skills for all staff 24/7 – core mandatory training report & action plan now monitored via the Risk & Compliance group
- A co-design meeting will take place with NHS Elect & the Trust's Valuing our People Group on 27th March 2019 to design and deliver our staff engagement approach "Big Conversations" with a focus in year one on culture, values & behaviours – launch date May 2019 to Sept 2019 to inform the values & behaviours of the Southport & Ormskirk Way – this includes a 'Big Board Conversation' scheduled June 2019
- The Trust's Library & Knowledge Service maintained a 97% achievement following the annual review against the Library Quality Assurance Framework
- A Board Development Programme focusing on: Culture – Leading change through compassionate leadership / How increased ownership of inclusive leadership behaviours will reduce discrimination, unfairness, bullying and harassment, and how it's everyone's responsibility". Included an External Well Led Review and proposal under review for High Performing Team. This programme will be reviewed in light of the Well Led Report for 2019/2020.

Medical Education – Undergraduate & Postgraduate

- The University of Liverpool conducted a successful Quality Assurance Re-visit on 13th March 2019. Initial feedback was largely very positive with some further reassurance sought in relation to consistency and effective of educational supervision for undergraduate medical students and access to a broad, expansive range of education and training opportunities. The Trust has provided additional evidence and insight to the University which assures them of ongoing improvements in these areas.
- On 28th March, 2019, the Trust will facilitate an inspection visit by Health Education England in relation to the provision of postgraduate medical education. A pre-visit meeting took place on20th March, 2019, with the HEE Quality Lead and Associate Patch Dean, which indicated positive improvements in areas highlighted previously as concerns, and with strong evidence emerging that there are areas of best practice at the Trust to showcase externally.

Payroll Services

The transfer of HR services on 1 April does not include the transfer of payroll and transactional services. An Executive review of options presented by a working group has agreed to continue with the outsourced arrangement with St Helens and Knowsley for Payroll and Transactional Services. A focus to improve efficiencies within this area will be progressed including utilisation of electronic systems.

Workforce Planning
The national operation plan is on plan for submission. The workforce elements were presented to the Workforce Committee in March with feedback included in the submission to board.

Not Assured/Most Deteriorated

Personal Development Reviews
PDR rates have increased to 75.98% in February 2019 which is a further 2.62%age point improvement. Work continues to achieve the target of 85%, and ultimately beyond this target. This is the fourth month of consecutive improvement however improvement is slow and has missed the target of 85% for the CBU plans by the end of February.

Sickness Absence
Sickness absence has decreased in month in February to 5.76% (the lowest rate since September 2018); whilst this is a positive trend a continued improvement is required to achieve assurance. Focused support for absence continues including review and challenge of monthly performance sickness data; focused input in “hot spot” areas of the Trust with exceptionally high sickness absence levels; review of compliance with return to work interviews, appropriate correspondence and the policy being followed correctly.

NHS
Southport and Ormskirk Hospital
NHS Trust

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

Overview

Vision 2020

Pre Consultation Business Case requirements 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 model of care has been to the Frailty Group for approval in principle and there is a follow on meeting being arranged with the CCG clinical leads for review and approval. Urgent & Emergency Care model has been drafted and is with the A&E Delivery group for review with final amendments and agreements due at the next group meeting. The Paediatric model of care has been reviewed by the Women & Children's Governance Group which will be agreed at the next meeting. The two Women's clinical models will be ready for review at the next Women & Children's Governance Group meeting.
ESTATES SOLUTIONS
The follow up GIRFT review of the Trauma and Orthopaedics pilot took place with Prof. Tim Briggs who continues to offer S&O support in delivering the hot/cold model.
A Strategic Estates Group has been set up with the inaugural meeting taking place on the 12th March 2019.
FINANCE SOLUTIONS
Work continues 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 will be presented at the Sefton Transformation Board on the 13th March. This will describe a six month plan to develop the blueprint for acute services with a implementation plan supporting a portfolio of projects.
The successful site visits to Cramlington and Golden Jubilee demonstrated some shared learning that will benefits the development of the programme. This learning will feed into the development of the acute sustainability programme.

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

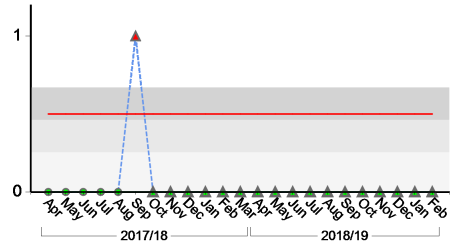
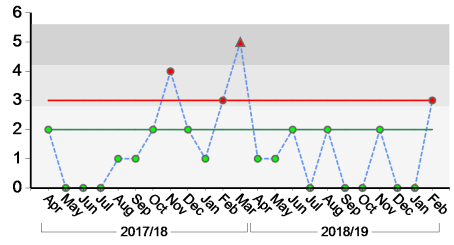
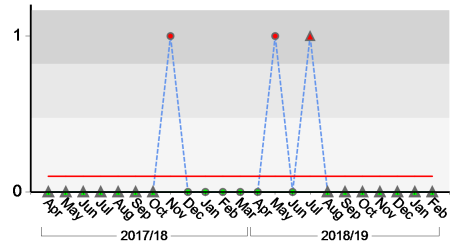
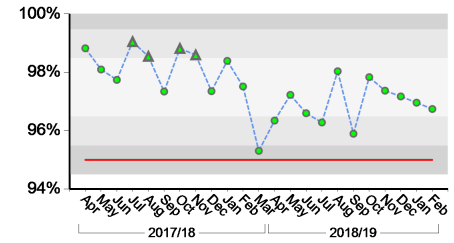
NHS
Southport and Ormskirk Hospital
NHS Trust

KPI Graphs and Update

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

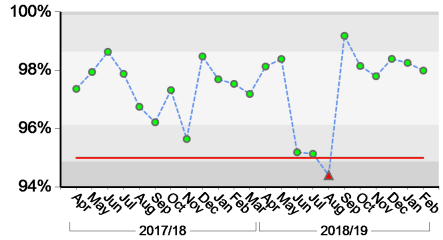
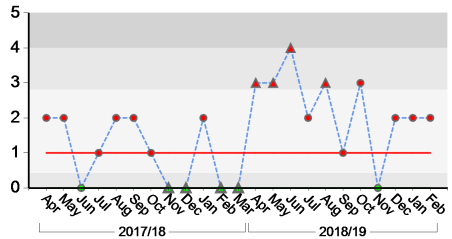
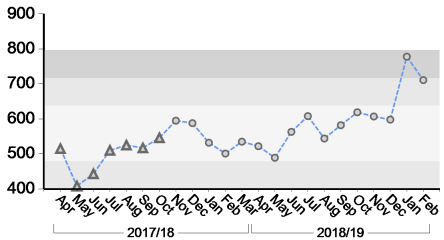
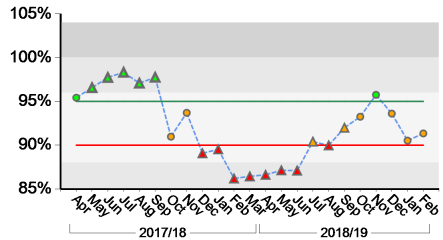
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	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.	
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.	In February there were 3 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 11 cases, therefore on our current trajectory the Trust is below both targets.	
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death.	There were no never events in February - All incidents are screened to see if they meet the Never Events Criteria	
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	Performance of 96.74% for February continues to be above required compliance level - There has been marginal dip in compliance for the last 5 months and individual CBU scrutiny to understand the reasons for this needs to occur and to determine if any further improvement action is required. The compliance rate can improve as the month progresses as further patient discharges in month occur.	

Board Report - February 2019

NHS Southport and Ormskirk Hospital NHS Trust

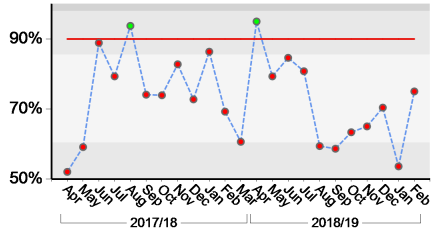
Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance was 97.99% during February 2019 and so remains above the threshold of 95% - The Trust reported a total of 8 harms which comprised of 3 x HAPU comprising of a G3 on 9b and 2 x G2 on 14b, 2 x CAUTI on spinal injuries unit and 3 x PE on EAU, 15a and 11a. All the reported Harms are subject to local investigation within the relevant CBU	
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	In February the Trust reported 2 falls in this category resulting in moderate to severe harm - (both fractures) ward 14A and ward 15A RCA to be undertaken and SIRG review	
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.	Reporting figures demonstrate a positive reporting culture - Staff recognise the importance of reporting incidents; this allows the Trust to mitigate risks All CBUs are encouraged to report incidents so we can take action to make care safe	
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 improved slightly in February 2019 to 91.34% but is still within tolerance - The ongoing 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.	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

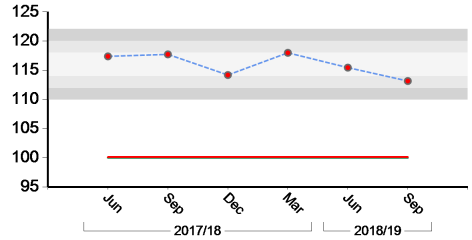
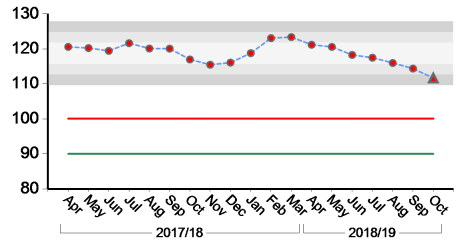
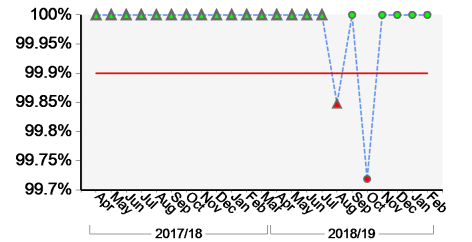
Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	In February 18 out of 24 patients (75%) received their treatment within 36 hours - Consultant of the week is now in place. Patients are being reviewed daily by a consultant. However orthogeriatrician reviews are not always happening within 72hrs, due to vacancy.	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

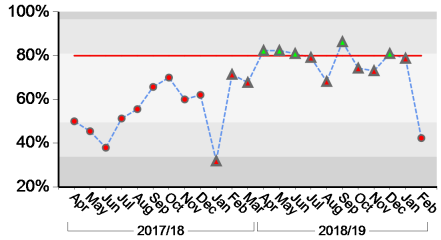
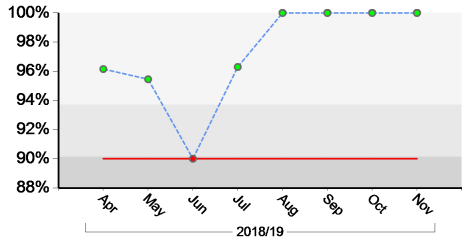
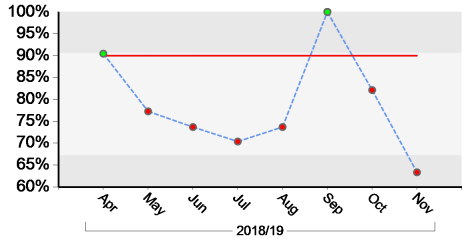
Effective

Indicator Name	Description	Narrative	Month Trend
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 the same period in the 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 the HSMR report. With the exception of palliative care coding which does not feature in the SHMI calculation.	
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 111.7 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.	
WHO Checklist	WHO Checklist.	Performance remains at 100% compliance for January 2019 - Checklist audits continue	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

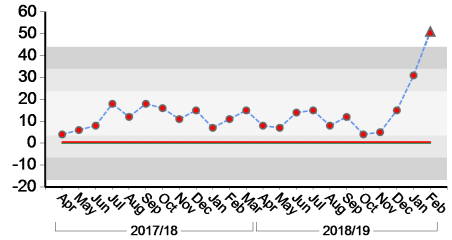
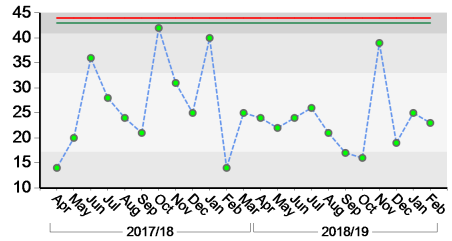
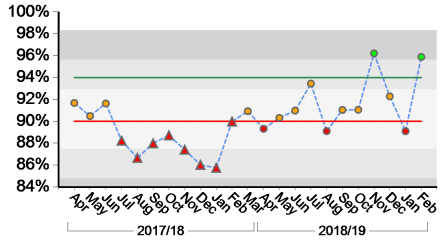
Effective

Indicator Name	Description	Narrative	Month Trend
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.	In February, 11 out of 26 patients spent 90% or above of their stay on the stroke ward. - unfortunately during February stroke performance declined which has resulted in the service SSNAP compliance moving from a B rating to a C rating. This was as a result of several contributing factors namely bed availability on the Acute Stroke Unit during the winter pressure months. Improvement is expected going forward.	
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. This is the latest available data	

Board Report - February 2019

NHS Southport and Ormskirk Hospital NHS Trust

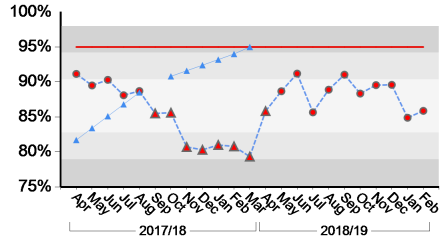
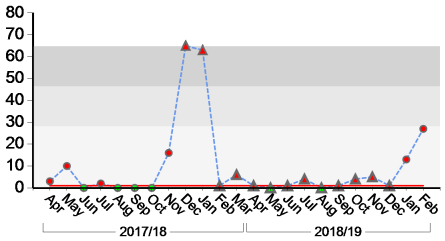
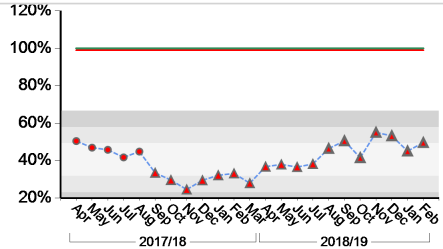
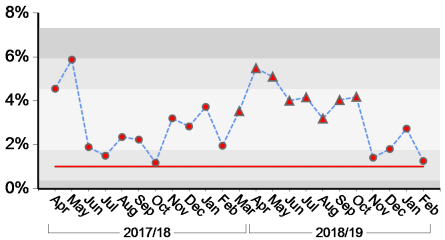
Caring

Indicator Name	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	DSSA breaches have risen significantly, from 5 in November, to 15 in December, 31 in January and 51 in February - This equates to 16 patients in February- all single sex breaches are from Critical care; all delays datixed by critical care; review of all patients to step down from critical care discussed and plan in place dependant on overall trust capacity; safety of patients throughout the trust is reviewed; manager from critical care unit now attends 12:30 bed meeting to provide update and identify suitable plans	
Written Complaints	The total number of complaints received. A lower number is good.	In February 23 complaints were received by the Trust, which is within the normal range. - 23 complaints received in February. Urgent Care accounted for 12 of these, of which A&E accounted for 5. They were the highest contributor to complaint numbers in month. Over half of the complaints relate to clinical treatment. The themes are as follows: 1. staff attitude/behaviour 2. clinical treatment issues 3. lack of support after discharge 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.	
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance has improved compared to the previous month's data. - However, overall Trust response rate continues to be low at 6.11%. The case for consideration of funding to support digital enhancement of FFT is ongoing. Results 2018 National Inpatient Survey to be reviewed to direct improvements over the next 12 months.	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

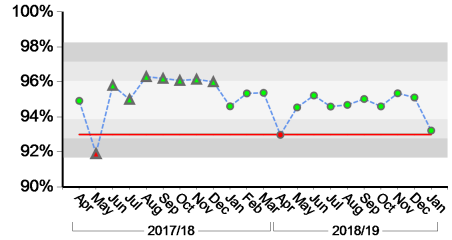
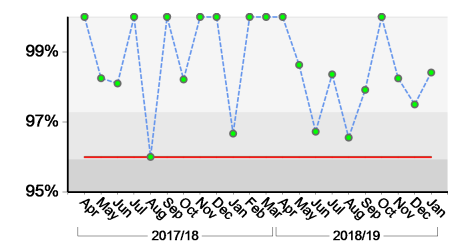
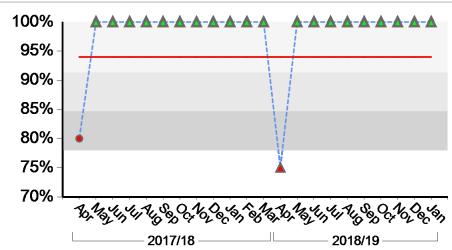
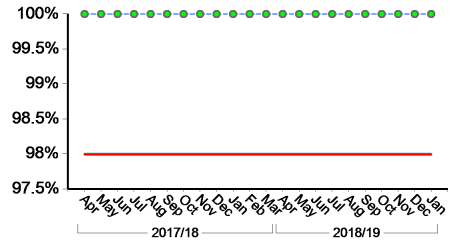
Responsive

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.	In February, there was 5% improvement in overall Trust performance against the 4-hour target performance in comparison to the previous year - There was a 12.8% improvement on the Southport site with 309 fewer patients spending longer than 4 hours in the department. February 2019 saw a 13.2% increase in attendances (equating to 569 patients of which 525 were majors category). The conversion rate from attendance to admission was 29.92% compared to 32.2% in February 2018. There has been successful recruitment to substantive Consultant and the next cohort of Physicians Associates and the department are currently scheduling Skype interviews with 2 potential middle grade doctors (who have RCEM).Bed occupancy levels remained high across February with ongoing reliance on escalation bed capacity, in addition to infection control pressures which resulted in bed closures across a number of wards. The final elements of the ED re-design are due for completion before the end of March.	
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0.	There were x27 reported 12-hour breaches across the month of February - 2 were down to mental health delays with the remainder due to bed pressures. The delays for patients requiring admission to mental health beds continue to cause concern despite continued escalations to all parties involved, which NHSE is fully cited on. With regards to the 12-hour breaches related to hospital beds, these were predominantly during or immediately following weekends, as the deficit between admissions and discharges increased, despite high numbers of escalation beds utilised. In addition, February saw beds closed across up to 5 wards for periods of time due to norovirus, and infection control pressures were also experienced in the community with a number of care homes closing to admission, in addition to patients presenting to A&E requiring side rooms. A&E and Medicine continued to bolster rotas wherever possible with increased senior decision making presence, and specialty in-reach into ED to ensure timely patient reviews and treatment. February also saw the introduction of the weekend huddle with attendance from social care and therapy to collectively work together to support next steps for patients considered suitable for discharge. RCAs for all 12 hour breaches are completed and presented at SIRG.	
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.	49.56% of patients brought in by ambulance were handed over within 15 minutes of arrival in Feb 2019. - This was a significant improvement compared to February 2018, when just 33.06% of patients were handed over within 15 minutes. The re-designed ED environment continues to support handover processes. February 2019 was a challenging month with an additional 569 patients attending across the month and the associated pressures that this creates in releasing ED cubicle capacity. The increase in attendances remains largely patients who self present to ED, rather than those brought in by ambulance.	
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 improved significantly and was the best YTD at 1.26% - The breaches were: Cardiology - Echo - 3 patients - 1% January) - unexpected staff sickness which is now ongoing Colonoscopy - 1 pt- 0.9% - patient choice Computed Tomography - 2 pts - 0.7% - equipment failure and patient choice Cystoscopy - 5 pts - 4.5% - Cystoscopy (Gynaecology) - 2pts - patient choice, ongoing lack of capacity (gynae) Dexa Scan - 3 pts - 1.6% - 1 pt requiring double slot, patient choice, difficulty contacting patient MRI - 18 - 2.9% - telecoms malfunction, interpretation delay, previous surgery issue, referrals back to radioloy for discussion, difficulty in contacting patients/patient choice. Non-obs Ultrasound - 3 - 0.3% - capacity, patient choice Urodynamics - 3 - 5.1% - 1 - long term staff sickness Out of 3017 patients in total, 38 breached beyond the 6 week wait. There has been prioritisation of inpatients over routine due to winter pressures to facilitate discharges. Dexa is antipicated to be back on track in May following training. Echo should be back on track in April.	

