NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10:15 – 13:15 on Wednesday, 1 May 2019
Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				**10:15**
TB086/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**10:15**
TB087/19 (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**		
TB088/19 (D)	**Minutes of the Meeting held on 6 March 2019** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB089/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB090/19 (D) **(D/V)** **(V)**	**Patients and Engagement Issues including:** • **Summary of Complaints & Compliments** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Patient Story: Gynaecology** To **receive** the Patient Story and **note** lessons learnt	**DoN** **NEDs EDs** **Michelle Kitson**	**30**	**10:25**
STRATEGIC CONTEXT				**10:55**
TB091/19 (D)	**Chief Executive's Report** To **receive** key issues and update from the CEO	**CEO**	**20**	**10:55**
QUALITY & SAFETY				**11:15**
TB092/19 (P/D)	**Quality and Safety Reports:** a) Monthly Mortality Report	**MD/DoN**	**40**	**11:15**

	b) Quality Improvement Plan Update c) Safe Staffing: Monthly d) Safe Staffing: Bi-Annual Review e) Guardian of Safe Working f) Freedom to Speak Up Annual Report To **receive** the presentation and reports			
PERFORMANCE & GOVERNANCE				**11:55**
TB093/19 (D)	**Assurance and Performance Reports:** **1. Alert, Advise and Assure (AAAs) Reports from:** • Audit Committee • Finance, Performance & Investment Committee • Quality & Safety 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** ***Introduced by COO*** **DoN/MD** **COO** **DoF** **DoHR**	**25**	**11:55**
TB094/19 (D)	**Financial Position at Month 12** To **receive** the report	**DoF**	**10**	**12:20**
TB095/19 (D)	**Risk Management:** • **Corporate Risk Register** To **approve** the risk register for 2019/20	**DoN**	**10**	**12:30**
TB096/18	**Items for approval/ratification**		**5**	**12:40**
CONCLUDING BUSINESS				**12:45**

TB097/19 (V)	**Questions from Members of the Public**	**Public**	**10**	**12:45**
TB098/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**5**	**12:55**
TB099/19 (V)	**Items for Forward Agenda – 5 June 2019**	**Chair**	**5**	**13:00**
TB100/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	**10**	**13:15** **CLOSE**
TB101/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**		
TB102/19 (V)	**Date and time of next meeting:** **Extra-ordinary Board, Wednesday 22 May 2019, 09:00** [in conjunction with the Audit Committee] Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN **Wednesday 5 June 2019** Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN	**Chair**		

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, 3 April 2019
Hesketh 2, Bliss Hotel/Ramada Plaza, Marine Lake, Southport, PR9 0DZ
(Subject to the approval of the Board on 1 May 2019)

Members Present

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

In Attendance

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

Apologies:

Gurpreet Singh, Non-Executive Director
Caroline Griffiths, NHSI

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB06519	**Chair's Welcome and Note of Apologies**	
	Mr Masom as Chair opened the meeting by welcoming members, attendees and members of the public. Apologies were received from Mr Singh and Mrs Griffiths. The Chair noted that the meeting was Mr Clarke's final Board meeting and thanked him for his work over almost three years and wished him well for the future.	
TB066/19	**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.	
TB067/19	**Minutes of the Meeting Held On 6 March 2019**	
	The Chair thanked Dr Bricknell for Chairing the March Board in his absence and asked members to approve the Minutes of the Meeting of 6 March 2019. **RESOLVED:** The Board **approved** the minutes as an accurate record.	
TB068/19	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **CEO Report: Human Resources (HR) Contractual Arrangement with St Helens & Knowsley (StHK)** All elements of the transfer had been smoothly completed and Workforce and Human Resources (HR) staff had moved from the Southport site to the Ormskirk site. Mr Nicholls thanked Mrs Royds and her team for their hard work in delivering a complex process to the agreed timescale. He also stated that doors to the Corporate Management Office (CMO) would be altered to enable easier access for clinical staff and members of the public and provide an environment which removed barriers to communication. There would also be a spring clean of the CMO and the provision of hot-desking in the area vacated by HR. **TB028/19: Monthly Mortality Report, including External Mortality Review** *The large numbers of Standard Operating Procedures continued to be reviewed to reduce and standardise these into a single document. An update would be brought to the Board in July 2019*.	**MD**
TB069/19	**Patient and Engagement Issues including:** • **Summary of Complaints & Compliments** • **NEDs & Executive Visits/Walkabouts** • **Patient/Staff Story: Winter Pressures – The Patient Experience**	
	Summary of Complaints & Compliments Ms Cosgrove presented the second Complaints & Compliments Report which provided themes and figures for the Trust in month. It was noted that under representation of compliments may have been taking place due to the way these were logged. 123 compliments had been received, with the Planned Care Business Unit (CBU) receiving the most, followed by the Day Case Ward, Urgent Care Business Unit, Physiotherapy and the Women and Children's Business Unit. It was recognised that the Day Case Ward was a particular area of excellence due to a good culture, staff retention, and positivity plus the ambience. There was a plan to understand why that team was particularly successful and to disseminate any learning across the Trust. Complaints received had related to staff attitudes and behaviours and complex complaints had arisen from relatively small issues. Mr Nicholls informed the Board that he and members of the Executive Team met with the families relating to the most serious complaints and commented that it had been a difficult, challenging time. The outcomes of those meetings had been to ensure that escalation of issues had arrested any deterioration of the patient, particularly in	

	relation to junior doctors being appropriately supported and consultants ensuring it occurred. Dr Hankin concurred that the meetings had been difficult and noted that the issues raised by the families had already been captured and were being addressed. Ms Cosgrove stated that some complaints related to front-line staff not being sufficiently compassionate or explaining issues correctly to patients and families. That was unacceptable however might have resulted from staff being under pressure. The Trust, therefore, needed to improve the working lives of staff and support them in busy environments to deliver the care expected and required. Mrs Gorry congratulated the CBUs on the compliments received and *it was agreed that further detail on patient experience would be included in subsequent reports.* • **NEDs & Executive Visits/Walkabouts** *The proposed participation in visits and walkabouts would be reported at the May Board.* The Chair noted that at the Non-Executive Director recruitment interviews on Friday 29 March at Ormskirk, all interviewees mentioned that they were welcomed with a smile on arrival and overall had a good impression of the Trust from that and the environment. He added that the experience in the two hospitals gave different impressions. • **Patient/Staff Story: Winter Pressures – The Elective Orthopaedic Service – Improvement Story** Mrs Sally Shorrock, Occupational Therapist and Mrs Joanne Kenyon, Orthopaedic Elective Therapy Team Leader gave the presentation. Mrs Shorrock stated that within the Orthopaedic Service Consultants and nursing staff worked closely and were very proud of the work they undertake. The service was multi-disciplinary, based at Ormskirk Hospital, and provided intervention for all Elective Orthopaedic patients and had been offered as a seven-day service, 08:30 – 16:30 since 2004. The Team focused both on pre and post operation, with the pre-operative patient group given information on what to expect, how to prepare for the operation and recovery. It also provided emotional support to the patient on what was a daunting process for them, which made a real difference. Patient goals for discharge included independent mobilisation, transfer and personal care, which could be completed within a day or so after surgery which was a shift from previous processes. To date the team had not had a day case of hip or knee replacement. In 2015, the Team was the first in the North West to cease the post-operative precautions traditionally used following hip replacement which had resulted in benefits such as a decrease in patient anxiety, equipment provision and an early return to activity for patients. On discharge, patients were supported by therapists which included	**DoN** **DCEO**