Board Report - February 2019

Southport and Ormskirk Hospital NHS Trust

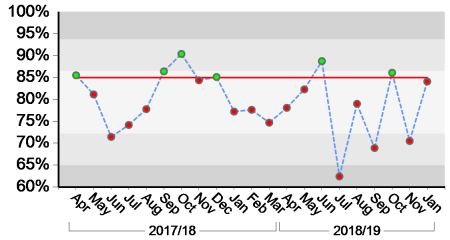
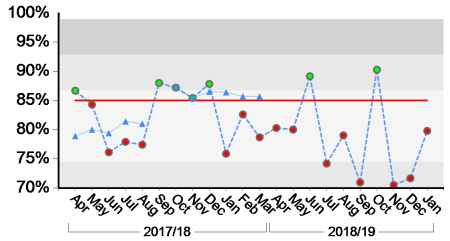
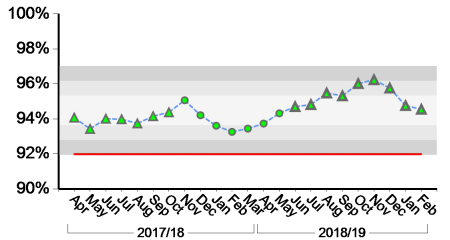
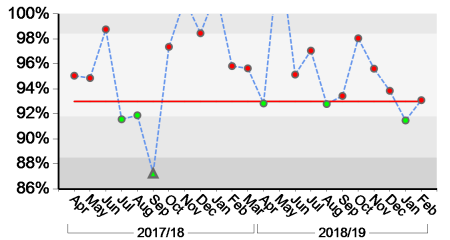
Responsive

Indicator Name	Description	Narrative	Month Trend
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher.	The Trust continues to meet the 93% standard - There is an aim to improve as we work towards the first appointment within 7 days	
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 achieve the standard - There is an aim to improve as we move towards 7 day working	
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 achieve the standard - 3 patients received their surgery within 31 days	
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 achieve the standard - 8 patients were treated within the 31 day target	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

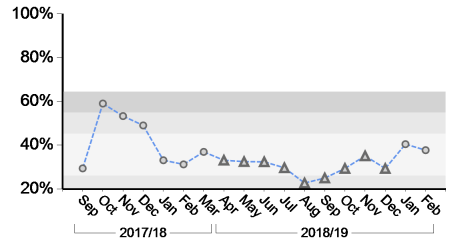
Responsive

Indicator Name	Description	Narrative	Month Trend
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 the 62 day standard, slightly below the 85% target at 84.09% - Of the 44 patients treated under this standard in January, 37 met the 62 day target. Cancer Services is working closely with the directorates to develop and implement an improvement plan to address our performance. Continued work on overall improvement plan is dependent on individual tumour site improvement plans.	
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.	
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 continues to perform above the threshold - with February's performance being recorded at 94.55%	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Bed occupancy was slightly increased in February at 93.1% - additional bed capacity continued on ward 1 to support winter pressures; closed beds due to infection for prolonged period has impacted on discharge and LoS. #longstayuesday with system partners, review of patients with LOS 20+ days continues weekly. Introduction of daily discharge huddle with LCFT and LA to support cross system working; trusted assessment document in place for ICRAS beds. red2green on all in-patient wards at SDGH; ward closures and restricted movements into February due to infection led to delays in discharge	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

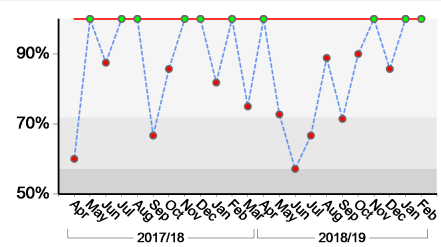
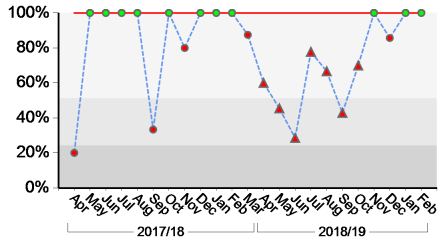
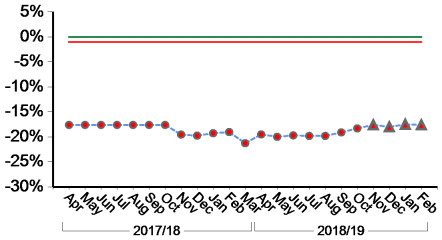
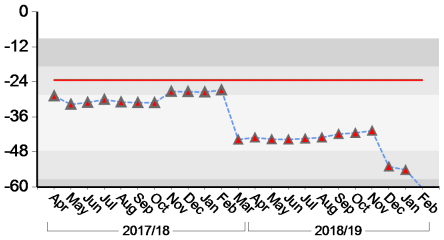
Responsive

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 dipped slightly in February due to a reduction in Orthopaedic activity due to annual leave of clinicians. This reduction impacted on H ward which is ring fenced and hence patient moves from SDGH were not possible. - Bed occupancy data is currently being validated to ensure we 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 - February 2019

NHS Southport and Ormskirk Hospital NHS Trust

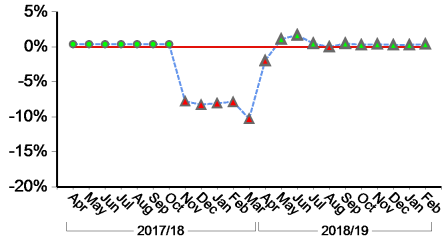
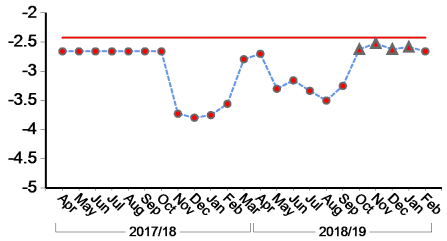
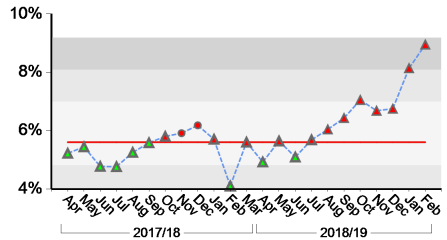
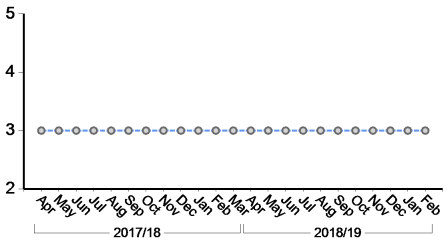
Well-Led

Indicator Name	Description	Narrative	Month Trend
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	All CBUs were 100% compliant with this statutory duty in February - The daily Duty of Candour alert has proven effective in that it prompts staff to complete within the timeframe	
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.	This February all CBU's were 100% compliant with this statutory duty - The Duty if Candour Alerts have proven effective staff are reminded on a daily basis to complete the Duty within 10 working days. Staff education and support continues with effect	
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.	Downward trend on this metric - As highlighted last month, DHSC are now re-classifying loans which mature in 12 months as current and this is having a step-change on this metric each month. We have been getting loans every month for a long time now so this metric is only going to get worse.	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

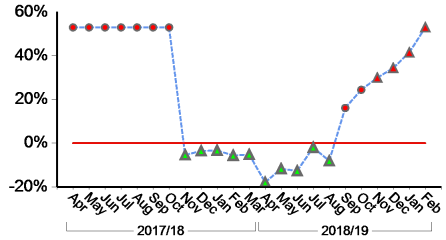
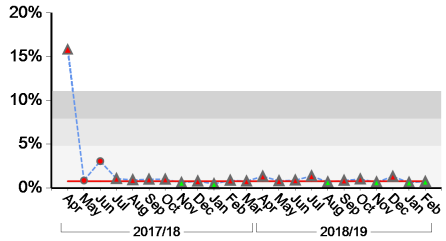
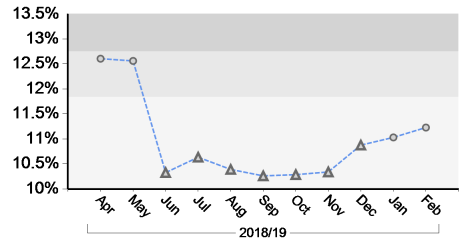
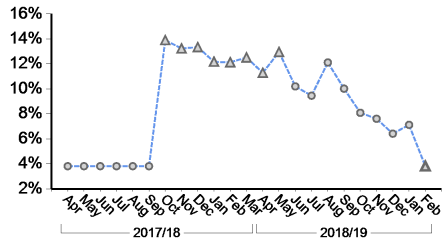
Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Control Total	Distance from Control Total.	The Trust is 0.4% ahead of plan - The Trust has delivered a higher I&E margin (-17.6%) than plan (-18%). Although the actual deficit is £385k worse than plan this is over a higher turnover (plan £148.3m; actual £153.8m).	
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 adverse movement on this metric - Metric now moving slightly away from plan (target in February is -2.56 against an actual of -2.66).	
% 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 February - Agency spend in nursing staff rose again in February to mitigate ongoing high sickness absence levels and provide additional resource to cope with the continued higher levels of demand resulting in additional escalation beds across the hospital. Additional escalation beds have been reduced in March. Utilisation of high cost nursing agencies remains under review with plans to increase the number of agencies available as an alternative in progress. Block bookings of lower cost agency nursing supply have been arranged and are being utilised to minimise high cost options.	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Overall score remains static at 3 (A score of 1 is best and 4 is the worst) - The unrounded metric has increased in February from 3.2 to 3.4. This is because the agency metric (distance from the agency spend cap) has increased to over 50% away from the cap. This has moved that metric from a 3 to a 4.	

Board Report - February 2019

Southport and Ormskirk Hospital NHS Trust

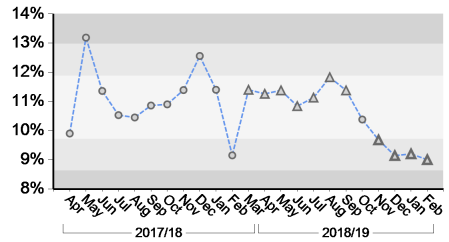
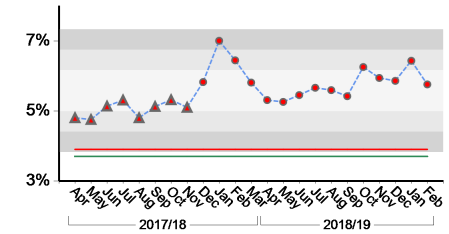
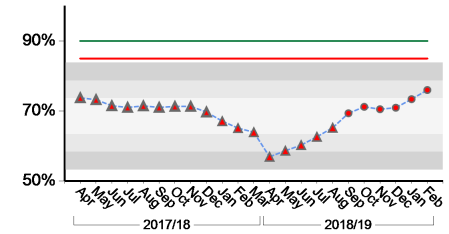
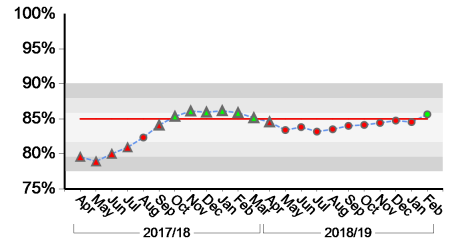
Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	A futher deterioration in this metric. - The Trust has now moved to a rating of 4 (last month 3). The deterioration has been due to higher than planned nursing agency costs due to a combination of sickness levels and increased activity staffing escalation beds.	
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 achieved target in February and remains stable - 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	
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 11.03% in January to 11.23% in February - Whilst monthly staff turnover is relatively consistent, there is some fluctuation, and over the last 12 months, the cumulative turnover shows an increase. Actions are as for Staff Turnover by month	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The vacancy rate dropped significantly in February to 3.82% - Recruitment activity continues to source candidate to fill vacancies, with alternative arrangements being considered as appropriate.	

Board Report - February 2019

NHS Southport and Ormskirk Hospital NHS Trust

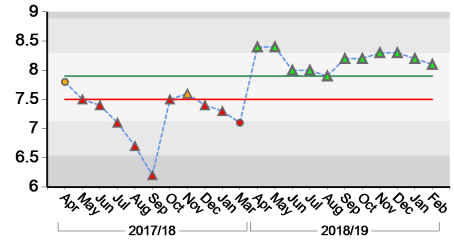
Well-Led

Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	The vacancy rate fell slightly in February to 9% - We have seen a monthly 'positive' decrease in the number of RN vacancies since the summer 2018. The Trust held an Open Day and attended an external recruitment event in February 2019 with further recruitment event for RN's planned in March and May 2019.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence levels fell in February but remin within the normal range for the Trust - There are a number of ongoing action plans that link into reducing sickness absence, there is the Health and Wellbeing Action Plan supported by NHSI 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.	
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance continues to improve and increased to 75.98% - This is the third month of consecutive improvement however improvement is slow. All CBU's have revised their PDR improvement plans to achieve the target by the end of March 2019.	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	The Trust has met the 85% target in month - A review of key areas of mandatory training management remains a priority for the training department and a paper / action plan will be presented to the Risk & Compliance Group in April 2019.	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

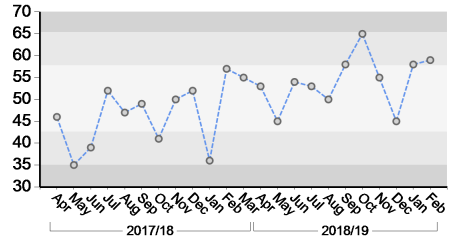
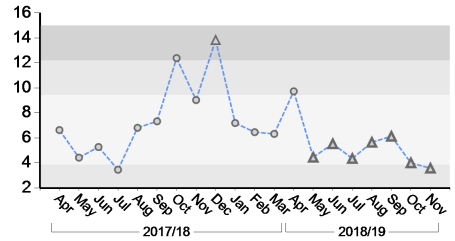
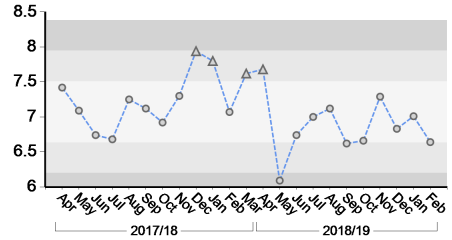
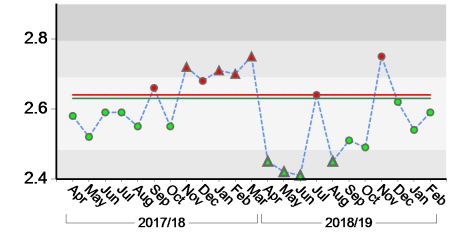
Well-Led

Indicator Name	Description	Narrative	Month Trend
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Performance remains stable above target at 8.1 - 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 from the Model Hospital Team.	

Board Report - February 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

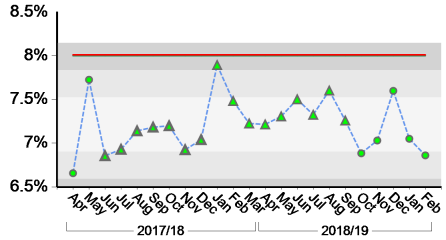
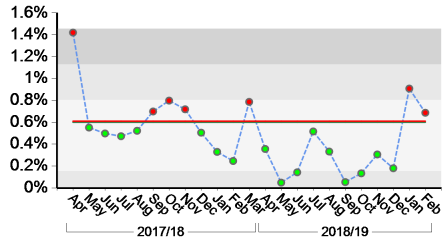
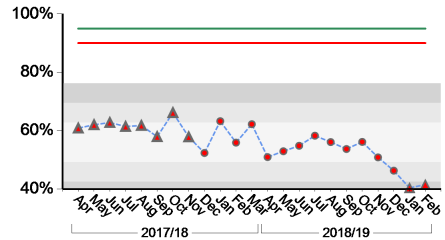
Efficiency

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.	Numbers remain within a similar range both compared to previous months and the same time last year. - on-going ward closures due to infection control. Ongoing management - #longstaytuesday currently being completed by Acute team, daily discharge huddle expanded to include both Sefton and WL patients to support cross system working; trusted assessment document continued for ICRAS referrals to D2A and ICB;red2green on all in-patient wards at SDGH; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements continued throughout February 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).	Improvement continues and are the lowest year to date at 3.57 and the lowest in the last sixteen months. - there are 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; introduction of the discharge huddle with system partners on Saturday and Sunday to support flow throughout weekend	
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.	slight improvement- remains within range - red2green and discharge reviews are ongoing in all in-patient areas. continuation of #longstaytuesday currently being completed by acute staff, daily discharge huddle now including all parties from both Sefton and WL to support cross system working; discharge huddles currently being undertaken over the weekend with system partners support and Acute senior leadership; trusted assessment document continues for ICRAS community beds. red2green on all in-patient wards at SDGH; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements continued into February due to infection led to delays in discharge of MOFD patients to alternative care facilities and increased LoS	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	New:Fu Ratio in February has increased slightly to 2.59% but the Trust continues to maintain stable performance and is performing within threshold. -	

Board Report - February 2019

Southport and Ormskirk Hospital NHS Trust

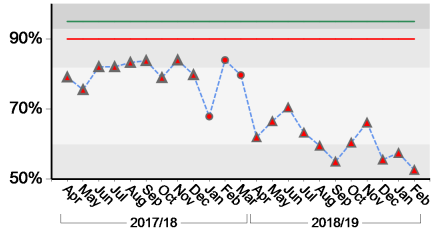
Efficiency

Indicator Name	Description	Narrative	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	The Trust is still performing under threshold with February's DNA Rate being recorded as 6.86% - the DNA Rate continues to reduce and this may be due to the current Telephone Reminder Pilot and an increase use of Text Reminders	
Cancelled Ops	Percentage of Operations Cancelled.	February performance still showed a slight improvement on January despite there being cancellations on both SDGH and ODGH due to bed pressures - A deep dive into reasons for cancellations has commenced to identify the "true" reasons for cancellation.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Utilisation was slightly higher than the previous month in February but remains under target - February's performance is partly due to cancelled operations. Continued bed pressures throughout February 19 has resulted in patients being cancelled the day before and on the day of surgery. Cases for the Ormskirk site continue to be reviewed and moved when appropriate.	

Board Report - February 2019

Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	The overall utilisation % fell in February as a result of losing 9 Ophthalmology lists in addition to foot and ankle lists due to leave/ no doctor. - These lists usually have a high utilisation. These are our highest utilisation lists hence the loss of those lists have a negative impact. We expect to see improved utilisation in March.	

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
3 April 2019

Agenda Item	**TB073/19**	**Report Title**	**Draft Annual Governance Statement**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Annual Governance Statement (AGS) is a statutory instrument (formerly known as the Statement of Internal Control (SIC)) which sets out how the system of internal control was managed during a specific period (usually the past year). It is based on a model issued by the Department of Health.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policy management, objectives of Southport and Ormskirk Hospital NHS Trust, to evaluate the likelihood of those risks being realized and the impact, should that occur and to manage them efficiently, effectively and economically. The system of internal control has been in place in Southport and Ormskirk Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

The AGS gives a snapshot of governance arrangements; risk management; work of the Board and assurance committees; equality and diversity; human rights, regulatory and compliance issues; information governance; key financial policies and processes, quality governance framework and a summary of the Quality Account. It is the CEO's summary of the effectiveness of the control he had in place in the Trust during the past year.

The AGS is independently audited by the External Auditors, Mazars, (currently with them for review) and the final version will be incorporated into the Annual Report.

The AGS has been reviewed by the ETM, the HMB and the Finance, Performance & Investment Committee, then Audit Committee. The AGS, the full Annual Report and Annual Accounts will be taken to the Audit Committee and Board of Directors on 22 May for final approval before submission to NHS Improvement.

Recommendations:
The Board is asked to **review** the AGS and **make recommendations** for improvement.

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 AGS, the full Annual Report and Annual Accounts will be taken to the Audit Committee and Board of Directors on 22 May for final approval before submission to NHS Improvement at the end of May 2019

Previously Presented at:

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

Annual Governance Statement 2018-19

Contents

Annual Governance Statement (AGS) 2018/19

1.0 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Accountable Officers' Memorandum.*

2.0 The Purpose of the System of Internal Control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Southport and Ormskirk Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact, should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Southport and Ormskirk Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

2.2 The objectives for 2018/19 and the associated principal risks were approved by the Board at its 7 March 2018 meeting. They are shown below at **Table 1**.

Table 1

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

The means by which strategic and operational risks are managed, monitored and reported in the Trust are set out below.

3.0 Capacity to Handle Risk

3.1 As Accountable Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the Risk Management Strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Responsibility	**Executive Director**
Overall Risk Management	Executive Director of Nursing
Clinical Governance	Executive Director of Nursing
Clinical Risk & Medical Leadership	Executive Medical Director (Caldicott Guardian & Responsible Officer)
Corporate Governance	Company Secretary
Board Assurance & Escalation	Company Secretary
Financial Risk	Executive Director of Finance
Compliance with NHSI Regulatory Framework	Executive Director of Finance & Company Secretary
Compliance with CQC Regulatory Framework	Executive Director of Nursing
Information Risk	Executive Director of Finance (*Senior Information Risk Officer*-(SIRO)/Company Secretary (Data Protection Officer)

3.2 In addition the Deputy Chief Executive/Executive Director of Strategy is responsible for risks related to Acute Sustainability and Strategic Planning; the Chief Operating Officer is responsible for the day-to-day management of risk and performance within the Clinical Business Units; there are designated roles of Assistant Director, Safer Care and Standards and Deputy Director of Nursing providing leadership and support in their respective areas; the Director of Human Resources & Organisational Development is responsible for workforce and organisational development risks.;

3.3 Our integrated governance structure at **Figure 1** illustrates the robustness and effectiveness of our risk management and performance processes via our governance structure. **Figure 2** gives a snapshot of our assurance framework and shows relationship with external stakeholders including regulators and inspectors.

Figure 1: Integrated Governance Structure

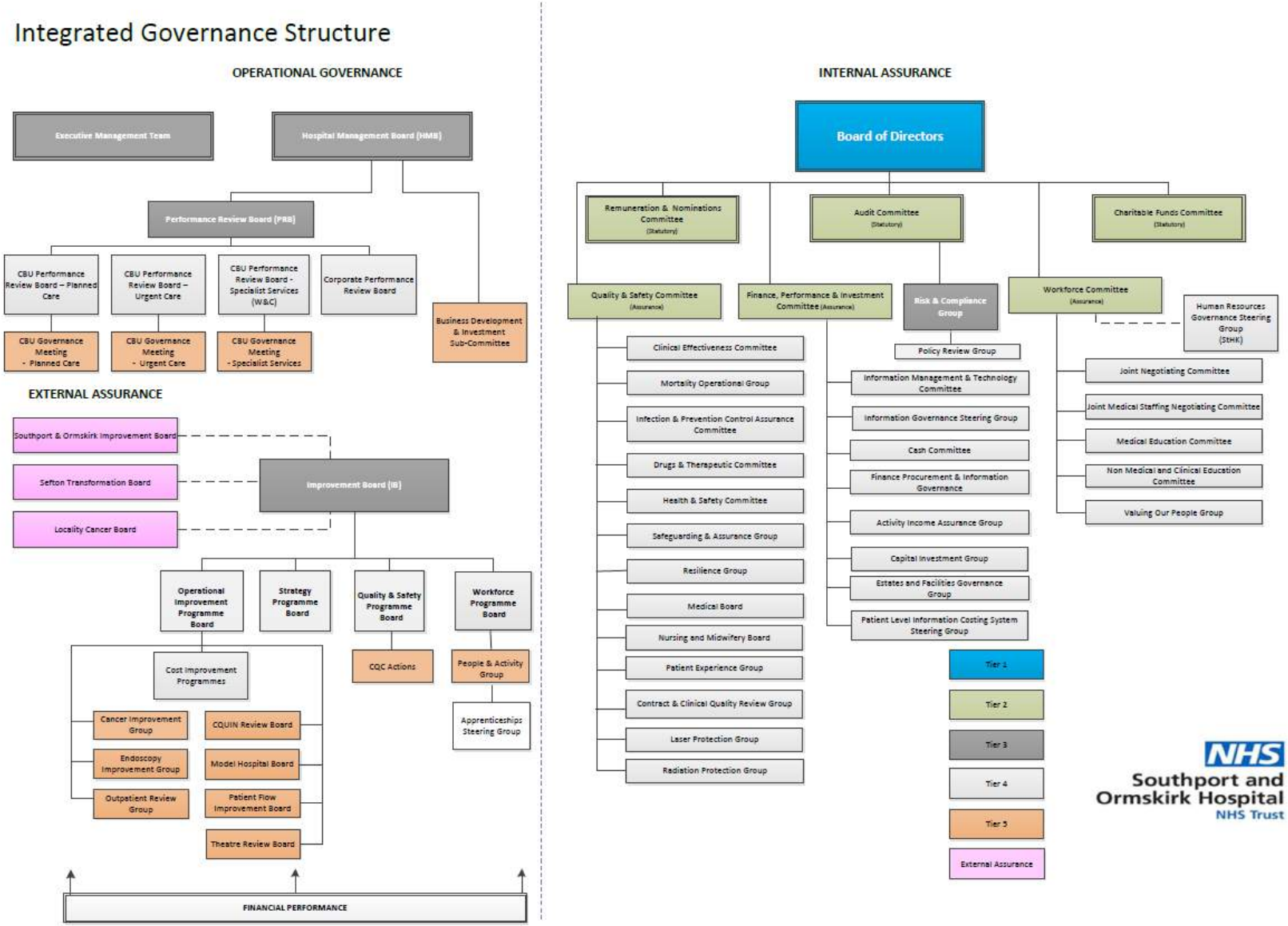
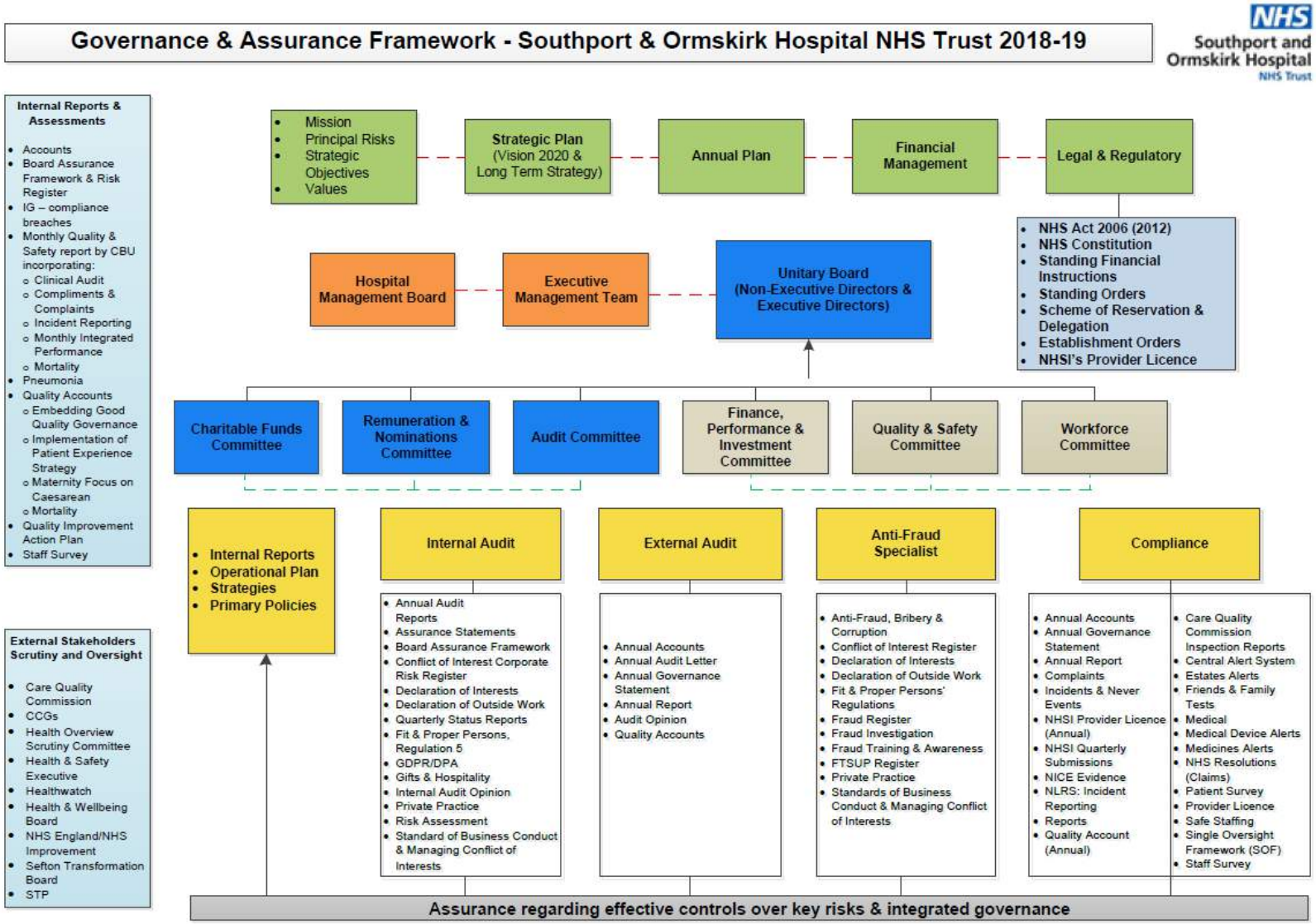


Figure 2: Governance & Assurance Framework



3.4 Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust. Mandatory training on key risk areas is undertaken by all staff at induction into the Trust and on a regular refresh basis.