	discharge visits and exercise classes and the Team could be contacted for up to 10 weeks post-discharge. Mrs Kenyon noted that Advancing Quality Alliance (AQuA) had recognised that 100% of patients had been receiving pre-operative education and 100% were mobilised within 24 hours of surgery. That figure had declined slightly due to staffing issues; however, Dr Hankin stated that across the AQuA domains, the Team was the best in the region. **Getting It Right First Time (GIRFT)** Mrs Kenyon had first encountered GIRFT, which was created and led by Consultant Orthopaedic Surgeon Professor Tim Briggs at a visit with colleagues to Gloucester Hospitals NHS Foundation Trust. The key objective was to improve patient outcomes, complete all arthroplasties within NHS hospitals and save the NHS money. The Trust Board had just agreed to provide support to the process for a year. Challenges for the Team included staffing and maintaining the Occupational Therapist 6-day service. Admin support was required, plus a dedicated therapy area to improve patient outcomes. There was also an appetite to produce videos via social media or create an app to provide physiotherapy, so that the Trust could match the provision of private organisations and be the provider of choice. Mrs Gorry thanked Mrs Kenyon and Mrs Shorrock and asked if the Orthopaedic Team had a presence on the new Trust website. Ms Patten responded that the support agreed by the Board would look at that as part of the process. Mrs Gorry also suggested that the Volunteer Manager be contacted to establish if a suitable volunteer could be put in place to help with the administrative requirements. The Chair, on behalf of the Board, thanked Mrs Shorrock and Mrs Kenyon for their uplifting presentation. **RESOLVED:** The Board **received** the presentation and **noted** the lessons learned.	
STRATEGIC CONTEXT		
TB070/19	**Chief Executive's Report**	
	Mr Nicholls presented the report which reviewed the past year, progress made and looked forward to the 2019/20 period. The Executive Team had been set their objectives for the coming year. Mr Nicholls commented that at his commencement, just over a year ago, one of his objectives, set by the Secretary of State for Health, had been for the Trust not to slip into special measures. The Trust had achieved this and was now in a much better position 12 months on with a strong Board with the full complement of Non-Executives and Executives to provide direction and stability throughout the Trust. He stated that he was delighted with the work on mortality which had taken place and been evidenced by an improvement from 123 to 111 in the Rolling 12 Month Hospital Standardised Mortality Ratios (HSMR)**.** Whilst that remained higher than it should be, that was the right trajectory.	

	Mr Nicholls commented that CBU reporting remained incomplete and would continue to be clarified. The Chair added that it was good to reflect on the past year and was also pleased that the Trust had come a long way in relation to mortality. He echoed Mr Nicholls comment about Board membership and in particular the strong Executive Team and thanked them all. Mr Birrell requested that the implementation of IT within the Trust be given priority to achieve greater benefits as this currently was not occurring quickly enough and *Mr Shanahan responded that it would be an item on the May Board.* The draft Annual Report would be produced by the end of April 2019 for review at the May Board. The Chair commented that the Report needed to be considered as a marketing document in the sense that internal and external messages should be conveyed through it and CQC would be reviewing it also. **RESOLVED:** The Board **received** the report.	**DoF**
QUALITY & SAFETY		
TB071/19	**Monthly Mortality Report**	
	Dr Hankin presented the report. **Rolling 12 Month HSMR** This indicator had reduced from 123 to 111 by October 2018 however it was anticipated that it would rise during the winter reporting period. **Disease Specific HSMR** A physician had been appointed to further enhance the team's capability and to help drive change up from the floor as well as following direction from above. **Crude HSMR** The rate remained below the national target. **Final Report on Progress for Reducing Avoidable Mortality (RAM) Phase 1 & RAM Phase 2** The report set out the achievements of RAM Phase 1 and detailed the draft project delivery model for RAM Phase 2 to be delivered 2019/20, which had been approved by the Private Board. Mr Nicholls commented that the Clinical Care Outreach Team had been outstanding in helping to drive change and should continue educate and not be considered as a 'fire brigade'. Dr Hankin concurred stating that the appropriate tools had been provided and it would be for the operational clinical staff to deliver the improvements. The results were not simply down to the correct coding of patients and were in part due to the actions of clinical staff driving change resulting in improvements. Mr Birrell stated that the Trust should be telling the world that improvements had been made, sustained and world-class care was being delivered.	