3.5 Risk management training is part of the Trust's Induction programme and mandatory training for all staff throughout the Trust which includes health and safety, fire, security, incident reporting, claims and complaints.

3.6 In order to support staff with writing responses to complaints, formal training has been provided to support all Clinical Business Units and departments. Training on managing complaints on a face to face basis has been in place to support staff on the wards and departments across the Trust.

3.7 To support investigations of serious incidents, *root-cause analysis* training has been provided to all areas of the Trust and was well supported by the clinical teams across the Trust.

3.8 Sharing learning through risk related issues, incidents, complaints and claims is an essential component of maintaining the risk management culture within the Trust. Learning is shared through Clinical Business Units' Meetings and Trust wide forums such as the Quality and Safety Committee and Clinical Effectiveness Committee and Serious Incident Review Group (SIRG). Learning is acquired from a variety of sources which include:

- Analysis of incidents, complaints, claims and acting on the findings of investigations.
- External inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections relating to other organisations.

3.9 In accordance with its *Standing Orders* and as required by the Health & Social Care Act 2006 (amended 2012), the Trust has an Audit Committee whose role is to review and report upon the adequacy and effective operation of the organisation's overall system of governance and internal control which encompasses risk management – both clinical and non-clinical.

3.10 In order to assist both the Board and the Audit Committee, specific risk management is overseen and scrutinised by three Board Assurance Committees:

- *Quality and Safety Committee* (which receives reports from the Mortality Operational Group and Clinical Effectiveness Committee) and has the specific purpose of delivering assurance to the Board on the management of clinical risk and operational performance against the CQC domains.
- *Finance, Performance and Investment Committee*, which provides assurance on management of risks relating to resources – both financial and human; performance and accountability.
- *Workforce Committee,* which provides assurance against safe staffing, workforce and organisational development issues.

Please see our Risk Management diagram at **Figure 3** and our Risk Escalation Model at **Figure 4**

4.0 The Risk and Control Framework

4.1 Risk management by the Board is underpinned by three interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Clinical Business Units, Departments and Teams)
- The Risk Management Process

In addition the Audit Committee monitors the risk management systems and processes and receives the BAF on a quarterly basis.

The Annual Governance Statement is a composite report on how risks are managed and how assurances were received in relation to the integrated governance and internal control.

4.2 Board Assurance Framework

Board assurance is a systematic method of:

- Identifying
- Analysing
- Evaluating, treating, monitoring, reviewing; and
- Communicating all risks; clinical and non-clinical and the integration and management of both types of risks.

and receiving assurance that the controls in place are effective and mapped against robust actions to close gaps in both controls and assurance.

4.2.1 The requirement to develop a Board Assurance Framework (BAF) was established by the Department of Health (now NHS England), *Assurance: The Board Agenda (July 2002).* The BAF is a tool for the Board to satisfy itself that risks are being managed and strategic objectives are being achieved. The Board has established a robust BAF so that I, as Chief Executive, can confidently sign the *Annual Governance Statement* which deals with statements of internal control and assurances.

4.2.2 A Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the 2018/19 *Annual Governance Statement*. The BAF, which is Board-owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved.

4.2.3 The BAF is robustly discussed and analysed at the Board on a quarterly basis. Updates of progress against actions are provided at two-monthly meetings of the Quality & Safety Committee, the Finance Performance & Investment Committee and the Workforce Committee. The Audit Committee and the Board receive quarterly reports.

4.2.4 Risks monitored by the Trust via the BAF over the year included:

Strategic Direction- *Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards.*

A number of key steps were taken during the year to address this; they include:

- The appointment of a Director of Strategy whose substantive role was to work with systems partners around an Acute Sustainability programme for the Trust
- The appointment of a Programme Director for Acute Sustainability
- The Establishment of a Programme Management Office
- Being a key and active member of the Sefton Transformation Board
- The involvement of the STP programme of which the Trust is a work-stream
- The development and rolling out of a Vision 2020 programme
- During the year planning the next strategic steps by setting key priorities, strategic objectives and principal risks
- Acute Sustainability Case for Change Review

Financial Resources-*Failure to live within resources leading to increasingly difficult choices for commissioners.*

A number of initiatives were taken to improve financial governance including:

- A review of the Scheme of Delegation and Reservation to reduce budgetary levels of control for operational managers
- The establishment of a sub-group of the Finance, Performance & Investment Committee called People Activity Group (PAG) to approve all expenditure not covered by an established budget
- The establishment of a Business & Development Investment Committee (BIDSC) which received proposals on new investment and initiatives and approve accordingly.
- Monthly report to the Board on financial performance and the control total
- Monthly reports to Hospital Management Board
- 2-weekly Efficiency Programme Group (EPG) meetings with the CBUs

In addition, a cost improvement programme was robustly pursued with one to one meetings with budget holders and monthly reports to the Executive Team and the Board of Directors. Details of the CIP programme and delivery process are set out below:

2018/19 Achievement

- The 2018/19 Cost Improvement Programme (CIP) target for the Trust was £7.5 million; the Trust achieved actual in-year CIPs of £6.9 million and full-year CIPs of £5.8 million. This equates to 92% and 77% of the target respectively.
- This represents significant improvement on prior year.
- The critical success factors in the successful delivery of CIPs include changes to the CIP governance structure, formalisation of weekly CIP check & challenge meetings, strong clinical engagement and leadership.
- There have been substantial changes made to the Trust PMO and how it operates which again had a positive impact on CIP delivery.
- The changes to the Trust CIP governance are based on the review undertaken by KPMG LLP.
- Throughout the focus has been on ensuring that schemes are subject to a rigorous quality impact assessment process to ensure that the cost savings are being delivered safely.

CIP Next Steps

- The 2019/20 CIP target will be circa £6.3 million, an increase on the initial target of £6.2million, which equates to nearly 3% target of the addressable spend and represents significant challenge for the Trust.
- Whilst the 2018/19 schemes were mainly tactical in nature; the 2019/20 schemes will focus on transformation and efficiency improvements and will be underpinned by the national programmes such as Model Hospital and Get it Right First Time (GIRFT) or by local programmes such as Right Care.
- The key flagship programmes will focus on:
    - Workforce (including significant reduction in recruitment times, reduction in dependency on agency staff and e-rostering for nursing and AHP workforce and job plans for medical staff);
    - Operational efficiencies (focus will continue to be on theatre, endoscopy, outpatients and GIRFT); and
    - Corporate areas (estates & facilities, procurement and general reduction in dependency on interim staff)

Financial Plans

The Trust submitted draft 2019/20 financial plans to NHS Improvement on 12th February 2019. The Trust has agreed the control total of £8.296 million deficit which requires the following to be achieved:

- CIP of £6.2 million
- Non recurrent Provider Sustainability Fund (PSF) of £3.464 million
- Non recurrent Financial Recovery Fund (FRF) of £14.807 million
- Both the PSF and FRF will only be paid providing the Trust achieves its financial plan each quarter.
- The Trust's final 2019/20 financial plan will be submitted to NHS Improvement on 11th April 2019.

Workforce-recruitment and retention- *failure to attract and retain staff, addressed by:*

- Having in place a Workforce and Organisational Development Strategy
- Workforce & Organisational Development Action Plan 2018-2020
- Conversations commenced with AQuA to co-design a Quality Improvement Strategy and training programme for all staff
- Quality appraisal conversations training programme commenced
- Staff Survey Action Plan
- Senior Leaders' Development Programme
- A Shadow Board Programme geared at Aspiring Directors
- Recruitment of a dedicated apprenticeship lead to deliver an extensive range of apprenticeship programmes to recruit and develop clinical and non-clinical staff
- Role re-design supported by new apprenticeship programmes i.e. Nursing Associates
- Launch of eLearning to deliver core mandatory training, clinical knowledge and management skills
- Conversations commenced with NHS Elect to design and deliver our staff engagement approach "Big Conversations" with a focus in year one on culture, values & behaviours

- The Trust's Library & Knowledge Service maintained a 97% achievement following the annual review against the Library Quality Assurance Framework

Leadership and culture-*inability to provide direction and leadership* has been addressed by:

- The appointment of a substantive Board with full complement of Non-Executive and Executive Directors.
- A Board Development Programme focusing on: Culture, How increased ownership of inclusive leadership behaviours will reduce discrimination, unfairness, bullying and harassment, and how it's everyone's responsibility". External Well Led Review, Cultural Change Through Compassionate Leadership and High Performing Team among others
- Development of a pool of coaches to create an in-house coaching service for staff
- All staff have access to Level 2-7 Leadership & Management Apprenticeships

Quality, patient safety and clinical outcomes- *poor clinical outcomes and safety records,* this was addressed by:

- A Quality Improvement Assurance programme being developed and led by AQuA
- The Quality Improvement Action Plan with monthly reports to the Quality & Safety Committee and the Board
- Monthly Safe Staffing Report to Board and Quality & Safety Committee
- External Reviews including:
    - Mortality,
    - A Rapid Review of Governance
    - Emergency Care Performance including Patient Flow Pathway
    - Acute Services Transformation plus CIP Reporting/CIP Governance/PMO Review
- The Serious Incident Review Group examines all serious incidents and ensures that lessons learned are rolled out across the Trust

Breach of performance data- *failure to meet key performance targets leading to loss of services,* this was addressed:

- By requesting a Consensual Audit of Specialist services in particular and the Trust as as a whole. This took place in August 2018 and at the time of writing all the recommendations were met
- Information Governance Training has been rolled out across the Trust with compliance rate at above 85%

4.2.5 It is a dynamic tool which supports the Chief Executive to complete the *Annual Governance Statement* at the end of each financial year. It is part of this wider '*Assurance and Escalation Framework'* to ensure the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

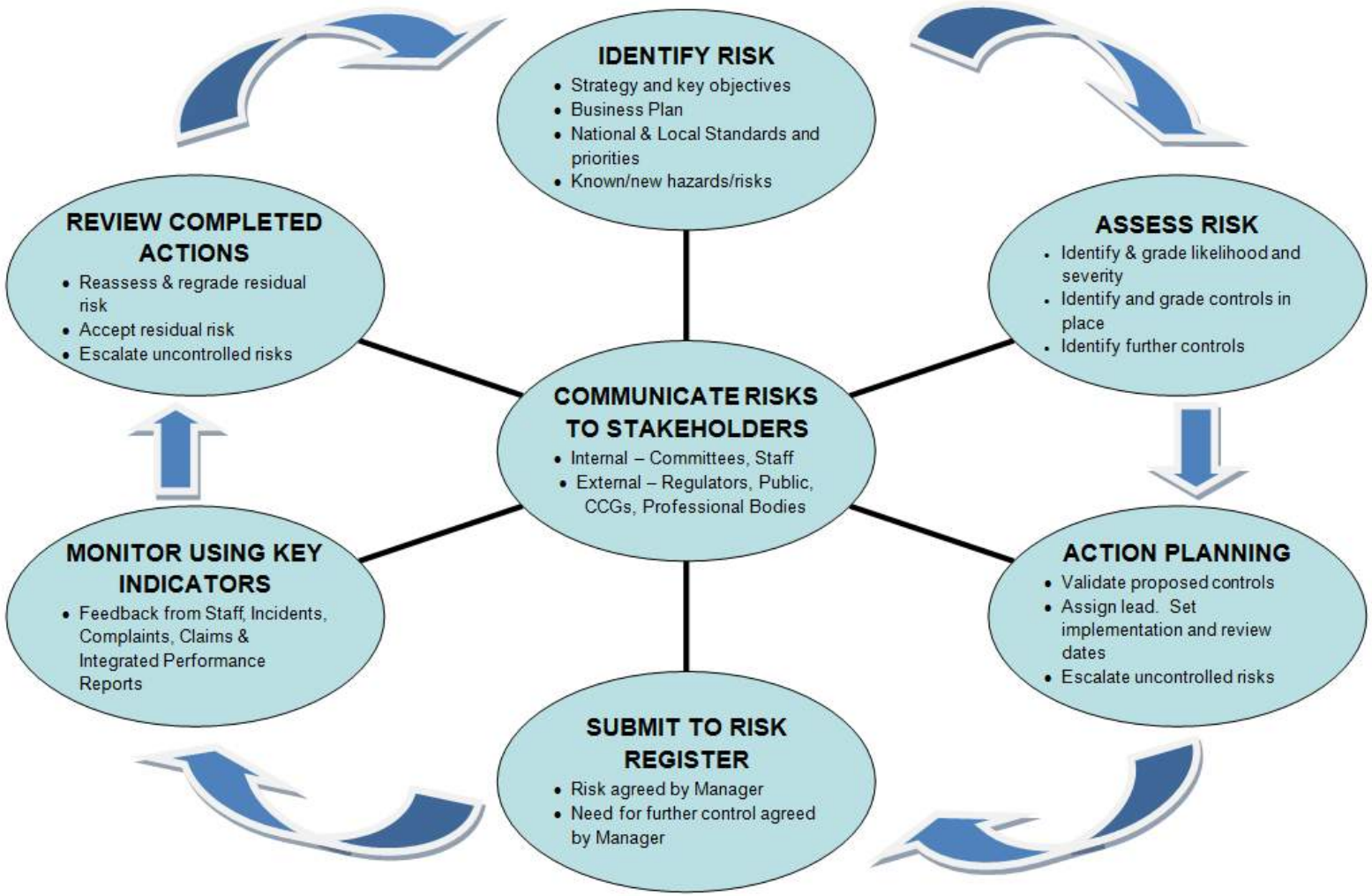
4.2.6 The formation and maintenance of the BAF is the responsibility of the Company Secretary and is regularly reviewed on the Trust's risk management system, Datix, by each Principal Risk Owner (Executive Directors). This is to ensure the controls and assurances

remain valid, are effective, of the right level and any identified gaps are mitigated by timely implementation of clearly defined actions.

4.2.7 The *Risk Management Strategy* and *Risk Management Policy*, which are effective guides on risk management, have continued to work effectively during 2018-19. Our Risk Management System, Datix, has continued to be a source of effective risk management across all levels and a source of *just-in-time* reports when needed. Both the Corporate Risk Register and the Board Assurance Framework are monitored and updated on Datix. The risk management processes remained the same as defined within the Board Assurance and Escalation Framework. These clearly outline the leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Board Assurance Framework, the Risk Registers, Business Planning and Performance Management processes enabling the coherent and effective delivery of risk management throughout the organisation.

4.2.8 Figure 3 shows how risk management involves the identification, analysis, evaluation and treatment of risks – or more specifically, recognising which events (hazards) may lead to harm and therefore minimising the likelihood (*how often*) and consequences (*how badly*) of these risks occurring

Figure 3: Risk Management Process



4.2.9 Risk is managed at all levels, both up and down the organisation and in order to ensure triangulation between the *Operational Plan* and the *Board Assurance Framework (BAF).* The Trust produces an Integrated *Performance Report* for the Board on activity within the Trust's Risk Register which details the risks that have either come onto the Trust risk register or those that the Executive Team has approved to come off the Risk Register. The key performance indicators (KPIs) were incorporated into the BAF to show synergy between the KPIs and controls shown within the BAF.

5.0 Trust's Risk Monitoring Escalation and Assurance Process

5.1 The Risk Management Strategy sets out how risk is identified and assimilated into the Risk Registers and reported, monitored and escalated throughout the directorate and corporate governance structures.

5.2 In addition to the Board Assurance Framework (BAF), the Trust operates three tiers of risk management which are all interlinked via an escalation process. The escalation of a risk is dependent upon the level of the risk, or on whether it is felt that the risk needs specialist management at a higher tier, such as the risk requiring a multi-directorate approach to its management. This is illustrated at Figure 4 below.

5.3 The registers are recorded using a standardised risk matrix and the severity of each risk is rated according to the *Consequence x Likelihood* risk assessment matrix within the Risk Management Strategy to establish the risk score which helps guide action at the appropriate level.

5.4 The Trust recognises the need for a robust focus on the identification and management of risks and therefore risk is an integral part of our overall approach to quality and the management of risk is an explicit process in every activity in which the Trust and its employees take part.

5.5 Risk management in the Trust is discharged through clearly focusing executive responsibility for all clinical and corporate risks with the respective Executive Directors. The Directors, working closely with the Chief Executive, have responsibility for all Trust's clinical services and supporting corporate functions in this context. The management lead for clinical risk rests with the Director of Nursing and Medical Director, who is also the Caldicott Guardian. The lead for corporate risks is the Company Secretary.

5.6 The Trust has a good track record in the identification and mitigation of risks, and when there have been untoward and serious incidents, responding to them quickly and ensuring that the lessons learned from them are being implemented swiftly across the organisation. The Serious Incident Review Group (SIRG) convenes every time there is a serious incident or data breach. The processes for these are embedded in the culture of the organisation and through robust processes and procedures such as raising concerns at work and the '*floor to board'* assurance and risk escalation processes.

5.7 Discussions have taken place at board meetings and workshops concerning the Trust's appetite for risk, the strategic parameters within which decisions involving various types of risks can then be made on a sound and consistent basis. There is a clear process for escalating risks (see **Figure 4**) from Ward to Clinical Business Units and onto the Corporate

Risk Register. There is also a clear process for escalating high or significant risks (see **Figure 4** below).

5.8 Risk Appetite is *'The level of risk that an organisation is willing to accept'*. The appropriate level will depend on the nature of the work undertaken and the objectives pursued. Precise measurement is not always possible and risk appetite may be defined by a broad statement of approach. The Trust has an appetite for some types of risk and may be averse to others, depending on the context of the risk and the potential losses or gains.

5.9 The Trust will develop measures for different categories of risk. For example it may inform a project to know what level of delay or financial loss it is permitted to bear, in the addition to using measures described in the *'Risk Matrix Severity definitions'* to define the likelihood and impact of risks; this can be used to define the maximum level of risk tolerable before action should be taken to lower it [Risk Appetite]. By defining its risk appetite, the Trust can arrive as an appropriate balance between uncontrolled innovation and excessive caution. It can be used to guide managers on the level of risk permitted and encourage consistency of approach across the Trust, and ensure that resources are not spent on further reducing risks that are already at an acceptable level.

6.0 Local and Directorate Risk Registers

6.1 Each ward, team, CBU or department produces a local risk register. The register is developed in response to the identification of local risks that may impact on the delivery of their immediate service. Local risk registers are recorded using the Risk module on Datix.

6.2 Appropriate steps have been taken to ensure that processes are in place at both clinical service and departmental levels to update and maintain their risk registers. Monthly updates from local and directorate risk registers are provided via the Risk & Compliance Manager for inclusion into the Trust's Risk Register. The appropriateness of updates, scores and escalation are discussed at the RCG.

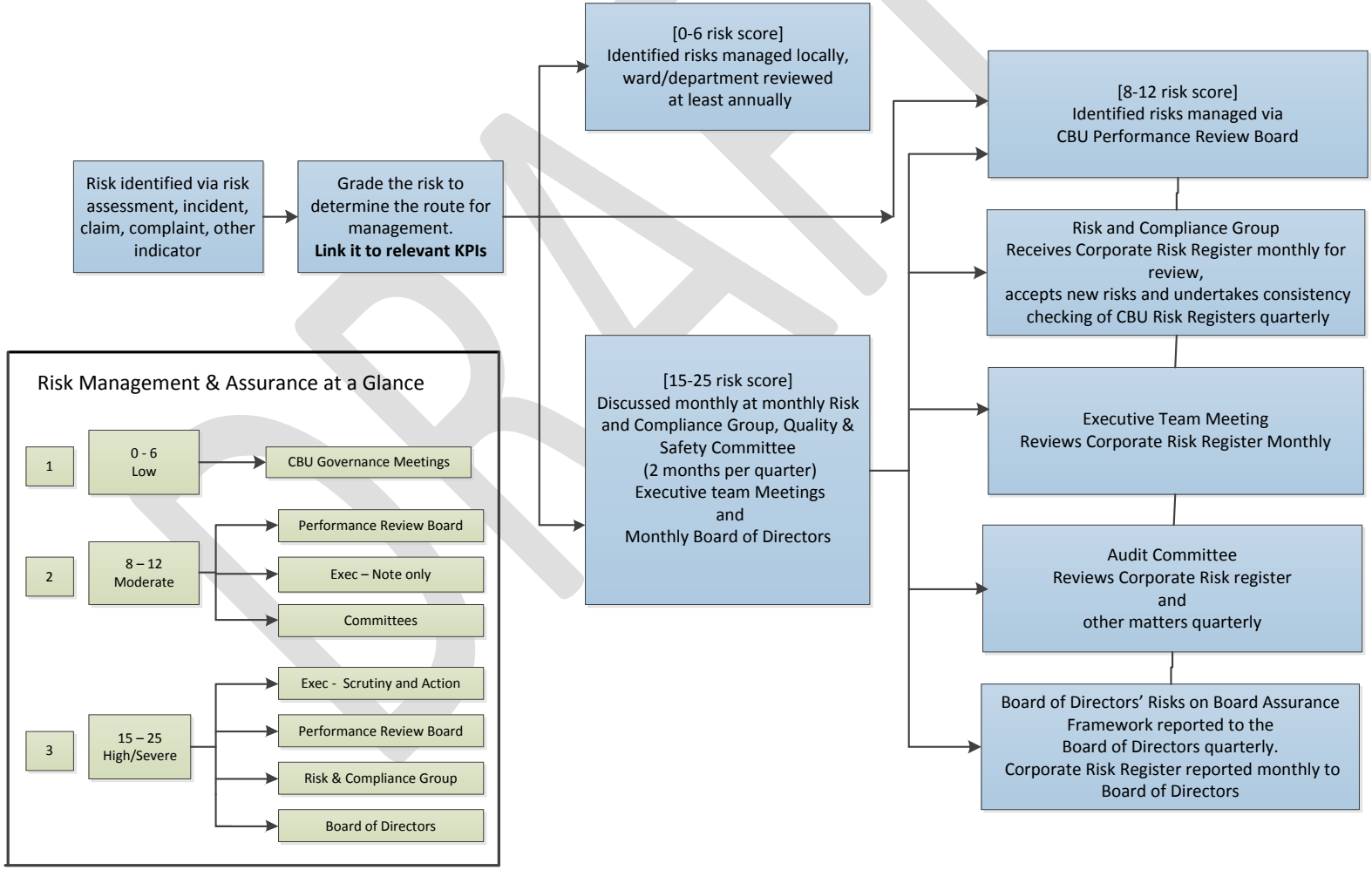
6.3 All local risks are systematically reviewed within a specified time frame by the local teams to ensure that controls in place are effective, and assess whether the risk changes over time.

6.4 Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may also be identified by external factors e.g. national reports and recommendations or regulatory and enforcement notices etc.

Figure 4:

Management and Assurance of Risks

Southport and Ormskirk Hospital NHS Trust



6.5 A description of the principal risks to compliance with the NHS provider licence[1, 2] condition 4 and actions identified to mitigate these risks, particularly in relation to items listed below are set out:

- the effectiveness of governance structures-these have recently been the subject of an external review by EY and the structures have been strengthened to include a new Hospital Management Board, Performance Review Boards for CBUs aimed at holding them to account
- the responsibilities of directors and subcommittees: each committee has robust terms of reference and annual business cycles. Assurance Committees are chaired by Non-Executive Directors. There are job roles for both non-executive and executive directors
- reporting lines and accountabilities between the board, its subcommittees and the executive team-the assurance committees on behalf of the Board holds management to account on operational issues and report monthly to the Board via three areas: Alert, Advise and Assure;
- the submission of timely and accurate information to assess risks to compliance with the conditions of the licence-this is done on an annual basis with sign off by the Board after review by the Audit Committee;
- the degree and rigour of oversight the board has over the Trust's performance-the Board receives a monthly Integrated Performance Report with each executive director giving assurance and/or action plans relating to regulatory and constitutional standards and other areas of performance.

7.0 Statutory and Assurance Committees

7.1 The Trust has three statutory committees as required by the *Health & Social Care Act 2012.*

They are:
- *Audit Committee*
- *Remuneration & Nominations Committee*
- *Charitable Funds Committee*

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local anti-fraud services. The Audit Committee reports to the Board quarterly via an *Assure, Alert and Advise* Highlight Report along with minutes of

[1] https://www.gov.uk/government/publications/the-nhs-provider-licence

[2] While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance. We aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. We therefore base our oversight, using the Single Oversight Framework, of all NHS trusts and NHS foundation trusts on the conditions of the NHS provider licence.

its monthly meetings and annually, on its work via the *Annual Report of the Audit Committee* in support of the *Annual Governance Statement*, specifically commenting on whether the BAF is fit for purpose, the efficacy of the assurances within the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements.

7.2 The Trust has created a Risk & Compliance Group (RCG) which ensures that risks are appropriately managed at operational level, that is, within the Clinical Business Units and that the appropriate risks are placed on the Corporate Risk Register and are appropriately escalated. In addition, the RCG monitors risks relating to policy management, claims and the Information Governance Risk Register which is also monitored at the Information Governance Steering Group the Group reports into the Audit Committee.

7.3 The Audit Committee met on a quarterly basis except for an extra meeting in May to review and make recommendations to the Board on the *Annual Governance Statement, Annual Report, Annual Accounts and Quality Accounts.*

7.4 The Remuneration & Nominations Committee has the delegated authority from the Board to:

Remuneration:

- Determine the framework for the remuneration of the Chief Executive, Executive Directors and Company Secretary including performance related elements, pensions and cars as well as arrangements for termination of employment and other contractual terms.
- Take into consideration when determining performance related elements the performance of individual directors and senior managers
- Oversee appropriate calculation and scrutiny of termination payments.

Nomination:

- Regularly review the structure, size and composition of the Board and make recommendations to it with regards to any changes.
- Give full consideration to succession planning for Directors and other senior managers, taking into account current challenges and future opportunities.
- Ensure appropriate job specifications are prepared for Board vacancies
- Be responsible for identifying and nominating for approval of the Board, candidates to fill Board vacancies as and when they arise.
- Review the results of Board performance evaluation as they relate to the composition of the Board.

7.5 The Charitable Funds Committee

The Committee is established to manage the charitable funds on behalf of the Trustees in line with appropriate legislation, Charity Commission requirements and the Trust's Charitable Funds Governance Procedures.

In order to achieve its purpose the Committee will:

- Ensure that the charity is managed and administered in accordance with the requirements of the *Charities Act 1993* and *Charities Act 2006* (or any modification of that Act).
- To agree appropriate limits, policies and procedures to ensure the effective distribution and management of the charitable funds.
- To make decisions involving the sound investment of charitable funds in a way which both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
    - *Trustee Act 2000*
    - *The Charities Act 1993 & 2006*
    - *Charitable Fund Governance Procedures*
- To receive reports for the ratification of investment decisions and action taken through delegated powers.
- To recommend a *Scheme of Delegation* and authorisation limits to the Board of Directors as Corporate Trustee.
- To monitor expenditure in line with the delegated authority.
- To approve all individual charitable fund expenditure within appropriate limits defined by the *Scheme of Delegation*.
- To ensure funding decisions are appropriate and consistent with the purpose of the fund, the donors' wishes and the Trust's objectives and values.
- To receive the Annual Report and Annual Accounts of the Charity and recommend them for approval by the Board of Directors as Corporate Trustee

7.6 The *Quality and Safety Committee* scrutinises and gives overview on clinical risks and holds the Executives to account by ensuring that clinical risks processes as set out in the Risk Management Strategy are adhered to and how they are being managed and controlled. This includes oversight of the performance and quality dashboards which show compliance with CQC registration requirements and other statutory compliance with quarterly reports being scrutinised prior to their submission to the Board.

The Quality & Safety Committee's other duties include:

- Seeking and providing assurance to the Board in respect of the effectiveness of the Trust's Integrated Governance arrangements underpinned by organisational development.
- Overseeing the development and implementation of the Trust's Risk Management, Quality and Nursing and Care Strategies including the Quality Improvement Strategy.
- To provide the Board with assurance regarding the effectiveness of all aspects of mortality and morbidity in the Trust.

- Triangulate mortality and morbidity with patient safety, quality and risk issues with workforce performance addressing areas of concern or deteriorating performance as required.
- Reviewing mortality data.
- Reviewing clinical outcomes.
- Receiving reports on recommendations made by internal or external forums or bodies and monitoring the achievement of associated action plans
- Reviewing clinical service changes
- Seeking and providing assurance to the Board in respect of the effectiveness of the Trust's risk management arrangements in respect of mortality.
- Reviewing forecasts of future performance and lessons learned from past performance.

7.7 The Finance, Performance and Investment Committee have delegated authority to monitor and scrutinise:

- Financial performance – includes monthly performance, working captial and Cost Improvement Plans (CIPs)
- Patient flow, includes activity levels, AED and waiting time performance
- Capital Programme, including IT
- Annual review of the Performance Framework
- Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee

7.8 The Workforce Committee has delegated authority to:

- Review evidence relating to external standards, including NHS Resolution (formerly (NHSR), Safe, Effective, Quality Occupational Health Service (SEQOHS), NHS Employers Guidance and CQC standards, raising any concerns regarding non-compliance in a timely manner and focusing on outcomes and improvements to the quality of patient and staff experience

- Review performance data and quality indicators covering key aspects of the Trust-wide workforce matters, identifying areas for action at a corporate and local level, ensuring follow up takes place:

    - Appraisal
    - Mandatory Training
    - Sickness
    - DBS
    - Staff Survey
    - Flu Vaccination
    - Recruitment & Staffing levels
    - CQUINs
    - Staff Friends & Family test
    - Bank & Agency
    - Volunteers

- Monitor the achievement of action plans covering key people management activities,

including response to the annual Staff Survey, Staff Engagement Strategy, Recruitment & Retention Strategy, Equality Strategy (Equality Delivery Scheme (EDS2), Workforce Race Equality Standard (WRES) the Health Work and Well Being agenda and other strategic workforce priorities including national recommendations, e.g. the *Francis, Berwick, Cavendish, Saville and Keogh reports*

- Review and take appropriate action based on reports from the Workforce Committee sub-groups
- With delegated authority from the Trust Board ratify relevant policies and procedures approved by Workforce Committee sub-groups
- Provide a report on activities of the Committee to the Trust Board on a monthly basis.
- Ensure any areas of risk relating to HR practices and activities are highlighted and escalated as appropriate

8.0 Equality, Diversity and Human Rights

8.1 As a public sector organisation, the Trust is statutorily required to ensure that equality, diversity and human rights are embedded into its functions and activities in line with the Equality Act 2010 and Human Rights Act 1998.

8.2 The Trust will have due regard to achieving the General Duties set out in the Equality Act 2010 to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share protected characteristics and those who do not.
- Foster good relations between people who share protected characteristics and those who do not.

8.3 To achieve the Specific Duties the Trust publishes on its public website a range of equality diversity and inclusion information:

- Annual Equality Diversity and Inclusion Report
- The Workforce Race Equality Standard Report (WRES)
- Equality Delivery System 2 Report (EDS2)
- Gender Pay Gap Report

8.4 Control measures are in place to ensure that the organisation complies with all relevant equality, diversity and human rights legislation. They are:

- Trust Board Sign Off
- Workforce Committee
- Valuing our Peoples Group
- Patient Experience Group
- Learning Disability Group
- Updates to the Clinical Commission Group (CCGs)
- Updates to NHS England

8.5 With regards to the *Modern Slavery and Human Trafficking Act 2015*, we are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation. We realise that slavery and human trafficking can occur in many forms, such as forced labour, domestic servitude, sex trafficking and workplace abuse.

8.6 Our policies, governance and legal arrangements are robust, ensuring that proper checks including pre-employment, fit and proper persons' in relation to *Schedule 5 of the Fit & Proper Persons' Regulation 2014* and due diligence take place in our employment procedures to ensure compliance with this legislation set out in the *Modern Slavery and Human Trafficking Act 2015.*

9.0 Workforce Strategies and Compliance

9.1 The key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place and which assure the Board that staffing processes are safe, sustainable and effective are described below and also shows how the Trust complies with the '*Developing Workforce Safeguards*[3]

9.2 Short-term Workforce

These are:

Daily safe staffing huddles with Terms of Reference

Currently Nurse staffing shortfalls are escalated, discussed and resolved on a day by day basis at the Safe Staffing Huddle. Safe Staffing Huddle is chaired by Head of Nursing/Midwifery, Associate Director of Nursing or Deputy Director of Nursing. Due consideration is given to the following:

- Any immediate adverse implications from staffing shortfalls
- Unexpected changes in acuity and dependency within a clinical area
- 1:1 supervision, Enhanced Levels of Care or co-horting of patients with specific nursing dependency needs is reviewed
- The mitigation of risk using professional nursing judgement for wards where nurse staffing numbers fall below planned levels

Out of hours this process is undertaken by the Site Manager, who is 'clinical'. In addition, any adverse incidents relating to nurse staffing are reported through the existing Datix system and discussed at the Daily Incident Review Meeting including the 'Red Flag Events'

9.3 Medium-term Workforce

Bi-annual staffing establishment review – The bi-annual nurse staffing establishment review is currently due to complete in March including the first data collection using Safer Nursing Care Tool. From the Review there is a Business Case being prepared to increase the current funded nursing establishment. This is due to be considered in April 2019 by Trust Board.

[3] https://improvement.nhs.uk/resources/developing-workforce-safeguards/

In October and November 2018 a gap analysis of Safe Staffing for nursing in adult inpatient wards in acute hospitals (National Institute for Clinical Excellence (NICE), July 2014), Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals (National Quality Board, January 2018) and 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – safe sustainable and productive staffing (NQB 2016) has been undertaken. The compliance with each set of guidance and summary of our 'gap analysis' has been shared with Workforce Committee & Trust Board over the same period of time. Updates on the Improvement plan are provided on a monthly basis.

A gap analysis of the Developing Workforce Safeguards' will be undertaken during March 2019 and any outstanding actions will be added to the Nursing & Midwifery Improvement Plan. The Trust is partially complaint with this guidance.

9.4 Long-term Workforce

These are:

- Workforce implementation plan post establishment reviews and outcome approvals via business case
- NHSI Improvement Plan- continued progression
- A Gap analysis of the deployment of nursing associates in secondary care

9.5 Care Quality Commission Regulatory Requirements

9.6 The Trust is fully compliant with the registration requirements of the Care Quality Commission.

9.7 The Trust registered with the Care Quality Commission (CQC) on 1st April 2010 and was inspected in December 2017 as part of a planned comprehensive inspection. Prior to the planned inspection in December, the CQC undertook an unannounced Well Led inspection of the Trust. The actions from that inspection are being addressed. The Trust achieved an overall rating of 'Require Improvement'. The Action Plan which emerged from the inspection focused on some 'Must Dos' and 'Should Dos'. In March 2018 the CQC also undertook an unannounced visit to A&E department. The Quality and Safety Committee has received monthly updates on the CQC action plan and so has the Board.

9.8 The Trust is in Quadrant 3 of a Challenged Provider Trust and is current and future risks are being addressed via a Quality Improvement Programme.

10.0 Register of Interests

The Trust has published an up-to-date register of interests for decision-making staff-the Board of Directors on the Trust Website and internally for other decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. Our policy, *Standards of Business Conduct and Managing Conflict of Interests,* has clearly set out these obligations which are monitored by the Audit Committee on behalf of the Board.

11.0 Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

12.0 Climate Change and Carbon Emission

12.1 The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18).

12.2 The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

12.3 The Trust has programmes aimed at minimising power and water use, and maximising the amount of waste sent for recycling

12.4 With regards to power and water**,** both Southport and Ormskirk hospitals generate their own energy from a combined heat and power (CHP) plant at each site.

12.5 Excess energy from these plants is exported to the National Grid. In 2018/19, 4 nearly 4.5kWh of energy was exported. This was enough to supply 1,118 three-bedroomed houses for a whole year.

12.6 The power plants have also reduced the Trust's reliance on the National Grid with only 15% of total power used on site being derived from that source (8% Ormskirk, 21% Southport).

12.7 After last success into reducing water consumption, the Trust has kept consumption level this year by continuing with the improved working practices in the laundry and the monitoring of the leak detection systems.

12.8 At the beginning of 2016, the Trust took delivery of an all-electric vehicle, loaned for four years by Veolia which runs the CHP plants, to help reduce fuel emissions and reduce costs.

12.9 This year the van has travelled 2,500 miles and has cost the Trust £43 (£102 at average National Grid rate). This is a cost of £1.80 per 100 miles – the approximate cost for an equivalent diesel vehicle is £14.65 per 100 miles, a saving of £300 for the year. We hope to see greater utilisation of the vehicle in 2018/19. Next year the Trust will consider:

- The viability of reopening a borehole at Ormskirk hospital to supply water for the laundry
- Modifying all large motors and pumps at Southport to make them run more efficiently
- Evaluate the costs/benefits of utilising solar heat for heating the swimming pool

12.10 With regards to Waste Management**,** the switch across the NHS from reusable items to single-use disposable items continues to increase the quantity of waste produced and the

cost of waste disposal. The new confidential waste disposal method has also caused logistical issue in working and this has led to a significant cost pressure on the waste budget**.**

Regarding Waste Segregation**,** in 2019/20, the Trust will review waste segregation from both a compliance and cost view point. It is widely accepted that improved segregation will provide costs savings.

Note: The figures above are estimates as we are currently not at the end of the financial year.

13.0 Review of Economy, Efficiency and Effectiveness of the Use of Resources

Information Governance

Within the last twelve months the Information Governance team has made a concerted effort to improve the Trust's training provision as well as update and improve the policies and procedures underpinning Information Governance within the Trust.

Information Governance training is now a standing item on all Corporate Inductions. Classroom sessions are given monthly as part of the 'You Choose' training events. A bespoke IG training session for facilities staff is now being delivered to accommodate their service needs. The eLearning Data Security Awareness session is also actively promoted as is the Information Governance Handbook. Information Governance Training is available at Southport and Ormskirk NHS Hospital Trust as a classroom, eLearning or training booklet in order to suit the different learning methods, staff availability and service requirements.

All the Information Governance training includes an outline of the relevant legal position, NHS guidance and the Trust's polices relating to the safe and appropriate processing, handling and storage of information.

Information security-related incidents are reported via the Trust's incident reporting system. Incidents are reviewed by the Information Governance Steering Group which has been chaired by the Senior Information Risk Owner. Where an ongoing information risk is identified, this is recorded on the relevant risk register, along with a note of actions to be taken to minimise the chances of re occurrence and impact.

There were six serious incidents requiring investigation during the period from April 2018 to March 2019, six of which were reported to the Information Commissioner's Office (ICO).

The first incident related to the theft or loss of four work diaries from a locked room which contained information relating to a number of patients. This was reported to the ICO on 15/06/2018 and there has been no response. Since the incident the Information Governance team has conducted two audits on the area and in both instances the preventive measures that were put in place have been found to be adequate.

The second incident involved discharge records being given to the wrong patient. This incident was reported to the ICO on 29/06/2018. The records where collected and the patients where provided with an apology.

The third incident was reported to the ICO on 12/07/2018 and related to the disclosure of patient's medical record within the chronology of another patient. The information was retrieved and an apology given.

The fourth incident was reported to the ICO on 26/07/2018 and involved a box of patient notes being lost in transit by Royal Mail. The box was sent by registered the post to a solicitor, the box arrived at the solicitor's office but the contents were missing. The Royal Mail Investigation Team could find no trace of the notes.

The fifth incident involved the disclosure of two patient's medical notes to another patient as part of a complaint. This was reported to the ICO on 23/08/2018.

The sixth incident involved the disclosure of the administrator username and password to the Doctor's Applicant Portal to successful applicants, the portal is used by HR to administer the on boarding on new doctors. 10 Doctor's received the administrator details but after an investigation conducted by the Information Governance Manager it was confirmed that nobody accessed the portal with the details. This was reported to the ICO on 13/12/2018, the ICO closed the incident on 08/01/2019.

In August 2018 Southport and Ormskirk NHS Hospital Trust was subject audit to a voluntary audit conducted by the Information Commissioner's Office (ICO). As a result of the audit an action plan containing thirty-four actions was created. In December 2018 the ICO carried out a follow up audit and published their report on the ICO website, the report found that *'The Trust has made meaningful progress to or completed all the actions agreed in the original audit'.*

14.0 Annual Quality Report

Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The Department of Health and Social Care has issued relevant guidance

The Trust has continued with following these steps to assure the Board that the Quality metrics present a balanced view:

- A review of information available to the Trust has been undertaken, as well as a quality care service review to agree quality priorities for the coming year, this has involved service users, carers, staff and partner agencies
- A monthly report via the Integrated Performance Report to the Board leading to scrutiny of whether the focus is right
- Sharing the draft Quality Account with partner agencies for comment, with the primary commissioners having the legal right to point out inaccuracies.

Processes are established to monitor compliance against Care Quality Commission (CQC) regulations (Health and Social Care Act 2008 Regulated Activities, Regulations 2014) using the updated Well Led Review Action Plan process which is based on the CQC's key lines of enquiry.

The content of the Quality Account has been prepared within the established Governance structures and framework and in accordance with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) and other guidance from NHS Improvement. The Draft Quality Account is shared with partner agencies and stakeholders and commissioners for comment. Leadership comes from the Board of

Directors with clearly devolved responsibility and accountability for individual quality improvement priorities.

Quality improvement priorities informed the Trust's Quality improvement Strategy and reflected the priorities of the Trust highlighted within Vision 2020. These measurable goals, against which progress can be monitored, are overseen by the Quality and Safety Committee.

The Director of Nursing is responsible for the preparation of the Quality Account and for ensuring that the document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads.

The Quality and Safety Committee is responsible for reviewing the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Board of Directors.

Mazars, our external auditors, undertook a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Progress against the Quality Account priorities for the reporting period, 2018/19, has been reported through the Trust's governance framework via the Annual Business Cycles of the Quality and Safety Committee and the Board of Directors receiving monthly reports on:

- Implementing the Patient Experience Strategy - The patient experience Pledge Group work commenced in October 2017 with the aim of each pledge group meeting bi-monthly. The groups are led by the matron for patient experience. The majority of groups also have patient representatives. For those that have not, there are links into the appropriate patient forums for any consultation. The Pledge Groups are now regularly reporting into the Trust Patient Experience Group and Quality and Safety Committee using the AAAs highlight reports.

The Trust is committed to continued quality improvement with the Reducing Avoidable Mortality Project and the Mortality Operational Group which are led by the Associate Medical Director for Patient Safety and the Trust's Programme Office.

Mortality data is reported each month to the Quality and Safety Committee and the Trust Board for assurance along with progress updates on the Reducing Avoidable Mortality Project.

The Trust rolled out the Structured Judgement Review (SJR) Method in 2018 to ensure comprehensive learning from deaths activity; quarterly reports for which are again submitted via the governance reporting structure for assurance.

In 2018, the Trust commissioned an External Mortality Review which, using the SJR method identified areas requiring improvement. As a result, workshops were held with key stakeholders from across the organisation to design a responsive action plan.

The current live action plan will be subsumed into the Reducing Avoidable Mortality Project, Phase 2 (April 2019 – March 2021) which will continue to drive quality improvement around the management deteriorating patient.

During 2018 / 2019 we aimed to reduce our number of caesarean sections which we have successfully achieved.