	Mrs Gorry requested that Learning from Deaths be included on the Trust's new website to share the successes and be transparent. *The Communications Manager would meet with Mrs Gorry to discuss it*. The Chair commented that the work had been good and it was very encouraging that improvement was being evidenced. **RESOLVED:** The Board **received** the monthly report.	**Comms**
PERFORMANCE & GOVERNANCE		
TB072/19	**Assurance & Performance**	
	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 advised on: • A review of storage areas on the Southport Hospital site had highlighted a need for additional space. Early indications suggested that the investment required, which was supported in principle by the Committee would be in the region of £600,000. • The Trust remained on course to outturn at the planned deficient of £28.8m, although discussions continued on forecast outturn contract values. • To date £5.8m of 2019/20 CIP schemes had been identified with a number of other opportunities being explored. The Committee was reasonably assured on the progress to date, albeit conscious that delivering the plans would be taken forward without the oversight of a Turnaround Director. The Committee assured on: • The Model Hospital Team was providing the Trust with significant support in addressing potential key impact areas. It was noted that this would be dependent on the Trust responding positively to requests for information, consideration of new approaches etc. **Workforce Committee** Mrs Gibson, in her role as Chair of the Workforce Committee, presented the AAAs report. The Committee alerted on: • **Delay in Policies being Published** It was highlighted that there was a delay in policies being published after being agreed at the Committee. This issue had previously been escalated and added to the Risk Register and raised as an alert as this would impact CQC and Well Led. The Director of HR and OD had agreed to liaise with the Company Secretary. The Committee assured on: • **Supporting Attendance** 70% of managers within the Trust had undertaken the Supporting Attendance Policy training and it was anticipated this	

would have risen to 100% by the end of April 2019.

- **TUPE Transfer**
  The TUPE transfer was making good progress. Updates on the transfer were provided to the Executive Team on a weekly basis. Communications on the transfer had been relayed to staff affected and the transfer was completed by 1 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 remained an issue and had been alerted through the Risk & Compliance Group. Committee

Executive Summaries from Executive Directors including Integrated Performance Report (IPR)

Medical Director
The Fractured Neck of Femur target had been improved in the month due in part to Dr Hankin's personal oversight and the new action plan being disseminated. GIRFT had also improved with the support of the consultants. Sepsis had appeared to increase however this was due to incorrect coding and the documentation was being revised by Dr Goddard to enable this was done correctly.

Director of Nursing
Infection control was highlighted as a concern due to data analysis and a policy was being developed in conjunction with the registered nurses. Falls remained an issue and root cause analyses were assisting in the learning. Delivery of Same Sex Accommodation was subject to a number of breaches in relation to Critical Care which was permitted to be mixed-sex. The challenge occurred when a patient was due to be discharged to a ward for on-going care and there was a delay due to bed capacity, which constituted a mixed sex breach. Mr Christian added that safety of the patient would always be the priority. He assured that the Intensive Care Unit and High Dependency Units acted upon this and prioritised care.

Chief Operating Officer
The 4-hour A&E performance had improved within the month of February 2019 from 80.9% to 85.9%, due predominantly to the performance at Southport, despite an increase in attendance of 553 patients that month. Ambulance handover times performance had improved by 47% year on year. Diagnostics performance had seen significance improvement on the January position due to activity within the service.

The 18 Week Referral to Treatment (RTT) performance was 94.5% against a target of 92%, however the ongoing waiting list target of a reduction to 9,000 by the end of March was unlikely to be achieved. Commissioners had agreed to fund the addition of a consultant locum to reduce the number of paediatric waits within the community.

Cancer 62-day performance for January 2019 remained below the 85% target at 79.8% but was an improvement against the December 2018 performance of 71.6%. Tumour Groups had agreed individual action plans to address this

The winter escalation Ward 1 had now closed, despite continued

	demand including a 40% increase year on year which resulted in an ongoing risk due to bed capacity returning to its correct level. **Director of Human Resources & Organisational Development** In continuing to support the CBUs and Corporate Services, HR had delivered attendance training to 70% of managers and anticipated that 100% would have received this by the end of April 2019. Mandatory Training continued to steadily rise with the overall Trust rate at 85.65%. The team continued to focus on reducing the cost of agency spend and was discussing options including developing a Tier 2 framework to enable this. Discussion took place regarding Falls and the concern regarding the trajectory of performance and the impact on patients. It was agreed that reports on falls should be reported to the Quality & Safety Committee on a quarterly basis and the trends reported to the Board. Ms Patten advised that a new way of working was being trialed on two wards to get Matrons, Facilities, Domestics, Waste Management and Infection Control working together more closely Mrs Gibson observed that the Red and Amber BRAG ratings (Blue Red, Amber, Green) throughout the IPR had seen minimal movement and asked what was needed to see movement to Amber /Green. *Ms Patten responded that the measures seen within the report were set 12 months ago and the challenge of high-level, relevant indicators would be brought to the May Board.* The Chair stated that the summary had been good and concurred with Ms Patten that the IPR measures would be reviewed and the Board would be looking to seeing the ratings move from Amber/Red to Amber/Green. He further stated that it was a challenge to look to the future with measures from the previous year. Key Performance Indicators would be a reflection of system performance and the IPR should relate to the Trust's performance and include the explicit impact for system failure on the community, primary care, the third sector and the Walk-In Centres etc. Mr Nicholls commented that a year ago it was acknowledged that regulators were dissatisfied with the local health economy performance and with a 40% increase in demand across both hospitals being evidenced the issue of provision became more critical to resolve. Theatre Utilisation was discussed and the Board was assured that this was an integral part of the Quality Strategy and Dr Hankin would be visiting operating theatres to investigate their performance against both electronic and paper records. Mr Christian would also now be chairing the Theatre Utilisation Group which would be monitored by the Finance, Performance and Investment Committee and would link with GIRFT. **RESOLVED:** The Board **received** the highlight reports from the assurance committees, the Executive performance summaries and assurance	**DCEO**

	from the Executives and reports on performance indicators.	
TB073/19	**The Annual Governance Statement**	
	Mr Charles presented the Statement which had been to various forums and committees with feedback from them incorporated. The Statement had now been sent to Mazars (External Auditors) and feedback was due within a week and would be incorporated in the Annual Report with the final draft being presented to the Board in May. *The Chair requested that Mazars provide their feedback in time for the Audit Committee on 10 April.* **RESOLVED:** The Board **received** the report.	**CoSec**
TB074/19	**Financial Position at Month 11**	
	Mr Shanahan presented the report and key highlights. The offer from West Lancashire CCG had reduced the deficit and the forecast remained in line to deliver the year end deficit of £28.8 million. Mr Clarke commented that a £1.8m loss in March 2019 was the lowest the Trust had seen, to which Mr Shanahan responded that this had been due to the balance of reserves. Mr Nicholls added that the Trust would maintain that position and it was anticipated that agency spend would reduce. The Chair commended the Finance Team for the excellent performance in holding the forecast given the increased demands throughout the winter period. **RESOLVED:** The Board **received** the report.	
TB075/19	**Risk Management:** **Risk Register**	
	Ms Cosgrove presented the report. The Register would be restructured to take into account the 2019/20 objectives and principal risks and would be presented at the May Board along with the Board Assurance Framework. *It was agreed that the Trust would look into the idea of setting a risk appetite* **RESOLVED:** The Board **received** the monthly report.	**CoSec**
OTHER REPORTS FOR RECEIVING		
TB076/19	**Quality Improvement Plan and CQC Progress Report**	
	Ms Cosgrove presented the report. Additional support had now been put in place to prepare for CQC and evidence supplied was being reviewed and triangulated against the Core Service Review including Medicines Management.	

Provider Information Request (PIR) was expected shortly and an update would be provided to Board. **Appendix 1** of the report had incorrect timescales which would be revised. Key improvements were detailed which demonstrated the breadth of the work that had taken place.

Focus now included:

- CBUs undertaking self-assessment
- Datix reporting including quality of services
- Acute Medicine focusing on older peoples' acute medicine
- Unplanned orthopaedic surgery

The Chair commented that Well Led including the Quality Improvement Plan should include the elements given in the earlier 8am meeting, particularly those to be achieved 0-3 months. In contrast with the positives which had been achieved the Board had not received a AAA report from the Quality & Safety Committee (QSC) as it had not taken place in March. Ms Cosgrove responded that QSC was now scheduled to meet on 8 April 2019 and would focus on CQC preparation.