Indicator Name	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Month Trend	YTD 18/19	YTD Target
Maternity - Caesarean Rates - Overall	23.9%	23.56%	21.59%	27.17%	29.67%	23.91%	23.76%	17.48%	29.44%	23.08%	33.81%	27.43%	30.48%		%	24.%
Maternity - Caesarean % - Elective	8.81%	10.34%	12.5%	15.03%	14.84%	12.5%	10.4%	11.17%	17.78%	13.74%	18.1%	14.86%	17.65%		%	12.5%
Maternity - Percentage of Elective C-Sections <39 Weeks	28.57%	44.44%	59.09%	42.31%	25.93%	26.09%	22.22%	26.09%	25.%	36.%	18.42%	30.77%	15.15%		%	30.3%
Maternity - Caesarean % - Emergency	15.09%	13.22%	9.09%	12.14%	14.84%	11.41%	13.37%	6.31%	11.67%	9.34%	15.71%	12.57%	12.83%		%	######

For 2018/2019 the year to date caesarean section rate is 26.15% compared with 24.3% at the end of March 2018.

For the year to date instrumental birth rate is 9.82% compared with 13.18% at the end of March 2018.

We continue to monitor our caesarean section rates and assisted delivery rates which are in line with the national rates.

We contribute to benchmarking via the regional maternity dashboard

This year the Trust has worked closely with the NHSI Intensive Support Team (IST) to ensure the validity and accuracy of our elective waiting times data. This has involved rigorous data quality and validation checks over the year on all aspects of waiting time information including recording, processing and reporting. Where advice was given additional training and processes have been embedded to mitigate any risks to quality and accuracy of this data.

Priorities for 2019/20 have been developed in line with the Trust's Quality Improvement Strategy and include:

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

Robust outcome metrics will be set for each priority and action to identify progress and success in achieving this improvement Strategy. The metrics we will use will be meaningful to both staff and patients. Measurement will be used to demonstrate the impact of change and then continued as on-going performance measures following the implementation of successful change, quarterly reports will be reported via Quality and Safety Committee to Board. Processes are established, previously set up to collect evidence of compliance in line with the CQC Inspection recommendations (*Must and Should Dos*) from 2016 and 2017. The new CQC Insight Reports are used to check our performance and anticipate any potential risks in the future. The Quality and Safety Committee is kept informed of the completeness of the data and any breaches.

15.0 The Key Financial Governance Policies and Processes

As Accountable Officer I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good

governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

The *Standing Orders* are contained within the Trust's legal and regulatory framework and set out the regulatory processes and proceedings for the Board of Directors and its committees and working groups including the Audit Committee, whose role is set out below, thus ensuring the efficient use of resources.

Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's *Standing Orders* and the Scheme of Reservation and Delegation and the individual detailed procedures set by directorates.

Scheme of Reservation and Delegation

This sets out those matters that are reserved to the Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

Anti-Fraud, Bribery and Corruption Policy

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board places reliance on the *Audit Committee* to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Anti-Fraud Service, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Counter Fraud Authority (formerly NHS Protect), reports from which are reviewed by the Audit Committee.

16.0 Work of the Board of Directors in Monitoring Finance

The Board of Directors receive on a monthly basis, a Director of Finance report which includes sustainability and CIP issues.

The Finance, Performance and Investment Committee meet on a monthly basis to scrutinise finance and performance issues and gives assurance to the Board where applicable. It further analyses finance and performance strategic and operational risks and make recommendations to the Board as to what actions are needed in relation to those risks.

17.0 Work of the Audit Committee

The Audit Committee provides an 'oversight' role on behalf of the Board, reviewing the adequacy and effectiveness of controls. It is supported by the Quality and Safety Committee, Finance and Performance Investment Committee, Remuneration and Nominations Committee, Charitable Funds Committee and Workforce Committee which carry out their duties as assurance committees, in reviewing systems of control and governance in relation to all matters of clinical quality and safety, financial control and investment and workforce and organisational development.

18.0 Work of the Finance, Performance and Investment Committee

As stated above *The Finance, Performance and Investment Committee* has delegated authority to monitor and scrutinise:

- Financial performance – includes monthly performance and CIP
- Patient flow- includes activity levels, AED and waiting time performance
- Capital Programme, including IT
- Annual review of the Performance Framework
- Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee
- Scrutinise strategic and operational risks in relation to performance and finance and receives reports on the above on a monthly basis. Any major concerns are escalated to the Board of Directors.

19.0 Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report/Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their Annual Audit Letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system that is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Board and Committees in this process:

The Board reviews the Board Assurance Framework on a quarterly basis along with the Risk Register on a monthly basis.

- The establishment of a Risk and Compliance Group whose purpose is to promote effective risk management, regulation and compliance and to maintain a dynamic Board Assurance Framework, risk registers and compliance and regulatory registers through which the Board can monitor the arrangements in place to achieve a satisfactory level of corporate integrated internal control, safety and quality.

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

- A programme of Risk Management training for all staff

- A number of external reviews were commissioned to ensure that corporate governance and performance were more robust. These included:

    - A Rapid Review of Governance undertaken by EY resulting in the establishment of a Hospital Management Board, Hospital Improvement Board, Performance Review Boards where CBUs are held to account and an updated Integrated Corporate Governance Structure as shown above

    - Nurse Staffing/e-Roster plus Estates and Facilities review which focused on delivery of CIPs in E&F and roll out of rostering on wards

    - Acute Sustainability Case for Change in conjunction with Cheshire and Merseyside Sustainable Transformation Partnership (STP) to establish the case for the Trust to consider its future sustainability

- The Internal audit Plan which is risk based and is approved by the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit

Committee on a quarterly basis with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly escalate any areas of concern to the Board via a Committee Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness.

- The Executive Team meets on a twice weekly basis and has a process whereby key issues such as performance management, serious incidents, recruitment and retention, safe staffing, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need. It also reviews plans and concerns relating to Well Led and any subsequent Care Quality Commission inspection. Members of the Clinical Business Units' (CBUs) Triumvirate are invited and in attendance at the Thursday meeting to give update reports on performance issues in the CBUs.

- The Board and its statutory and assurance committees have clear cycles of business and reporting structure to allow issues to be escalated via the *'floor to board'* risk escalation framework.(**see Figure 4**). The purpose of each committee is outlined in the Governance Structure at **Figure 1** and their work is summarised above.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the Clinical Negligence Scheme along with the NHS Resolution and the Care Quality Commission.

During the year a Well Led Review led by Advancing Quality Alliance (AQuA) and Mersey Internal Audit Agency (MIAA) was undertaken by the Board in preparation of a planned inspection by the Care Quality Commission later in the year. The CQC published its last Report in March 2018.

Work is continuing on a robust action plan to address the Must Dos and other recommendations. The Executive Team has prepared a robust action plan to meet the recommendations made by the CQC and this is monitored at each Executive Team meeting. Updates on the CQC Action Plan are discussed on a monthly basis at both the Quality and Safety Committee and the Board of Directors.

There are internal discussions on-going to ensure that the response to the recommendations should be used as an opportunity to move from *Requires Improvement* to *Good.*

20.0 Director of Internal Audit Opinion

Internal Audit reviews the system of internal control during the course of the financial year and report accordingly to the Audit Committee. The Director of Internal Audit has provided an overall opinion of **TBC assurance** based on their work during 2018-19, which gives me confidence that we have a good foundation on which to build our improvement work.

Specifically, the Director of Internal Audit has stated:

TBC

Conclusion

Notwithstanding the risks and challenges highlighted above, no significant internal control issues have been identified.

Accountable Officer:

Silas Nicholls:……

Chief Executive

Date: 22 May 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	TB074/19	Report Title	Financial Position Month 11 - February 2019
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 11 year to date (YTD) the Trust's financial performance is a deficit of £27.052 million; this is £417,000 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 seen in January continued in February due to the need to safely staff areas due to higher levels of non elective activity. The cumulative pay budgets overspend was maintained as expenditure reserves were used to mitigate the reduction in income from recognising the application of sanctions for the national A&E target. Non-pay expenditure in February lower than January. CIP programme is forecast to be £0.6 million lower than the £7.5 million plan.

The following are the key risks to delivering the year end deficit of £28.8 million:

- 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. This issue has not been fully accepted by commissioners.
- There is a risk to income of £3.8 million for these two issues.
- Non recurrent assistance of £2 million from NHSE reduces this risk to £1.8 million. Discussions are ongoing regarding the remaining risk and a verbal update will be provided to the Committee.

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

Recommendation:
The Board is asked to **receive** the month 11 Director of Finance report.

Strategic Objective(s) and Principal Risks(s) (*The content provides evidence for the following Trust's strategic objectives for 2018/19)*	
Strategic Objective	**Principal Risk**
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
☐ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
☑ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
☐ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

Director of Finance Report – February 2019

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 11 (the financial period ending 28th February 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 £5,000 behind the plan for February, resulting in a year to date deficit of £24.502 million which overall is £417,000 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. Although this has still not been resolved Southport & Formby CCG have secured £2 million recurrent assistance from NHSE and this has now been paid to the Trust.

2.4. Significant increase in A&E attendances in February resulting in additional YTD income of £654,000 (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 £5.68 million above the Trust's initial plan.

2.6. Elective activity is balanced in month but year to date is down by 11.5%; which is worth £1.1 million in income.

2.7. Outpatient activity is up in month and YTD.

2.8. A provision of £425,000 has been made for non-achievement of CQUIN. The year-end forecast shortfall is now expected to be £461,000.

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

2.10. The expenditure run rate increase seen in January continues. This is mainly related to additional emergency activity resulting in higher levels of premium rate expenditure for nursing and medical staff. The cumulative pay budget overspend reduced from £1.835 million (month 10 YTD) to £1.790 million (month 11 YTD) assisted by the utilisation of reserves.

2.11. Non-pay expenditure reduced in February.

2.12. Agency spend up on January levels (£952,000 in month; YTD £7.8 million).

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

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	148,958	136,457	139,082	2,625	12,079	12,034	(45)
PP, Overseas & RTA	1,387	1,271	914	(357)	116	69	(47)
Other Income	14,575	13,333	13,983	650	1,273	1,451	178
Total Income	**164,919**	**151,061**	**153,978**	**2,917**	**13,468**	**13,554**	**86**
Operating Expenditure							
Pay	(129,333)	(118,702)	(120,492)	(1,790)	(10,681)	(10,636)	45
Non-Pay	(53,221)	(48,771)	(50,204)	(1,433)	(4,404)	(4,543)	(139)
Total Expenditure	**(182,554)**	**(167,473)**	**(170,696)**	**(3,223)**	**(15,085)**	**(15,179)**	**(94)**
EBITDA	**(17,635)**	**(16,412)**	**(16,718)**	**(306)**	**(1,617)**	**(1,625)**	**(8)**
Non-Operating Expenditure	(11,217)	(10,282)	(10,291)	(9)	(933)	(935)	(2)
Retained Surplus/(Deficit)	**(28,852)**	**(26,694)**	**(27,008)**	**(315)**	**(2,549)**	**(2,560)**	**(10)**
Technical Adjustments	63	58	(44)	(102)	6	11	5
Break Even Surplus/(Deficit)	**(28,789)**	**(26,636)**	**(27,052)**	**(417)**	**(2,543)**	**(2,549)**	**(5)**

2.14. Capital expenditure is within the plan and continues to be managed through the Trust's Capital Investment Group (CIG). Significant expenditure is planned to take place in March with half of this already committed through medical equipment orders.

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

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

2.16.3. There is a risk to income of £3.8 million for the above issues.

2.16.4. Non recurrent assistance of £2 million from NHSE reduces this risk to £1.8 million. Discussions are ongoing and a verbal update will be provided to the Board.

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 was close to plan in February resulting in two consecutive months where the underperforming trend has been reversed. However, the YTD adverse variance remains at £1.1 million.

3.2. Outpatient activity overperformed in month.

A&E

3.3. The significant increase in A&E attendances seen over winter continued into February where attendances exceeded plan. Income overperformance is £654,000 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 £1.955 million.

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 £3.8 million.

3.8. Income of £2.334 million was accrued at month 11 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 £5.68 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 there is a shortfall of £425,000 at month 11 YTD (FOT £461,000).

Sanctions

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

3.14. Sanctions for February are £230,000 (based on the national target of 95% for A&E 4 hour performance). Although this is lower than January it is £80,000 worse than in the FOT (£150,000) which is driven by ambulance handovers and compliance with the 4 hour A&E standard.

3.15. Based on performance for the first eleven months sanctions of £2.138 million (now £2.3 million forecast for full year) will be levied by commissioners.

3.16. The Trust believed it was more appropriate to only levy the A&E sanction for breaches against the Trust's NHSI agreed trajectory (lower than 95%). This has not been agreed and the full £2.138 million income reduction has been actioned in month 11 with mitigation from expenditure reserves.

4. Expenditure

4.1. Underlying pay expenditure levels consistent with January.

4.2. 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.

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

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

4.5. Non pay spend has reduced overall in month compared to January.

5. Agency spend

5.1. The Trust has spent £952,000 on agency staff in February (10.7% 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 £7.8 million, £2 million above the NHSI agency cap with another month 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 February 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 Non framework agency staff resulting in the consistent high nurse agency spend.

5.6. Additional agency other medical staff have also been used to cover the additional ward.

5.7. Ward 1 has been closed on 8th March.

5.8. Overall nurse vacancy levels have increased by 0.1% to 8.8%, the increase is in registered nurses.

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

5.10. The cost of providing cover for nurse sickness in February was £218,000 (bank £143,000; agency £75,000) based on the information provided by NHSP. Any non framework bookings are made via NHSP.

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

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

5.13. 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.

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

rates.

5.15. The cost of providing cover for medical sickness in February was £8,000 (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	6,270	5,746	(524)	734	574	(160)	6,355
17/18 Balance to FYE	535	491	491	0	45	45	0	535
Total	7,541	6,761	6,237	(524)	779	619	(160)	6,890

6.4. The total value for ACU/CDU income in the YTD actual of £5.618 million is £2.334 million.

6.5. 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. (February's cash flow was sent on 9th January).

7.3. The Trust borrowed £2.64 million in February.

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

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

Description	Target £000	Actual £000	Comments
Opening balance	1,000	1,075	Brought forward balance.
Cash inflows	16,572	17,280	Majority of additional cash inflows relates to VAT recovery @ £494k.
Cash outflows	-16,572	-16,653	Whilst cash outflows were in line with the plan, there was a delay on the Santander modular building lease (taken by direct debit, £487k) which did not debit the account until 4th March.
Closing balance	**1,000**	**1,702**	

7.6. Santander had not updated the lease to reflect the new contract and as such they were not able to take the new direct debit until March and this is the reason that the closing cash position in February was higher than planned.

7.7. 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.

7.8. March's loan request was £2.19 million and this is aligned to the 2018/19 planned borrowing of £32 million (split between £28.8 million deficit funding and £3.2 million to tackle prior-year cash settlements with the CCGs).

7.9. Initially the cash flow forecast for March was looking challenging; however, an initial settlement of £2.475 million from Southport & Formby CCG was agreed and paid on 1st March.

7.10. Further discussions with the CCGs and both regulators will result in further significant cash inflows later in March.

8. Capital

8.1. Although the in-month capital spend is relatively low at £406,000, there is confidence that the Trust will spend up to its statutory Capital Resource Limit (CRL).

8.2. At this time of year the plan is monitored daily and large projects such as the anaesthetic machines (£643,000), sexual health accommodation (£279,000), UPS theatres (£139,000), further IT spend (£230,000), reverse osmosis plant (£100,000) and a number of other schemes are all progressing well with completion due before the end of March.

8.3. Additional monies of £12,000 for pharmacy define software have been received in February from DHSC.

8.4. In March a further £98,000 was received form DHSC for IT projects and this has been built into the plan.

8.5. To achieve the Trust's CRL, capital spend (excluding donations and IFRIC 12 – GE radiology equipment) needs to be £5.229 million.

8.6. Current forecast annual spend is £5.203 million and there are plans to utilise the remaining £26,000.

9. **Risks**

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

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

9.1.3. There is a risk to income of £3.8 million for the above issues.

9.1.4. Non recurrent assistance of £2 million from NHSE reduces this risk to £1.8 million. Discussions are ongoing and a verbal update will be provided to the Board.

10. **Forecast Outturn 2018/19**

10.1. The Trust's £28.8 million deficit plan is achievable providing the full value of activity is received in income. The full value of sanctions (both performance against standards and CQUIN) can be accommodated within the forecast.

10.2. The table below shows the current contractual position:

	SF CCG £M	**SS CCG £M**	**WL CCG £M**	**Total £M**
Contract value Trust asked for in opening 2018/19 plan	65.4	6.5	46.4	118.3
Contract shortfall (Trust confirmed in letter to CCG)	(1.3)	(0.2)	(1.1)	(2.6)
Contract value agreed for 2018/19	64.1	6.3	45.3	115.7
Trust FOT 2018/19 contract (delivers £28.8m deficit)	68.1	6.6	46.5	121.2
CCG FOT 2018/19 Offer	68.1	6.2	45.1	119.4
Gap from rejected CCG offers	**0**	**0.4**	**1.4**	**1.8**

(Note that S&F CCG FOT 2018/19 offer includes £2 million non recurrent assistance from NHSE).

11. **Recommendations**

11.1. The Board is asked to receive the month 11 Financial Position report.

List of Appendices

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

	ODGH				SDGH				Trust		
	In Month	YTD	Pr YTD	Growth	In Month	YTD	Pr YTD	Growth	In Month	YTD	Pr YTD
GP Referrals									3,056	37,097	38,600
Consultant Referrals									2,746	33,020	30,789
Other Referrals									2,823	33,401	30,559
AAE Attendances	2,312	25,831	24,662	4.7%	4,468	52,175	48,069	8.5%	6,780	78,006	72,731
NEL Full Admissions	271	2,849	2,333	22.1%	984	11,242	10,503	7.0%	1,255	14,091	12,836
NEL Ass. Ward Admission	178	1,586	1,783	-11.1%	1,036	11,064	4,876	126.9%	1,214	12,650	6,659
Daycases	1,105	12,642	13,036	-3.0%	745	7,917	7,564	4.7%	1,850	20,559	20,600
Electives	138	1,482	1,651	-10.2%	53	785	938	-16.3%	191	2,267	2,589
Maternity	220	2,356	2,670	-11.8%					220	2,356	2,674
Births	179	1,937	2,190	-11.6%					179	1,937	2,190
Outpatients First Att.	3,875	44,143	42,202	4.6%	3,857	45,523	42,350	7.5%	7,732	89,666	84,552
Outpatients Follow Up Att.	12,024	135,243	133,940	1.0%	10,271	119,329	113,645	5.0%	22,295	254,572	247,585
Scopes	24	5,323	6,115	-13.0%	188	500	175	185.7%	212	5,823	6,290
Radiology Exams A&E Attender	981	12,495	11,987	4.2%	2,579	30,437	31,171	-2.4%	3,560	42,932	43,158
Radiology Exams GP Direct Access P	1,711	18,846	16,633	13.3%	1,366	15,870	16,961	-6.4%	3,077	34,716	33,594
Radiology Exams Inpatient	191	2,467	1,924	28.2%	1,503	17,554	14,408	21.8%	1,694	20,021	16,332
Radiology Exams Outpatient	2,477	29,417	29,905	-1.6%	2,050	23,129	22,090	4.7%	4,527	52,546	51,995
Radiology Other	33	314	642	-51.1%	8	98	222	-55.9%	41	412	864

Pr YTD is Previous Year to Date

Growth
-3.9%
7.3%
9.3%
7.3%
9.8%
90.0%
-0.2%
-12.4%
-11.9%
-11.6%
6.1%
2.8%
-7.4%
-0.5%
3.3%
22.6%
1.1%
-52.3%

Statement of Financial Position (Balance Sheet)

Southport & Ormskirk Hospital NHS
NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/01/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	125,914	(876)	(117)
Other assets	1,382	1,139	(243)	17
TOTAL NON CURRENT ASSETS	**128,172**	**127,053**	**(1,119)**	**(100)**
CURRENT ASSETS				
Inventories	2,454	2,448	(6)	13
Trade and other receivables	9,591	13,962	4,371	(485)
Cash and cash equivalents	1,079	1,702	623	627
Non current assets held for sale	0	0	0	
TOTAL CURRENT ASSETS	**13,124**	**18,112**	**4,988**	**155**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(25,876)	(645)	(46)
Provisions	(131)	(201)	(70)	0
PFI/Finance lease liabilities	(1,746)	(1,746)	0	0
DH revenue loans	(4,220)	(17,628)	(13,408)	(3,410)
DH Capital loan	(400)	(400)	0	0
Other liabilities	(471)	(662)	(191)	10
TOTAL CURRENT LIABILITIES	**(32,199)**	**(46,513)**	**(14,314)**	**(3,446)**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(28,401)	(9,326)	**(3,291)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**98,652**	**(10,445)**	**(3,391)**
NON CURRENT LIABILITIES				
Provisions	(278)	(214)	64	0
DH revenue loans	(66,615)	(83,017)	(16,402)	770
PFI/Finance lease liabilities	(13,807)	(13,556)	251	72
DH Capital loan	(1,400)	(1,000)	400	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(97,787)**	**(15,687)**	**842**
TOTAL ASSETS EMPLOYED	**26,997**	**865**	**(26,132)**	**(2,549)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	98,116	875	12
Retained earnings	(83,484)	(110,491)	(27,007)	(2,561)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**865**	**(26,132)**	**(2,549)**

In month material movements are as follows:

The only significant movement is on DH revenue loans. This is a combination of reclassifying a loan which matures in 12 months as current (£3.41m) and February's new loan of £2.64m.

Movement on the retained earnings line is consistent with the in-month deficit.

The Committee should note that the overall value of the balance sheet is now less than a £1m. Given the forecast deficit for March plus an anticipated reduction in our buildings valuation, the balance sheet will go negative in March.

Whilst a negative balance sheet in the commercial world would stop the business trading, in NHS world we can continue to operate as we have DHSC loan support.

Statement of cash flows

NHS
Southport and Ormskirk Hospital
NHS Trust

	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Actual Nov-18	Actual Dec-18	Actual Jan-19	Actual 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)	(2,147)	(1,421)	(23,880)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)	(20)	0	(6)	(12)	(7)	0	(10)	(180)
Depreciation and Amortisation	523	524	523	524	523	524	518	522	522	524	523	469	6,219
Impairments and Reversals	0	0	0	0	0	0	0	0	0	0	0		0
(Increase) in Inventories	(50)	59	(83)	0	(39)	19	95	62	(60)	16	(13)	(6)	0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818	(805)	(540)	(4,585)	100	(803)	469	1,929	(2,198)
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	(144)	492	472	1,324	(1,172)	(453)	1,501	672
Increase in Provisions	(3)	(3)	(61)	82	0	(3)	7	0	(7)	(7)	0	(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)	(1,621)	2,417	(19,407)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	5	4	4	5	4	4	2	40
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(8)	0	(2)	(35)	(36)	(15)	(697)	(1,002)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(214)	(114)	(114)	(1,515)	780	(292)	(2,701)	(5,889)
Receipts from disposal of fixed assets	0	0	1	2	0	0	37	31	1	0	0	0	72
Receipt of cash donations to purchase capital assets	5	52	30	18	20	20	0	6	12	7	0	10	180
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(197)	(73)	(75)	(1,532)	755	(303)	(3,386)	(6,599)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	127	0	280	456	0	12	98	973
Public dividend capital repaid	0	0	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	2,640	2,190	32,000
Loans repaid to DH	(200)	0	0	0	0	0	(200)	0	0	0	0		(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(554)	(122)	13	(29)	(8)	(243)	(991)
Capital element of PFI, LIFT	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(16)	(162)	(14)	(13)	(163)	(760)
Interest Paid	(99)	(103)	(148)	(104)	(136)	(484)	(145)	(150)	(165)	(181)	0	(1,242)	(2,957)
Interest element of finance lease	0	0	0	0	0	0	(262)	(5)	0	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	0	(7)	(84)
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	2,551	267	25,927
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**(1,076)**	**194**	**(9)**	**(98)**	**(45)**	**627**	**(702)**	**(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	1,702	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**	**1,702**	**1,000**	**1,000**

NHS Southport and Ormskirk Hospital NHS Trust

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2018/19 £'000	YTD to M11 £'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	735	479	256	781		12	1,272
	Beds / Trolleys	G0060	50	50	51	(1)				51
	Sub total MEDICAL DEVICES		**920**	**785**	**530**	**255**	**781**	**0**	**12**	**1,323**
IM&T	Electronic Patient Record	F6409	190	190	70	120	29			99
	Patient Service Signposting	G0081	0	456	149	307				149
	Vitalpac	G0007	30	30	14	16				14
	eDMS	F6447	160	147	11	136				11
	Wireless network upgrade	G0073	150	302	261	41	84		1	346
	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	46	18	28	16			34
	Fixed network infrastructure	F6498	100	92	27	65	4			31
	Datacentre	G0075	50	50	189	(139)	23			212
	Virtual desktop infrastructure	G0076	25	25	2	23	56			58
	Equipment refresh	G0077	50	46	5	41			6	11
	Sub total IM&T		**1,000**	**1,554**	**1,018**	**536**	**213**	**0**	**7**	**1,238**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	400	200	241	(41)				241
	Southport A&E Redesign	G0068	350	753	834	(81)	15		17	866
	Ward reconfigurations	G0064	140	140	134	6				134
	Medical gasses	G0067	30	30	43	(13)				43
	UPS Theatre	G0053	50	140	94	46	3	42		139
	Waste management storage facilities	G0080	100	100	10	90			3	13
	Theatre airplant controls		45	45	0	45				0
	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				0
	Additional Car Parking	G0083	0	50	15	35	12		20	47
	Sexual Health Accomodation	G0079	0	260	161	99	34	71	13	279
	Doctor's Mess Facilities	G0082	0	40	67	(27)	1			68
	Capital team	F6305	155	98	157	(59)		12		169
	Aseptic isolator	G0084	30	75		75			39	39
	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						26			26
	Reverse Osmosis Plant SDGH								100	100
	Sub total ESTATE IMPROVEMENT SCHEMES		**1,845**	**2,349**	**1,909**	**440**	**91**	**125**	**251**	**2,376**
FACILITIES	Catering equipment	G0026	100	100	24	76				24
	Sub total FACILITIES		**100**	**100**	**24**	**76**	**0**	**0**	**0**	**24**
	CONTINGENCY	**F6301**	**319**	**266**	**118**	**148**	**124**			**242**
	Capital plan excluding donations and IFRIC 12		**4,184**	**5,054**	**3,599**	**1,455**	**1,209**	**125**	**270**	**5,203**

Required capital spend to achieve Capital Resource Limit (CRL) is £5,229k. Received additional DHSC capital monies for Define software £12k and HSLI £98k.
Currently tracking £26k under CRL
Note the above excludes donated asset spend (£170k) and IFRIC 12 (£1,173k) as these do not impact on the achievement of the CRL.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	TB075/19	Report Title	Risk Management
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 or removed from this risk register.

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 Board is asked to:

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

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

MARCH 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 21/03/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-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	Risk Closed - awaiting confirmation of staff survey results before new risk added	
1329	SO3 - Provide care within agreed financial limit	Returning to financial balance by 2021	Director of Finance	=16	=16	=16	Risk Closed - replaced with Risk 1942		
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	15	=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	=16
1917	SO2 - Improve clinical outcomes and patient safety	Quality of Older Peoples Care	Director of Nursing & Quality	!16	=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	9	=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	16	=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	=16
1942	SO3 - Provide care within agreed financial limit	Eradicating the Trust's deficit by 2023/24	Director of Finance				!16	=16	=16

TRUST RISK PROFILE AS AT 21/03/2019

	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	18/03/2019	18/04/2019	
Assurance	Monthly Planned Care governance meetings						**Gaps in Assurance**			
Action Plan	Reviewing job descriptions to be in line 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 12/04/2019	**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 CQC Programme Manager in post working to Assistant Director of Quality					**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	13/03/2019	16/04/2019

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, and look at re-establishing the Quality Improvement Development (QUID)Group 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 30/04/2019	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made Moderate Progress Made Little or No 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	18/03/2019	18/04/2019	
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**	07/05/2019 07/05/2019 07/05/2019	**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 patients wishes and best quality end of life care possible. Review of wards to take place to establish how to maximise potential of the areas we have to provide better environments for patients particularly with enhanced needs. Particularly looking at signs, colour of objects, orientation devices, tables/chairs to encourage interaction, stimulating activities, getting up dressed and moving. Continue to roll out Red2Green and education across all wards		07/05/2019 07/05/2019 29/05/2019		Progress Made Moderate Progress Made Moderate Progress Made Little or No Progress Made Actions Almost Completed

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	13/03/2019	30/04/2019
Assurance	Data for 4 hour standard, 12 hour breaches monitored daily and analysed and presented at PRB, Q&S, A&E Delivery Board and Trust Board NHSI Monitoring of ED performance with daily reporting Escalation to Commissioners of current shortfalls in mental health beds and delays experienced in A&E Emergency Care Improvement Support Team (ECIS) undertaking full review of mental health pathway Nov 2018 Conflict Resolution training figures Timely Datix Incident Reporting for any incidents						**Gaps in Assurance**	12 hour breaches still occurring for mental health patients as provider capacity doesn't match need	
Action Plan	Establish office space to accommodate Merseycare on site Mental Health Sub-Group of the A&E Delivery Board has been established to review and agree appropriate actions to support mental health patients An audit has been completed into the 12 hour breaches which is being reviewed at SIRG with a retrospective trend analysis to be completed by 20/12 to be shared with partners and NHSI. The actions associated with this audit will be monitored within our internal governance arrangements 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	18/03/2019	15/04/2019
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 identify 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	18/03/2019	15/04/2019	
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	Review of Model Hospital data to ensure its accuracy and relevance in driving Trust efficiency improvements 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.						**Action Plan Due Date**	31/03/2019 31/01/2019 31/03/2019	**Action Plan Rating**	Little or No Progress Made Actions Almost Completed Little or No Progress Made

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	**TB076/19**	**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)*	
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 Trust board with an update on the development of the Quality Improvement Action Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November/December 2017 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018.

2. BACKGROUND

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

3. TRUST PROGRESS

The 2017 Action Plan and the Urgent and Emergency Services Quality Improvement Plan have been merged into one overarching Quality Improvement Plan containing 114 Must and Should Do recommendations.

A review in relation to the accountability framework is underway in order to realigning responsibility between operational, nursing and medical management, this will enable clear lines of accountability for 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 and the BRAG status to be confirmed.

Assurance Panels for the North West Regional Spinal Unit and Urgent and Emergency Care tool place in March 2019. The next Assurance panel will be Maternity planned for end March 2019.

Following review a number of recommendations have moved from Amber to Red due to lack of evidence having been submitted from core services, the CBU's have been asked to urgently develop timescales and trajectories for improvement.

In order to demonstrate improvement by the next inspection, we have modelled where we need to be to get back on trajectory, subject to the increased engagement and improvement accountability.

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	4	2	6
Action Completed	12	15	27
On track to deliver	43	29	72
No progress / Not progressing to Plan	4	5	9
TOTAL	63	51	114

BRAG rating monthly reported completion

Rating	June 18		July 18		August 18		Sept 18		Oct 18		Nov 18		Dec 18		Jan 19		Refresh	Feb 19
	Corp	ED	Corp	ED	Corp	ED	Corp	ED	Corp	ED	Corp	ED	Corp	ED	Corp	ED		All
Delivered and Sustained	1/96	N/A	1/96	N/A	1/96	N/A	2/96	0/25	5/96	1/25	5/96	1/25	5/96	1/25	5/96	1/25		6
Action Completed	0/ 96	N/A	6/96	N/A	22/96	N/A	21/96	4/25	19/96	15/25	34/96	17/25	34/96	17/25	34/96	17/25		27
On track to deliver	95/96	N/A	89/96	N/A	73/96	N/A	73/96	21/25	72/96	9/25	57/96	7/25	57/96	7/25	57/96	7/25		72
No progress / Not progressing to Plan	0/96	N/A	0/96	N/A	0/96	N/A	0/96	0/25	0/96	0/25	0/96	0/25	0/96	0/25	0/96	0/25		9

Our expected forward trajectory is – Trust wide

Rating	Current Position Feb 19	Forecast March 19	Forecast April 19	Forecast May 19
Delivered and Sustained	6	8	12	20
Action Completed	27	35	47	51
On track to deliver	72	64	52	43
No progress / Not progressing to Plan	9	7	3	0

The areas identified as red are around themes of:

- Mandatory training
- Documentation quality
- Collaborative working to enhance decision making
- Medicines management and storage
- Oxygen prescription
- Management of Controlled drugs
- Infection prevention regarding cannulation in ED
- ED flow
- Risks identified and minimised regarding patient safety

These areas are being focused on over the coming month to enable areas to move once evidence is generated.

4. CQC Preparation

As the committee is aware the cycle for a CQC inspection is imminently expected, in order to support, coach and prepare colleagues across the organisation work is underway to ensure the organisation is in the best position possible to be ready for this and for staff to share the improvements that have been made since the 2017/18 inspections.

We have developed a Provider Information Request (PIR), to enable colleagues to start to gather the relevant information and for this information to be reviewed to ensure accuracy and clarity prior to submission to the CQC.

The Quality team has been enhanced and have now got an interim regulatory consultant, interim programme manager and interim support officer within the team to ensure greater support to corporate teams and clinical teams.

A communications strategy has also been developed to ensure key messages and information about what to expect from a quality inspection are shared with staff across the organisation.

5. CORE SERVICE REVIEW

The core service quality review was commissioned and organised by the Trust and involved staff from the Trust, partner and stakeholder organisations as well as patient representatives who visited wards and departments to speak to patients and staff and directly observe the care and environment delivered to patients.

This aim of the review was to provide the Trust with an independent view of the care patients were receiving. There was also the need to provide a clear focus to identify any areas that the review teams believed would further improve patient care and enhance patient and staff experience.

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

- Is the service safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Key lines of enquiry (KLOE) for each area were developed for the areas that were visited.

Templates for each member of the review team to record their findings against specific prompts were developed, and the teams met together for a briefing session before the review commenced with a debriefing session at the end of each day to collect and collate findings.

- The following core services were grouped together for the review:
- Medicine (including Older People's Care)
- Emergency Department (including ACU, CDU, SAU and EAU)
- Outpatients and Radiology
- Children and Maternity (including Emergency Department)
- Surgery (Theatres and Wards)
- Spinal Injuries and Critical Care

As a response to the CQC report (2017 & 2018) the Trust developed a Quality Improvement Action Plan which has been the focus for improvements since the last inspection. The review teams provided their findings highlighting areas of good practice, potential actions as well as identified as 'quick wins' that could be implemented where identified. The full report is attached in Appendix 1.

6. CQC Engagement March 2019

The next CQC Engagement Visit is scheduled for Tuesday 19th March 2019, Corporate Staff based at the Ormskirk Site were invited to focus groups in the morning.

Overall feedback was positive, staff appreciated the team being on the Ormskirk site again, but there was a feeling that Ormskirk was the inferior site compared to Southport

The research team were very positive, and felt a lot better and commented that they were seeing a big difference across the organisation.

Weekly trust news was complimented and the CQC Relationship Manager commented that Vision 2020 mentioned consistently and positively.

Multiply IT systems were highlighted as a challenge from the focus group attendees.

Flow over the winter period was discussed and positive work shared in relation to corridor care and ambulance waits all being considerably down.

The Trust quality team shared the agreed quality priorities and the ongoing partnership with Leeds Teaching Hospitals NHS Foundation Trust and the work relating to sharing best practice. An update was given regarding the work commenced with AQUA in relation to quality improvement.

7. RECOMMENDATIONS

The Board is 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.

APPENDIX 1

Southport and Ormskirk Hospital NHS Trust

QUALITY CORE SERVICE REVIEW

11 & 12 December 2018

Final Report

Paul Jebb

Deputy Director of Nursing

1. Introduction

As part of the preparation for the Trust CQC visit expected in spring 2019, the Trust planned a core service review to be used as a self-assessment. The review was completed over two days, 11th and 12th December 2018 and chaired by Peter Weller, Senior Clinical Lead (Greater Manchester and Lancashire), NHS Improvement.

The purpose of the review was to give the Trust the opportunity to critically appraise the care delivered based on core service standards.

The aim of the review was:

- Recognise the areas where the Trust needs to focus further efforts to improve the standards or consistency of care to our patients.
- To identify good practice so we can celebrate the good work our staff do.
- To help our staff to become increasingly comfortable with answering questions about the care they provide.
- Identify ways in which we can support the smooth running of a formal inspection process.

The Trust had a CQC inspection in November 2017, which gave an overall rating of requires improvement.

During this inspection the CQC rated six of the Trust's seven services inspected as requires improvement and one as good. In rating the Trust, the CQC took into account the current ratings of the five core services not inspected at this time. Overall, the Trust was rated as requiring improvement.

In March 2018 the Trust Urgent and Emergency Services were inspected as an unannounced responsive inspection due to concerns regarding patient safety and how responsive the department was to people's needs, at this time the CQC did not rate the Trust.

The CQC had previously inspected the urgent and emergency care service in 2017, which was given a rating overall as requires improvement and inadequate in terms of patient safety. At this inspection the CQC looked at specific areas of concern including: patient safety, medicines, staffing levels, the environment, infection prevention and control, record keeping, mandatory training of staff, how services were planned, whether services met patients' individual needs and how the flow of patient through the department was managed.

The 2017 rating was:

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Mar 2018	Requires improvement →← Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Inadequate ↓ Mar 2018	Requires improvement →← Mar 2018

The core service and overall ratings for Southport and Formby and Ormskirk hospitals are shown below reflecting the impact of service configuration and non-elective service pressures across all domains included in the inspection.

Ratings for Southport and Formby District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Medical care (including older people's care)	Requires improvement ➔➔	Requires improvement ➔➔	Good ➔➔	Requires improvement ➔➔	Inadequate ↓	Requires improvement ➔➔
Surgery	Requires improvement ↑ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Inadequate ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Critical care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Outpatients	Requires improvement Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Spinal Injuries	Requires improvement ↓ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Overall*	Requires improvement ↑ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Inadequate ↓ Mar 2018	Requires improvement ➔➔ Mar 2018

Ratings for Ormskirk District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018
Surgery	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Maternity	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Services for children and young people	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016
Outpatients	Good Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018

2. Core Service Review Methodology

The core service quality review was commissioned and organised by the Trust and involved staff from the Trust, partner and stakeholder organisations as well as patient representatives who visited wards and departments to speak to patients and staff and directly observe the care and environment delivered to patients.

This aim of the review was to provide the Trust with an independent view of the care patients were receiving. There was also the need to provide a clear focus to identify any areas that the review teams believed would further improve patient care and enhance patient and staff experience.

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

- Is the service safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Key lines of enquiry (KLOE) for each area were developed for the areas that were visited.

Templates for each member of the review team to record their findings against specific prompts were developed, and the teams met together for a briefing session before the review commenced with a debriefing session at the end of each day to collect and collate findings.

3. Areas covered in the review

On both days a range of wards and departments on both the Southport and Ormskirk Hospital sites were visited. The managers and clinical leads for the wards and departments were notified on the day.

The following core services were grouped together for the review:

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

4. Participants of the review team

Teams comprised the following core members:

- Clinicians and service leads (not responsible for an area under review)
- Patient representative/lay members of the public / Health Care students
- External reviewers e.g. staff from agencies such as NHS Improvement, local CCGs, NHS England, local partner agencies and higher education institutions
- Colleagues from other providers and Student Quality Ambassadors
- Each review team had a nominated team leader.

5. How was the review conducted?

The format of the review included:

- Briefing to the whole review team from the team leader. The review team was split into respective groups and roles defined and agreed. The team leader had the responsibility of ensuring the members are clear on the KLOE, navigation around the hospital sites and led on the feedback at the end of the review to the wider group.
- Review teams visited wards and departments and then regrouped to agree key messages to be fed back to the wider group and executive team.

- At the end of Day 1, Feedback from each team was provided by the relevant team leader in an open session to the Trust Executive Directors.
- At the end of Day 2, specific feedback from the day and a roundup of the review was provided to the Executive team by the review chair.

6. Review Findings

As a response to the CQC report (2017 & 2018) the Trust developed a Quality Improvement Action Plan which has been the focus for improvements since the last inspection. The review teams provided their findings as detailed below highlighting areas of good practice, potential actions as well as identified as 'quick wins' that could be implemented where identified.

Appendix 1 highlights key risk areas and broad areas, as well as highlighting the responsible executive team member, to enable future work relating to the Trust Quality Improvement Plan.

Findings within core services are:

ITU/HDU/CCU	
Environment	• Good signage and use of notice boards for relatives/visitors/patients and staff • KPI Information was up to date and very clear/well presented • Very tidy and organised – easy to find stock in store and colour coded. • Very clean – seemed to take personal responsibility as well as dedicated cleaner – saw HCA cleaning trolley thoroughly • Décor and art work could be updated/more contemporary • Minimal clutter – well organised – exemplar for the hospital • Need/want to improve visitors/family room and facilities • Sluice was tidy, clean and not accessible to public • Staff room well looked after with good notice board information
Equipment	• Resus checks completed • Meds storage secure and room and fridge temps monitored • Need new fridges – unreliable hence room temp monitoring • Good signage re clean equipment – using red stickers 'I need to be cleaned' as well as green sticker
Records (5 sets of notes)	• 2 patients had partial evidence of MCA and 3 for bed rails • Some care plans needed updating • IPC have written in the notes in red pen • Nursing care plans long and could be more personalised • Majority of relevant criteria/standards met
Staff (3 interviewed)	• Very welcoming, empathetic and caring leadership and staff – e.g. concerned about elderly bereaved person after leaving the unit • Some vacancies but new staff joining • Assistant practitioner role very positive with plans to further develop • Good supervision and support from practice facilitator – very positive comments about training sessions (including a solicitor re medical records and simulation exercises), information, support and reviews/appraisal • Staff moved to support other areas • Undertaking ICNARC audits and feedback information in team meetings • Staff concerned about DSSA breaches • Matron is on roster/does shift which is seen as really positive by all

	staff due to visibility • Key gap is in bereavement care for relatives/carers (good for children less available for adults) • Need to update organ and tissue donation forms/information – clinical lead returning to unit
Patients/carers (5 interviewed)	Due to nature of the environment no patients were questioned.
Areas of Good Practice	• This is an exemplar service – good teamwork and open culture – model re Matron's approach and practice facilitator could be used elsewhere • Really good signage and use of notice boards for relatives/visitors/patients and staff • Approach to safely is dynamic and positive • Practice facilitator is key and very effective • Consistency re name badges to identify all staff • HCA approached us in very professional way to explain the temperature monitoring as she could see us looking at the thermometer in the meds room – this was excellent and should be encouraged. • Evidence of seeking and use patient/carer feedback • Aware of key policies e.g. safeguarding • Using incident reporting well – monthly safety meetings for all staff focusing on learning – immediate response to incidents also in place as required • Culture of raising concerns • Matron has introduced 'happy and sad' boxes to get staff feedback – being used and helpful • Good examples of 'checklists' and housekeeping to ensure tasks were done daily/monthly • There is a champion for mental health issues, staff support and debriefs held

Spinal Injuries	
Environment	• Very little storage for unit needs • Broken notice board lying on floor by stairs • Cleaning equipment and waste/rubbish bags left on corridors • Lift button can't be reached by someone with limited mobility in a wheelchair witnessed patient appearing to struggling to use lift. • Broken equipment and bags of linen on the floor of the Gym • Courtyard in need of maintenance • Cleanliness of corridors and clutter e.g. linen on floor. • Sluice – clutter, bags of waste and accessible to the public • Pool out of order • Limited waiting area for OP appointments especially for trolley and wheelchair patients • Décor needs updating to make the environment more modern/contemporary/inspirational • Revise/update and clearer signage • Consistency re information and location points – could use the corridors/walls in systematic and easy to find key areas – colour

	coding to help orientation
Equipment	• Toilet without seat/cover • New white board has been ordered • Clearer information/prompts on hand hygiene and IPC
Records (5 sets of notes)	• Lacking evidence of falls care plans • MUST partially completed in 3 out of 5 notes reviewed – no evidence of fluid and nutrition monitoring • Psychologist has easily identifiable stamp for notes • Medical , nursing and therapy notes separate • Minutes of goal setting meeting were good • Out of date care plans
Staff (3 interviewed)	• Relatively good staffing levels and follow-up patients on general wards to maintain bowel and continence care • Good discharge process – team awarded 2nd place in QI programme – KPIs and update on the office wall – significant reduction in delays. • Attracted loyal and stable staff – very positive about working on the unit • New recruit – exemplar re the uniform policy and able to answer majority of KLOES or identify who and when to ask for help • Staff felt induction, mandatory and statutory training was accessible and good – felt well supported and clear about roles • Able to speak up and raise concerns • Described monthly meetings and daily huddles which involve all staff • Concern about staff safety in relation to a patient but felt well supported
Patients/carers (5 interviewed)	• Not able to bring photos in personalise space (as had been able to in acute unit) • Staff not always identifiable/wearing name badges • One patient commented on the mood of staff – most warm and empathetic • Staff communicate well and are helpful • Responsiveness varies – AHP staff take breaks together and less accessible at hand over times • Relatives would like to be asked more about personal care • Call bells need to be more accessible – in holders/mounts? • Harsh lighting kept on late at night • Poor communication with Local Authority and social care delaying discharge • Slope at unit entrance is difficult for wheelchair users • Day room ceiling needs repair
Areas of Good Practice	• Trailing antimicrobial curtains • Isolation facilities being completed • Patient forum in place to provide real time feedback • Range of supported activities, to help with Technology and Backup re wheelchair skills and assistance dog training – suggesting more information and profiling of this support in public areas • Carer training and education programmes • Community beds to increase capacity and support home pathway • Long term follow-up provided and direct access to consultant/unit • Notes secure in trolley

	• New SLA for respiratory physician support from Aintree – partnership working and to reduce respiratory risks/complications • Very positive feedback and majority of KLOES achieved • HCA observed feeding patients and patients going to the day room for lunch • Relatives room with tea and coffee making facilities • Mentoring and one to one therapy sessions are good • Great facility – Pressure Ulcer care is good

Surgery – including wards and Theatre	
Environment	• Some areas were described as a noisy environment • 10B was described as tidy, although some notices needed laminating • Some signage not clear • Source isolation not compliant • Minimal handwashing observed
Equipment	• Refrigerator temperature checks inconsistently completed on wards and theatre • Resuscitation checks inconsistent • Cytotoxic spill kits in theatre 4 not stored correctly • When jobs logged these regularly need to be chased to be completed • Clinell labels need to be consistently used
Records (5 sets of notes)	• Charts not fully completed • Care plans not individualised • Wide use of abbreviations with no explanation • Difficult to navigate • Some risk assessments not completed • Oxygen not prescribed
Staff (3 interviewed)	• Adherence to uniform policy poor – medical staff and therapy • Preferred name not always used and over bed boards not updated • Staff attitude at times reported as not respectful • Staffing levels seen as not managed effectively • Releasing staff for training challenging due to operational demands and shortages, especially in theatres • Feedback from incidents and risks not evident in some areas • Theatre staff reported lack of awareness around Freedom to Speak up Guardian • Red bag system to support communication with care homes recently implemented although staff commented on lack of community nursing input to complex discharges • Communication not seen as effective as focus on e-mails • Lack of awareness of patient experience strategy
Patients/carers (5 interviewed)	• Staff described as ‘lovely’ • Feel unprepared for discharge at times • Unaware of how to make a complaint • Several patient would not recommend the Trust to friends and family • Ad-hoc completion of comfort rounds
Areas of Good	• Awareness of Vision 2020 evidence in some areas

Practice	• Safeguarding link nurses in the theatre environment • CEO had visited theatre recently and discussed issues with staff who reported feeling empowered • Promotion of organ and tissue donation seen as strong and regular • Staff had access to a MH resource pack • Theatre staff positive about theatre improvement programme

Maternity	
Environment	• Appeared cluttered with maternity services • Antenatal was seen as bright, clean and calm • Clear calm environment within areas with refreshment facilities in delivery suite • Staff smiling and helpful
Equipment	• Blood samples not carried in a receiver • Soap dispenser was empty for 2 days - addressed by staff at the time
Records (5 sets of notes)	• Use of fax machine needs review, fax receipts not retained for records. • Red book given to parents, incidents raised if not. • Lack of awareness around MCA process and documentation
Staff (3 interviewed)	• Post-natal staff not aware of reported risks within the area • Staff felt supported from leadership team on ward and support for new starters needed to improve with consistent approach to supernumerary working • Ante natal team positive about team working and relationships • More PMAs needed to support new supervision requirements • Night time staffing on post-natal ward was needing review • Retention seen as good within delivery suite
Patients/carers (5 interviewed)	• Staff do not introduce themselves at times • Patient using a trolley as a bed side table whilst table on corridor with linen on – addressed by staff at the time
Areas of Good Practice	• Easy access to safeguarding information and referrals • Delivery suite was seen as an area of good practice relating to sepsis awareness, DoLS, partner facilities • Staff have seen a change relating to patient safety • Staff uniform are compliant with uniform policy • Clear understanding of reporting FGM & confidence in safeguarding team • Lesson of the week clearly displayed and understandable • 'Welcome to our Ward' booklet excellent

Child & Young People	
Environment	• Good waiting area for family • Staff smiling and helpful

Equipment	• Medicines management around PGDs needs review • Infection prevention policies relating to removal of linen needs review
Records (5 sets of notes)	• Use of fax machine needs review, fax receipts not retained for records. • Lack of awareness around MCA process and documentation
Staff (3 interviewed)	• Bed management cover arrangements seen as ad hoc • Out of hours medical cover not consistent • Staff felt support from leadership team on ward and support for new starters needed to improve with consistent approach to supernumerary working • Limited training on LD care and use of passports
Patients/carers (5 interviewed)	• Payment for WiFi was commented on • Staff do not introduce themselves at times • No TV was on
Areas of Good Practice	• Recent CAMHS training been undertaken and recently implemented protocol seen as positive • Easy access to safeguarding information and referrals • Good use of social media • Staff have seen a change relating to patient safety • Staff uniforms are compliant with uniform policy • Lesson of the week clearly displayed and understandable • Home IV service for children seen as positive • Parental involvement in care also positive

Out Patients & Radiology	
Environment	Radiology • flooded area, as roof was leaking. • Lack of linen bags on skips and full linen bags left on floor by skip • Patients waiting for transport in foyer- OP staff bring them in from all specialties to wait, often having to stay after their shift to deal with this Out Patients • Blood on the floor for 4 days, same cloth used to wipe floor and surfaces • Accessibility and flow issues mentioned but no detail of issues • 2 hand cleanse pumps not working • Access for patients in wheelchairs could be improved
Equipment	Radiology • No wipes for BP machines • Tops of glass dirty • Cluttered environment • Issues cleaning equipment between patients • Lockable cupboards left open • TV screens- change WIFI system to give access

Records (5 sets of notes)	Radiology • Availability of patient records improved using evolve and missing notes as all available electronically Out Patients • Blood tests available to view electronically • Medway is a slow system and staff are unable to access info when it freezes – causes delays
Staff (3 interviewed)	Radiology • Support staff to be friendly and approachable • Lack of radiologists • Issues raised with turnaround times • Lack of team meetings and information being disseminated • Duty of Candour - lack of knowledge and no detail on noticeboard • Staffing levels in Radiology- feel unsupported • IPC- delegate responsibility • Sickness rate 10% • Students need supervising • Poor communication across specialists staff • Reliant on medical colleagues Out Patients • Patients observe staff not washing hands- not all staff apply hand gel • Admin staff did not feel fully supported • Satellite teams excluded from the department • Ensure enough staff for busy periods
Patients/carers (5 interviewed)	Radiology • Privacy and dignity for non- clothed patients and patients in gowns walking through public areas • Reports of long waiting times • Unsure of how long wait is • Lack of sleep on ward 9 due to noisy environment (staff described as loud)
Good practice	• Fast, responsive service- clinics on time • Friendly, approachable staff • Clean and tidy environment Outpatients • Good team dynamics- shared learning, regular meetings • Staff considerate and caring

Emergency Department (including ACU, CDU, SAU and EAU)	
Environment	Observation Ward • Check if single sex accommodation is compliant with current guidance. No separate areas for single sex care. EAU/SAU • Free standing gas cylinders ED • GP use it as a fast track for investigations – need to develop hot clinics • Majors dept. – damage to wall • Poor signage to toilets

	• Uniform policy adherence poor • Medications room temperature high • Fridges kept on the floor not table top
Equipment	• Broken commodes- staff are carrying bed pans and wheeling commodes on two wheels • PGD's- when they were in place- 'not fit for purpose' and 'out of date' • Patient in corridor using a wheelchair with no brakes. • Bed rails up on most patients – need to ensure risk assessments have been completed. • Bed in corridor with linen on it • oxygen cylinders loose and on floor • Messy trolley- cupboards would be more suitable • Boxes on top of bins • Stock control and rotation system needed EAU • Red sepsis trolley out of date • Commodes urgently required • Recalibration of dynamap needed – actioned at the time
Records (5 sets of notes)	• Prescription charts are not labelled on each page • Incomplete records- not signed • No evidence of food, drink registered, toileting, position changes • Information regarding history from GP including medications, past medical history and collateral history is collected. • PGDs out of date • Records left in areas with no staff or patients present • GMC and NMC numbers not recorded in documentation • ED patient safety checklist not completed Observation ward • Falls risk assessments no scores completed – even when falls documented • Nutrition assessments poor • VTE assessments not complete • Prescription charts not labelled on each page
Staff (3 interviewed)	• ED staff- no ID (says no clips available) • Uniform policy not adhered to especially by medical staff - Dr observed in trainers and jeans • Agency staff impact on sense of team work, makes substantive staff member have more concerns re care and safety • Ensure GP history surrounding patient is obtained for all previous admissions • Lack of support for non-medical prescribers • Lack of awareness of names of executive teams • Some courses fill quickly and minimal numbers running for vital skills i.e. cannulation
Patients/carers (5 interviewed)	• Care home patients with no escalation plan • Lack of food and drinks as machine was surrounded by medical gasses. • Patient on trolley 6 hours, not offered food or drinks • Phone on TV didn't work • Analgesia delayed in patient with fracture • Routine medications not given

Good practice	• Good team and mentor support – weekly updates • Patient centred care seen on observation ward & promotion of call bells and fluids • Good knowledge of patients • Staff responsive to feedback and learning from the review • LD link nurses on observation ward • Awareness of passports good • Agency nurse seen positive changes within Trust in past year • Consultant felt overall improvement in patient safety • Observation ward OT very patient centred • Harm meetings occur and patient safety nurses making a difference • Use of Greatix (staff appreciation initiative) very positive

Medicine (including Older People)	
Environment	15a • Medical staff compliance with uniform policy ad-hoc 15b • Clean, bright and tidy environment 14b • Cluttered environment in corridor, linen bags left on floor, drip stands stored in bays of corridor • Waste disposal –not segregated and IP risk Medical Day Unit (MDU) • Area clean and tidy Frail Elderly Short Stay (FESS) • Cluttered, noisy, smell of urine • Curtains need to be replaced • Blue tac stuck to wall • Floor covering untidy as patched with tape • No dementia friendly toilet seat and environment including signage 7a • Cluttered General • IPC adherence needs attention • Compliance with uniform policy • Food standards mixed feedback
Equipment	14b • Dirty equipment stored in bathroom • Commodes clean- not labelled 7a • Bed rails used with no evidence of risk assessment MDU • No schedules of cleaning- pumps, BP machines General feedback • Controlled drug checks not consistent • Trolley checks not consistent • Waste disposal not segregated
Records (5 sets of notes)	15b • IG issues regarding records storage, i.e. notes on trolley which is open and unattended. • One doctor left note on reception- no challenge 15a

	• Nursing risk assessments stored together on table 7a • Trolley open containing notes • Notes left on worktops • Awareness of DOLS & MCA process but lack of understanding regarding documentation • Intention rounding appeared to be 2 hourly for all patients General • Documentation needs standardising • No initial frailly assessments completed until OT review • GMC and NMC numbers not used in documentation • Poor compliance with MUST & bed rail assessments • Checklists not consistent
Staff (3 interviewed)	15b • Lack of knowledge of Trust's strategy plans (vision 2020) • Matron not visible • No volunteers available to assist with feeding during meal times • One member interviewed was unaware of Johns Campaign/ passports • Felt lack of training opportunities and resources 7a • Lack of knowledge regarding documentation of MCA process- unsure who the decision maker was 9a • Felt lack of support from community teams when planning discharges • Minimal awareness of Vision 2020 • Awareness and visibility of CEO but no other executive team members • Good team work • More support needed at weekends General • Staff feel not listened to around patient flow when advocating for patients • Staff communication needs attention as focus on email. Board to ward communication needs to be improved
Patients/carers (5 interviewed)	General • No involvement in discharge plans, not dressed, independence not encouraged • Patient rated food 5/10- adequate and bland • Distressed patient interviewed • One patient reporting of lack of staff, but care is good • FESS • No therapy input for 2 weeks • No involvement in discharge planning • Patients not dressed and appears that independence is not encouraged 7a • Bedside TV and phone not working • Relatives unable to get a speedy answer to phone calls
Areas of Good Practice	14b • Pathways used appropriately • Documentation clear

	9a • Feedback from ward manager seen as positive to staff • Good consistent checks of resuscitation equipment 15a • Dementia tree and activities in place for patients to access General • Recent leadership development programme positive • Thanks a bunch seen as positive initiative • Relative facilities (Oasis Room) FESS • Staff kind and smiling • Red bag system in place • Red tray service in place and out of hour snacks available • Support to learners identified as good

7. Key Improvements Highlighted Since 2017

- Ward Processes – good examples where highlighted and the increasing use of checklists to ensure standards are met along with some innovative approaches to improving quality.
- Caring Staff – staff were described as welcoming, empathetic, caring, kind and friendly.
- Leadership – comments from frontline teams in relation to the CEO visibility, support from Matron's and practice facilitator, visibility of senior nursing team as well as enhanced team work.
- Culture – positive changes in culture were seen including raising concerns and alternative approaches to enhancing safety, especially within critical care.
- Patient involvement – examples were evidenced within the spinal unit regarding involvement and partnership working with third sector organisations.
- These are excellent examples (many more were identified) and demonstrate change in focus following new leadership and staff commitment to driving quality improvement forward.
- At this stage the key issue is variation across services and sites and an opportunity to develop more consistent and systematic approach to improving core standards. This approach could include the following key themes and priorities regarding Quality Improvement;
- Environment – access to equipment, appropriateness and accuracy of signage, clutter, décor and cleanliness
- IPC – compliance with hand hygiene standards, universal precautions and management of equipment maintenance
- Documentation – full review needed including risk assessments, content of medical records as well as storage.
- Uniforms and name badges – need to review and ensure consistent approach to policy
- Discharge – need to increased joint working with community services and local authority
- Mandatory training compliance – in particular around MCA/DoLS and safeguarding competencies.

Some further strategic findings were highlighted, these are;

- The need for the Trust to align values, behaviours, systems and processes, although in some areas Vision 2020 was understood and staff awareness of the drivers incorporated

within the vision were evident. Staff were also aware of the changes within the senior leadership team and commented on the visibility of individuals.

- It was recommended that the Trust consider holding a review within the overnight period and a review of mortuary/bereavement services. Since the review the senior nursing team have developed plans to increase visibility and have reviewed care out of hours and overnight.
- Ensuring learners have a satisfactory learning experience including:
    - Mentor and learner working together, in February 2019 the senior nursing team met with students to identify key areas of development and improvement
    - Leaning opportunities to be maximised across organisation. Greater opportunities with Edge Hill University have been scoped and are being developed to enhance joint working. The Trust establishment review is also enabling greater opportunities to enhance learner support, enabling ward leaders to be supervisory is also being scoped as part of the establishment review.
- The Trust needs to shift the narrative to 'safety and quality', away from 'flow and myths'. Over the winter period the Director of Nursing and the Chief Operating Officer worked jointly as 'Gold Control' to ensure safety and quality was an integral part of the management of patient flow through the Trust.
- In relation to the multiple frequent items that were highlighted during the review several checklists have been developed to highlight these areas and ensure system in place to monitor compliance.

8. Key Actions Following the Review

Critical Care was highlighted as an area of good practice, the organisation needs to ensure other core service areas visit to view the good initiatives including staff boards, safety board etc. potentially develop a buddying system with Matrons and Ward Managers. A sharing good practice day, linked to quality improvement is planned for March 2019; this will enable this work to be shared with other members of the nursing leadership team.

It was recommended that the Trust Executive team develop quality priorities which will enable the Trust to highlight key areas of focus. Following a successful quality week held in January 2019, five priorities were identified and confirmed as:

- Management of the deteriorating patient
- Care of older people
- Infection prevention and control
- Medicines management
- Documentation

These priorities are now being developed in partnership with staff and built into the quality improvement plan.

There was a perceived need to review the quality priorities and work within them in collaboration with Leeds Teaching Hospitals NHS Foundation Trust (LTHFT) as part of the partnership arrangements. On 20th December 2018 an agreement with LTHFT was formally made. In relation to this in early 2019 the Head of Older Peoples Care and a Frailty Practitioner have visited LTHFT to review models of care and provision of care and in March 2019 a Board to Board session has been arranged.

The review highlighted the need for support to be targeted to known hotspots including trauma orthopaedics. The recently appointed Head of Nursing for Planned Care who

commenced within the Trust in January 2019 has reviewed the ward leadership and made changes in order to enhance leadership and develop specific objectives relating to standards of fundamental care. In order to support the enhancement of clinical standards an Advanced Care Practitioner is also working in the area, again to support the embedding of relevant standards relating to orthopaedic care.

9. Review Summary

The two day review was extremely useful and feedback was received by the CEO and other executive team members, as already detailed the findings reflected those previously identified to the Trust by other organisations (MIAA, CQC), this highlights the need for accountability around these areas to be strengthened to re-establish momentum and align accountability across the Chief Operating Officer, Medical Director and Director of Nursing as well as with the corporate Estates and Facilities team via the Deputy Chief Executive.

Appendix 1 highlights the potential risk areas, the senior responsible officer, actions needed, explanation as to why these areas have been highlighted as a risk, and potential impact of actions, including timescales. In light of this the CEO has commenced weekly executive team meetings, along with the Associate Medical Directors from the CBUs to review progress with CQC preparation.

10. Recommendations

With the review complete and the triangulation of previous CQC reports and MIAA reports, the following recommendations are made:

- Prioritise actions by service and corporate areas
- Develop a quality improvement programme (QIP) and priorities for 2019/2020
- Continue to build relationship and access Leeds Teaching Hospitals NHS Foundation Trust for ongoing support and improvement
- Identify and promote areas of good practice
- Develop a series of out of hour checks especially overnight.
- Expedite relationship with AQUA regarding roll out of Quality Improvement methodology
- Need to review project management regarding all aspects of CQC inspection including well led, use of resources, and quality and safety
- Develop key quality priorities and build into quality improvement plan and build governance around the project management.

11. Appendix 1

Highlights the senior responsible officer and relevant actions needed, explanation as to why these areas have been highlighted as a risk, and potential impact of actions, including timescales. In light of this the CEO has commenced weekly executive team meetings, along with the Associate Medical Directors from the CBUs to review progress with the CQC preparation.

Appendix 1 Risk Areas

Area of Risk	Potential Actions	Explanation	Executive Responsible Officer	Impact	Timescales
Medicines Management	• Review all PGD's to ensure in date • Review medicines storage locations (especially within ED) including fridge temperatures as well as temperature of storage rooms/areas • Review governance of NMPs	• Regulatory requirement • MHRA compliance	T. Hankin – Medical Director	• Enhance medicine safety • Increased governance around NMPs	31.03.19
Equipment	• EBME governance to be reviewed • Clear plan to strengthen the governance • Weekly insight at exec team • Monthly report to quality & safety committee • Ward equipment inventory • Review consistency of resuscitation trolley checklist, possible electronic solution	• Recent CQC enquiry • Regulatory requirement	T. Patten - DCEO	• Increased access to equipment • Enhance governance around EBME	31.03.19
Infection Prevention & Control	• Develop initiatives to make IPC have greater visibility across org	•Regulatory requirement	J. Cosgrove – Director of Nursing/DIPC	• Increased confidence of public • Increased adherence	31.03.19

	• IPC roles to be clarified • Develop IPC metrics • Clearer prompts/info around handwashing • Implement, enforce and monitor new uniform policy/dress code • Decluttering exercise to be undertaken • Ward layouts to be reviewed (with DCEO)			to standards • Increased role of the IPC team	
Policy Management	• All policies to be reviewed • Potential policies that are aligned to be united to one policy • Reflect theory of policy on a page ethos	• Regulatory requirement	A. Charles – Company Sec	• Clear expectation on ways of working • Clear standards	31.03.19
Patient Experience	• Review patient experience strategy in line with Vision 20/20 utilising IHI Always event methodology and a co-production approach. • Review awareness of pledges across staff groups • Review patient groups across the Trust & promote their role & work • Link patient groups into improvements to enable greater co-production	• Regulatory requirement	J. Cosgrove – Director of Nursing	• Increased public confidence • Increased in patient satisfaction survey results • Increased customer service skills across staff	31.03.19

	• Recruit volunteers to support the experience of patients • gap analysis against the Palliative care network bereavement guidelines, completed an action plan and reported through QSC				
Environment	• Declutter exercise to be undertaken • Review all ward environments re storage • Collate ward equipment list regarding décor • Review org against Kings Fund healing environment work • Develop cleaning schedules and checks. • Develop programme of work around re decoration • Develop maintenance standards and checks • Develop replacement programme for equipment and furnishings	• Regulatory requirement	T. Patten - DCEO	• Cleaner environment • Increased public confidence • Increased in patient satisfaction survey results Increased staff morale and staff satisfaction.	31.03.19
Staff Engagement and Communications	• Develop communications strategy • Communicate improvements in a timely manner • Engage with staff	• Core aspect of Well Led framework	T. Patten - DCEO	• Greater staff engagement • Staff aware of trust improvements • Staff can articulate good news stories	31.03.19

	around any improvements • Renew and celebrate 'you said we did' • Develop alternative ways of communication i.e. film, social media • Review how FTSU concerns are shared • Develop a strategy regarding staff appreciation & share recipients stories. • Review alternatives to email				
Documentation	• Care Plans reviewed and updating started. • Review documentation policy and link to professional standards – develop policy on a page • Explore need to GMC/NMC numbers to be used – possible use of stamps • Ensure documentation standards audited regularly • Develop checklists with documentation built in • Explore avenues to ensure effective communication outside the organisation • Review abbreviation use and ensure explanations evident	•Regulatory requirement	J. Cosgrove – Director of Nursing T. Hankin – Medical Director Jointly with S. Christian - COO	• Increased confidence of public • Increased adherence to standards • Increased patient safety • Increased consistency in record keeping • Enhance communication across MDT	

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	**TB077/19**	**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 Trust Board with the current position of nursing staffing in line with National Quality Board, National Institute of Health & Care Excellence and NHS Improvement guidance.
This report presents the safer staffing position for the month of February 2019.

- **Alert** – There has been an increase in the number of 'red flag events' that have been recorded in February, no patient harm has been caused due to insufficient staffing levels.
- **Advise** – A gap analysis of the NHS Improvement 2018 paper 'Developing workforce safeguards' has been undertaken and demonstrates that the Trust has minimal compliance with the guidance. Non-compliant actions have been incorporated within the Safe Staffing Improvement plan.
- **Assure** - For the month of February 2019 the Trust reports safe staffing against the national average (90%) at 91.34%.
  There has been a slight decrease in the number of Nursing & Midwifery (N&M) vacancies across the Trust.
  The inaugural Nursing & Midwifery Recruitment & Retention Operational Group (N&M R&R O Group) took place.

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

Strategic Objective(s) and Principal Risks(s)

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

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*

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

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

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

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

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

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

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

On-going support for the Nurse Establishment Review Business Case

Previously Presented at:

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

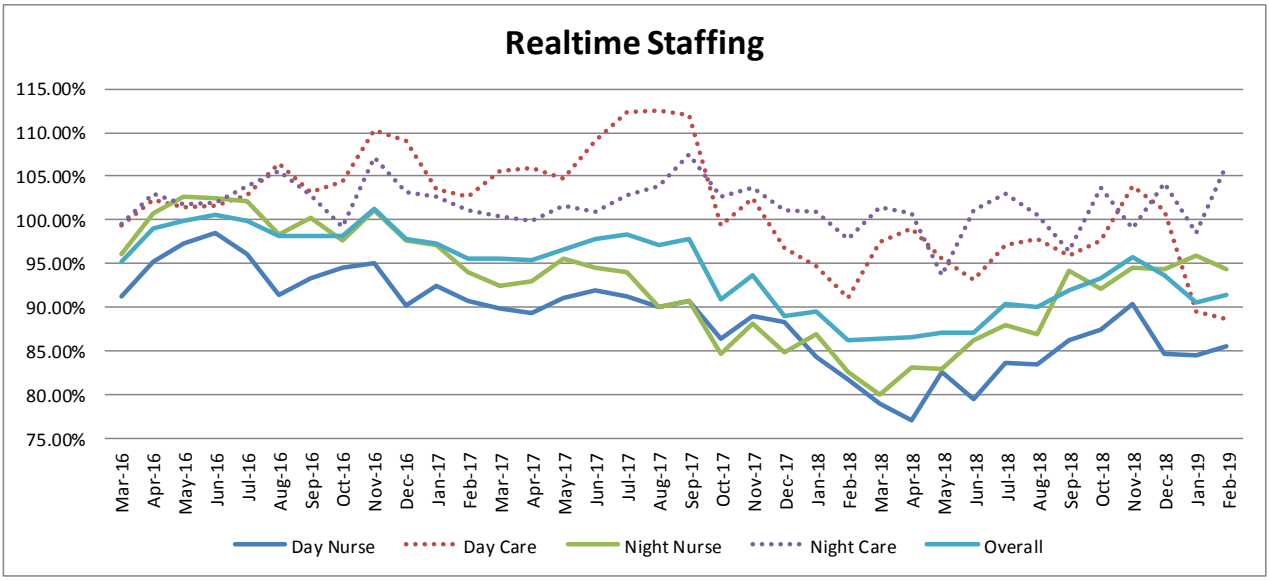
1. Introduction

This report provides an overview of the staffing levels in February 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 February 2019 was 91.34% compared to January 2019 that was 90.52% and December 2018 that was 93.61% (Appendix 1).

- 85.48% Registered Nurses on days
- 94.35% Registered Nurses on nights
- 88.62% Care staff on days
- 106.31% Care staff on nights

There has been a slight increase in our overall fill rate since last month.



The overall Care Hours per Patient Day (CHPpD) for the Trust is 8.1hr (Appendix 1) and slightly above the national average, there are a number of wards that have a low CHpPD, for example 11B, medical gastroenterology shows 5.0 CHpPD. This means that in a 24hour period a patient would receive 5hrs of direct care, which could be registered nurse (RN) or Healthcare Assistant (HCA), against the national average of 7 CHpPD.

2. February Safe Staffing

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

	Funded WTE	Contracted WTE	Feb Vacancy
Registered	864.12	774.70	89.42
Non-registered	381.63	361.79	19.84
Total	1,245.75	1,136.49	109.26

Registered nurse vacancy against overall establishment has increased by 3 wte. Non – registered vacancy has (positively) decreased in month by 5 wte.

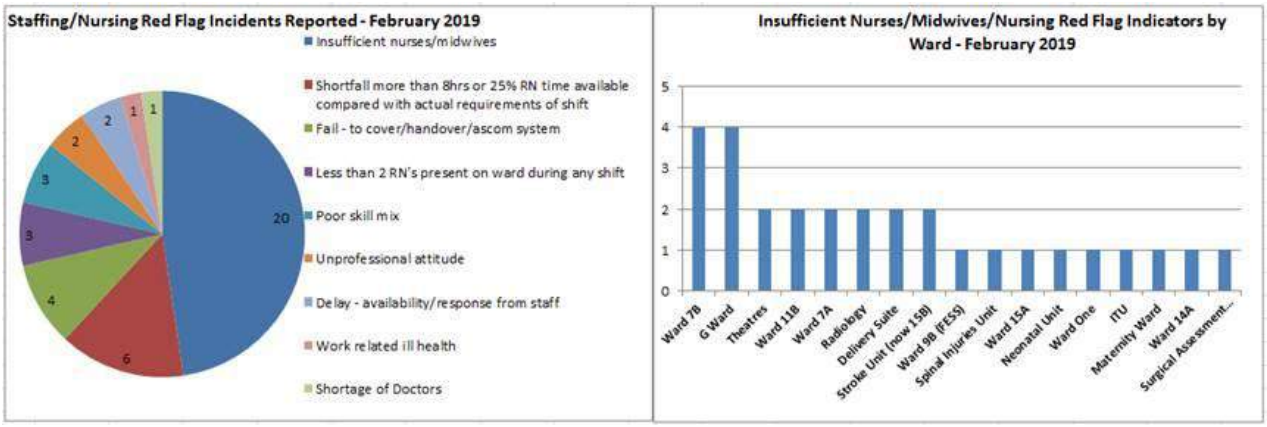
There has been a detailed 'deep dive' review of all the RN & HCA candidates that are currently in our recruitment 'pipeline'. The findings of the review highlighted that there have been some delays within the recruitment process that have now been identified and will be monitored with detailed reports from the Recruitment Team based off site.

From April 2019 our Recruitment Team will be based on-site. Their engagement and support at a recent internal recruitment event has already shown positive responses from potential candidates.

The inaugural meeting of the Recruitment & Retention Steering Group occurred in March 2019. This steering group will monitor the on-going recruitment process and 'pipeline'. The group will also support and monitor the delivery of the NHS Improvement **(**NHSI) Recruitment and Retention action plan and its key deliverables over the next 3-12 months engaging with NHSI regarding outcomes as required. The terms of reference for the group are to be ratified by the Workforce Committee in March 2019.

On-going scrutiny of roster performance continues to be facilitated by the Trust's work with Price Waterhouse Cooper (PWC). Following initial diagnostics PWC have actioned a 'deep dive' approach to key wards and departments to facilitate further support and challenge going forward. The two weekly 'support and challenge' meetings within each CBU has commenced and this is highlighting further areas for improvement and engagement by the Matrons.

3. Staffing Related Reported Incidents February 2019



There has been an increase in the number of staffing related incidents and/or 'red flag events' reported in February 2019. It is believed this is due to the combination of re-launching the red flag event criteria and school half term. There were 42 staffing incidents/nursing red flags reported, 32 more than the previous month. 29 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, an increase of 25 on the previous month, of which 9 were reported as 'red flags' and are reflected in the CHPPD report Appendix 1. One 'red flag' was on Ward 1 which isn't listed in Appendix 1.

No patients suffered harm as a result of these incidents/'red flag events'. The majority of the 'red flag' events occurred during the weekday and were proactively managed through the Safe Staffing Huddle and the internal escalation process. The 'red flag events' will be reviewed as part of the Recruitment & Retention Operational Group by the Heads of Nursing.

Trust compliance with relevant and recent National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI guidance

The Committee is aware of the previous gap analysis undertaken for:

- Safe staffing for nursing in adult inpatient wards in acute hospitals NICE, 2014
- Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing, NQB 2016

The Trust remains partially compliant against these national recommendations with 18 recommendations not completed.

In March 2019 a gap analysis of the NHS Improvement 2018 'Developing workforce safeguards- supporting providers to deliver high quality care through safe and effective staffing' was completed (Appendix 2). The Committee will note that the first recommendation of this document is that the Trust ensures that it is compliant with 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing (NQB 2016). Therefore, with the completion of the gap analysis of the NHSI 2018 guidelines the Trust remains non-compliant.

The Safe Staffing Improvement Plan now incorporates all of the above recommendations to enable the Trust to monitor our progress. Updates will be provided to the Workforce Committee and Trust Board on a monthly basis for those actions that are not 'on-track'.

Action	Timescale	Progress Update
Development of Establishment review Standard Operating Procedure	March 2019	Due to be ratified at N&M Group in March as previous meeting not 'quorate'.
Review & Update Health Roster policy	March 2019	Final draft to be sent for consultation mid-March 2019
Enhanced levels of care guidelines	March 2019	Draft guidelines currently being trialed
Development of Clinical Metrics dashboard	February 2019	Ward Co-ordinator & Ward Manager checklist currently being trialed. Quality Care Indicators being trialed by Head of Nursing & Deputy Director of Nursing across the Trust Limited capacity by BI team to develop dashboard.

6. Recommendations

The Trust 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 – February 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	1,395.50	1,017.00	1,899.98	1,212.23	998.50	818.50	688.00	833.42	759	72.88%	63.80%	81.97%	121.14%	2.4	2.7	5.1	Y	Two red flag events - Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift, supported by Matron. No patient harm
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	695.00	570.75	336.00	455.50	657.00	645.00	331.50	339.00	239	82.12%	135.57%	98.17%	102.26%	5.1	3.3	8.4		
E A U	300 - GENERAL MEDICINE	1,532.00	1,330.50	1,238.25	1,006.00	982.50	922.50	662.00	662.00	517	86.85%	81.24%	93.89%	100.00%	4.4	3.2	7.6		
FESS Ward	300 - GENERAL MEDICINE	1,414.85	1,024.17	1,262.42	1,076.25	990.92	843.92	674.00	727.50	730	72.39%	85.25%	85.17%	107.94%	2.6	2.5	5.0	Y	Two red flag events. Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift, supported by
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,227.25	925.92	1,021.75	1,171.50	995.00	637.00	655.50	892.50	731	75.45%	114.66%	64.02%	136.16%	2.1	2.8	5.0	Y	Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift supported by Matron - no patient harm
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,397.25	1,293.25	1,228.00	1,282.75	1,004.25	979.75	671.50	664.00	833	92.56%	104.46%	97.56%	98.88%	2.7	2.3	5.1		
Short Stay Unit	300 - GENERAL MEDICINE	1,349.25	1,028.00	1,621.75	1,529.25	986.00	938.00	995.00	910.50	772	76.19%	94.30%	95.13%	91.51%	2.5	3.2	5.7		
Ward 15a General Med	300 - GENERAL MEDICINE	1,045.42	1,031.67	776.00	1,210.50	1,021.50	962.67	650.00	1,010.00	656	98.68%	155.99%	94.24%	155.38%	3.0	3.4	6.4	Y	Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift supported by increase in HCA and Matron
Stroke Ward	300 - GENERAL MEDICINE	1,269.75	1,081.75	1,102.50	1,012.98	974.75	902.75	671.50	611.50	550	85.19%	91.88%	92.61%	91.06%	3.6	3.0	6.6		
Rehab & Discharge Lounge	314 - REHABILITATION	1,278.67	1,033.75	1,312.25	1,307.08	667.50	643.50	826.50	978.50	694	80.85%	99.61%	96.40%	118.39%	2.4	3.3	5.7		
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,192.48	1,186.48	1,539.25	1,608.00	702.50	970.50	751.50	1,328.00	817	99.50%	104.47%	138.15%	176.71%	2.6	3.6	6.2	Y	Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift due to complex patient needs, no patient harm.
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,581.50	1,102.25	1,553.25	996.75	660.00	626.70	334.50	610.00	437	69.70%	64.17%	94.95%	182.36%	4.0	3.7	7.6	Y	Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift supported by Matron - no patient harm
Ward H	110 - TRAUMA & ORTHOPAEDICS	705.50	594.00	671.00	369.00	666.50	558.50	331.00	235.00	180	84.20%	54.99%	83.80%	71.00%	6.4	3.4	9.8		
Surgical Ward	100 - GENERAL SURGERY	1,192.00	962.00	985.75	944.98	676.50	640.00	668.00	416.00	481	80.70%	95.86%	94.60%	62.28%	3.3	2.8	6.2		
Spinal Injuries Unit	400 - NEUROLOGY	3,495.25	3,070.92	3,328.00	2,783.50	2,649.25	2,508.75	1,361.00	1,249.00	1088	87.86%	83.64%	94.70%	91.77%	5.1	3.7	8.8		
Ward G	101 - UROLOGY	1,018.25	688.25	650.00	596.50	667.50	595.50	342.50	306.50	205	67.59%	91.77%	89.21%	89.49%	6.3	4.4	10.7		
TOTAL		**21,789.92**	**17,940.65**	**20,526.15**	**18,562.78**	**15,300.17**	**14,193.53**	**10,614.00**	**11,773.42**	**9689**	**82.33%**	**90.43%**	**92.77%**	**110.92%**	**3.32**	**3.13**	**6.45**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
A&E Nursing		3,830.08	3,476.08	1,771.25	1,418.50	3,040.75	3,225.75	668.50	829.00	0	90.76%	80.08%	106.08%	124.01%					
Ambulatory Care Unit		487.00	350.25	532.00	377.50	150.00	244.50	150.00	0.00	91	71.92%	70.96%	163.00%	0.00%					
TOTAL		**4,317.08**	**3,826.33**	**2,303.25**	**1,796.00**	**3,190.75**	**3,470.25**	**818.50**	**829.00**	**91**	**88.63%**	**60.19%**	**77.98%**	**101.28%**	N/A	N/A	N/A		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
ITU/CCU	192 - CRITICAL CARE MEDICINE	4,433.25	3,697.30	1,084.75	956.75	3,696.50	3,134.50	1,053.00	753.00	356	**83.40%**	**29.34%**	**88.20%**	**71.51%**	19.2	4.8	24.0		

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	1,537.00	1,568.00	336.25	293.58	1,404.50	1,392.50	335.50	312.00	61	102.02%	87.31%	99.15%	93.00%	48.5	9.9	58.5		
Maternity Ward	501 - OBSTETRICS	941.25	973.50	675.50	551.00	669.00	694.25	445.00	649.00	330	103.43%	81.57%	103.77%	145.84%	5.1	3.6	8.7		
MAU	501 - OBSTETRICS	1,152.25	999.75	436.17	400.17	667.00	668.00	331.00	319.50	77	86.77%	91.75%	100.15%	96.53%	21.7	9.3	31.0		
TOTAL		**3,630.50**	**3,541.25**	**1,447.92**	**1,244.75**	**2,740.50**	**2,754.75**	**1,111.50**	**1,280.50**	**468**	**97.54%**	**85.97%**	**100.52%**	**115.20%**	**13.45**	**5.40**	**18.85**		

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	996.75	1,005.75	315.00	170.50	1,007.50	984.00	96.00	12.00	167	100.90%	54.13%	97.67%	12.50%	11.9	1.1	13.0		
Paediatric Unit	420 - PAEDIATRICS	3,481.25	3,025.25	1,012.00	921.25	2,003.25	1,823.25	671.50	623.50	287	86.90%	91.03%	91.01%	92.85%	16.9	5.4	22.3		
TOTAL		**4,478.00**	**4,031.00**	**1,327.00**	**1,091.75**	**3,010.75**	**2,807.25**	**767.50**	**635.50**	**454.00**	**90.02%**	**82.27%**	**93.24%**	**82.80%**	**15.06**	**3.80**	**18.87**		

PLANNED		13,618.23	11,301.20	9,812.00	8,255.48	9,718.75	9,034.45	4,841.50	4,897.50	3564	82.99%	84.14%	92.96%	101.16%	5.3	3.4	9.4		
URGENT		16,922.02	14,163.08	14,102.15	13,060.05	12,468.67	11,763.83	7,644.00	8,457.92	6572	83.70%	92.61%	94.35%	110.65%	6.8	3.7	5.7		
W&C		8,108.50	7,572.25	2,774.92	2,336.50	5,751.25	5,562.00	1,879.00	1,916.00	922	93.39%	84.20%	96.71%	101.97%	5.7	4.0	18.9		
TRUST TOTALS		**38,648.75**	**33,036.53**	**26,689.07**	**23,652.03**	**27,938.67**	**26,360.28**	**14,364.50**	**15,271.42**	**11,058**	**85.48%**	**88.62%**	**94.35%**	**106.31%**	4.8	3.3	8.1		

Green- 80% and above
Red- Under 80%

Appendix 2 – Gap analysis of 'Developing workforce safeguards- supporting providers to deliver high quality care through safe and effective staffing'

Recommendation		Southport & Ormskirk (S & O) current position	Action required
1	Trust must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Gap analysis undertaken in November 2018 demonstrating partial compliance	Safe Staffing Improvement plan incorporates NQB 2016 recommendations
2	Trusts must ensure the three components are used in their safe staffing processes: • evidence-based tools (where they exist) • professional judgement • outcomes	As part of the Nurse Establishment Review (NER) all 3 components can be demonstrated	
3	Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement	S&O can confirm that majority of governance processes are in place for Safe Staffing however, partial compliance of NQB guidance remains outstanding	Governance process for Safe Staffing to be finalised On-going improvements in line with NQB recommendations
4	The Trust annual governance statement will be reviewed through usual national regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	S&O will continue to improve upon the governance and compliance of the NQB recommendations	Safe Staffing Governance framework Compliance with NQB 2016 Compliance with NHS I 2018
5	As part of this yearly assessment NHS I will also seek assurance through the Single Oversight Framework, in which a provider's performance is monitored against five themes.	S&O has further improvements to be made against the five themes (quality of care, finance and use of resources, operational performance, strategic change and leadership & improvement capability)	Dashboard with quality metrics Budgetary expenditure, Bank & Agency usage, E roster compliance HR metrics Service development/changes that require QIA Implementation of NER
6	As part of the safe staffing review, the director of nursing and medical director **must** confirm in a statement that to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Director of Nursing and Medical Director fully supportive of NER. QIA undertaken	Final statement for support of the business case and NER will be through Trust Board
7	Trust must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The Board should discuss the workforce plan in a public meeting.		Workforce Plan will be developed following the final NER business case.
8	The Trust must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.	Currently there are a number of different dashboard available however, they do not cover all the requirements of the NQB	Draft dashboard that incorporates both qualitative and quantitative data is being developed with support from BI unit.
	An assessment of re-setting of the nursing establishment	The NER is compliant with these requirements	

9	and skill mix (based on acuity and dependency data and using evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgement and outcome.		
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	No alteration of the Safe Nursing Care Tool data has occurred	
11	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill mix changes, must have a full quality impact assessment (QIA) review.	A QIA has been undertaken as part of the business case to invest in the NER	
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – (ACPs)) would be considered a service charge and must have a full QIA.		The Trust will complete the necessary QIA as part of the implementation of the Nursing Associate roles due to complete in April 2019
13	Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	The Trust holds a daily safe staffing huddle to assess the staffing across the trust based on acuity and dependency of our patient case mix.	Draft Escalation process due to be ratified in March 2019.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	This will form part of the Escalation process	As above

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 April 2019

Agenda Item	**TB078/19**	**Report Title**	**Healthcare Workers' Flu Vaccination Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Linda Lewis, Assistant Director of Health Work and Wellbeing		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This report details the Occupational Health (OH) activity in support of the 2018/19 flu vaccination campaign at Southport and Ormskirk Hospitals

- Serves to assure NHS Employers that Trust staff are offered the vaccine and how organisationally we will achieve the highest possible level of vaccine coverage for 2019/20 winter.
- The Commissioning for Quality and Innovation (CQUIN) target of 75% uptake for front line healthcare workers for 2018/2019 campaign. In addition to this, NHS Employers and Public Health England proposed that 100% of healthcare workers with direct patient contact are vaccinated as part of the 'flu campaign'.
    - This CQUIN has been increased to 80% uptake for the 2019/2020 campaign.
- Evaluate the 2018/19 campaign with a view to improving the uptake for the 2019/2020 flu campaign

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

Previously Presented at:

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

Healthcare Worker Flu Vaccination Report

Executive Summary

1. This information paper details the Occupational Health and Wellbeing activity in support of the 2018/19 flu vaccination campaign.

Background

2. This year NHS Employers have proposed that 100% of healthcare workers with direct patient contact are vaccinated.

3. In 2018/2019, the uptake of healthcare workers (providing direct patient care) is 81.9%.

4. The Flu CQUIN target for 2019/2020 has been increased to 80% uptake for healthcare workers.

Data

5. Uptake Data:

	Baseline	**Vaccination Uptake**	
Cumulative Data	**Staff Group Total**	**Staff Vaccinated**	% vaccinated
Doctors	**258**	212	82%
Qualified Nursing	**804**	573	71%
Qualified STT - Allied Professionals	**180**	165	92%
Support to Clinical Staff	**586**	546	93%
Total Number of Health Care Workers	**1828**	**1496**	**82%**

6. Reasons for staff gave for declining the vaccine:

Reason	**Total**
I don't like needles	9
I don't think I'll get flu	6
I don't believe the evidence that being vaccinated is beneficial	7
I'm concerned about possible side effects	4
I don't know how or where to get vaccinated	0
It was too inconvenient to get to a place where I could get the vaccine	0
The times when the vaccination is available are not convenient	0
Other reason	5
	31

Conclusion

Appendix 1 demonstrates our delivery of best practice in the effective delivery of the flu campaign for our workforce. Despite the desire to achieve 100% uptake amongst our frontline staff by NHS employers we will likely have a cohort of employees who chose to make an informed decision and decline the offer (see above data) of the vaccine.

Recommendation

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

Appendix 1

Southport and Ormskirk Hospitals – Assurance Plan

A.	Committed Leadership	Comments	Lead
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Board committed to achieving the ambition of 100% of front line healthcare workers being vaccinated and for any healthcare worker who decides on the balance of evidence and personal circumstances against getting the vaccine should anonymously mark their reason for doing so.	**Executive's**
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	We have ordered quadrivalent (QIV) flu vaccine for healthcare workers trivalent (aTIV) vaccine for those over 65.	**Assistant Director of HWWB**
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt.	The evaluation of flu programme 2017-2018: **Data:** • achieved 80% vaccination for front line healthcare workers. **Successes** • achieved 'herd immunity' (75% or above) which provides the best protection for our staff and patients (and wider community). • Front line healthcare professionals fully engaged in programme. **Challenges** • Previous campaign successful challenge to improve on last year's campaign. • taking the campaign to staff, which gives us the best uptake but requires resource and does impact on clinic time and other clinical activity within the occupational health dept. **Lessons Learnt** • accessible clinics • flexible times • vaccines need to be taken to staff whenever possible to maintain high uptake • plan trajectory • provide weekly updates against trajectory	**Assistant Director of HWWB**
A4	Agree on a Board Champion for flu campaign.	Director of Nursing	**DoN**

A5	Agree how data on uptake and opt-out will be collected and reported.	Process agreed, occupational health will continue to manage the data collection including the opt-out data.	**Assistant Director of HWWB**
A6	All board members receive flu vaccination and publicise this.	Completed	**Assistant Director of HWWB and Head of Comms**
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	Flu team formed with representatives from across the organisation.	**Assistant Director of HWWB**
A8	Flu team to meet.	Flu team met and plan agreed.	**Assistant Director of HWWB**
B	**Communications Plan**	**Comments**	**Lead**
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions.	Comms team publish regular promotional materials including myth busting etc	**Head of Comms**
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Health and Wellbeing Day planned October to use as a platform to launch the campaign. Drop in clinics and mobile vaccination scheduled planned and to be published electronically and on social media and on paper.	**Head of Comms**
B3	Board and senior managers having their vaccinations to be publicised.	Board and senior managers having their vaccination to be published.	**Assistant Director of HWWB and Head of Comms**
B4	Flu vaccination programme and access to vaccination on induction programmes.	Dates built into diary.	**Assistant Director of HWWB**
B5	Programme to be publicised on screensavers, posters and social media.	Programmed to be published on screensavers, posters and social media.	**Head of Comms**
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	Weekly feedback will be provide to Board on the uptake for professional groups, a monthly report providing uptake from directorates, will also be provided.	**Assistant Director of HWWB**

C	Flexible accessibility	Comments	Lead
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	Peer vaccinators in place, training completed.	**Assistant Director of HWWB**
C2	Schedule for easy access drop in clinics agreed.	Scheduled to take place	**Assistant Director of HWWB**
C3	Schedule for 24 hour mobile vaccinations to be agreed.	Scheduled to take place	**Assistant Director of HWWB**
D	**Incentives**	**Comments**	**Lead**
D1	Board to agree on incentives and how to publicise this.	Pens purchased	**Assistant Director of HWWB**
D2	Success to be celebrated weekly.	Publish weekly uptake with specific recognition to professional group achieving the best uptake.	**Assistant Director of HWWB**