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

TB077/19 **Monthly Safe Nursing & Midwifery Staffing Report**

Ms Cosgrove presented the report.

The overall fill rate for February 2019 was 91.34% compared to January 2019 which was 90.52% and December 2018 which was 93.61%.

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

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

	Funded WTE	Contracted WTE	Nov Total Vacancy
Registered	864.12	774.70	89.42
Non - registered	381.63	361.79	19.84
Total	1,245.75	1,136.59	109.26

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

Investment in the Nursing Workforce was taking place and the proposal for a Tier 2 agency was being considered which should reduce agency spend. Ms Cosgrove assured the Board that when agency staff were used to fill gaps and urgent requirements a member of Trust staff would also be on the shift. The Nursing Quality Board 2016 guidance was being used as the benchmark to deliver high quality care through safe and effective staffing and the Trust's position and actions required reported.

	RESOLVED: The Board **received** assurance on the actions taken to maintain safe nurse staffing.	
TB078/19	**Healthcare Workers Flu Vaccination Report**	
	Ms Cosgrove presented the report outlining the number of staff who had taken the flu vaccinations. **RESOLVED:** The Board **received** the report	
APPROVAL & RATIFICATION		
TB079/19	**Items for approval/ratification**	
CONCLUDING BUSINESS		
TB080/19	**Questions from Members of the Public**	
	Mr Johnson asked if Dermatology was within the scope of the Board and Ms Patten confirmed that it was. Mr Ryan stated he would send an email with his question.	
TB081/19	**Any Other Business**	
	To **receive/discuss** any other business not on the agenda. • Performance and Effectiveness of the Board to be brought to the May Board. • Ms Patten stated that the visit of Professor Briggs, originally scheduled for 7 April 2019 would now take place in early June 2019.	
TB082/19	**Items for Forward Agenda – 1 May 2019** • Strategy Update • Development of QIP	
TB083/19	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • *Culture Review Report contents to be communicated internally* • *Chief Executive's Report* • *Patient Experience*	**Communications**
TB084/19	**Meeting Evaluation**	
	To give members the opportunity to evaluate the performance of the Board meeting	
TB085/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 1 May 2019, 09:15 Seminar Room, Clinical Education Centre, Southport	

There being no other business, the meeting was adjourned

Board Attendance 2019/20												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓											
Jim Birrell	✓											
David Bricknell	✓											
Ged Clarke	✓											
Juliette Cosgrove	✓											
Julie Gorry	✓											
Terry Hankin	✓											
Silas Nicholls	✓											
Therese Patten	✓											
Steve Shanahan	✓											
Gurpreet Singh	**A**											
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓											
Audley Charles	✓											
Steve Christian	✓											
Jane Royds	✓											
A = Apologies ✓ = In attendance												

Public Board Matters Arising Action Log
as at 1 May 2019

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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. **May 2019 Update** The 2019/20 BAF Model will be discussed at a session post the Board meetings in May	**GREEN**

Public Board Matters Arising Action Log
as at 1 May 2019

Southport and Ormskirk Hospital NHS Trust

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OUTSTANDING ACTIONS

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TB018/19	Jan 2019	**AOB**	The Chair agreed that the Board should be regularly informed via a litigation report on the subject of claims, damages and liability expectations and reputational risk.	**CoSec**	Mar 2019	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 was discussed at Audit Committee **May 2019 Update** The position is that the Company Secretary will be the conduit through which legal advice is sought by the Trust. Systems and processes have been put in place to ensure authority is sought before advice should be sought from solicitors	**GREEN**

Public Board Matters Arising Action Log
as at 1 May 2019

NHS Southport and Ormskirk Hospital NHS Trust

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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	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	July 2019	**March 2019** Dr Hankin to review ward by ward use of SOP pro-forma to support daily activity. **April 2019** Large numbers continued to be reviewed to reduce and standardise these into a single document. **May 2019** Review and standardisation to be completed by July 2019	**GREEN**
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	July 2019	**March 2019** Dr Hankin and Dr Goddard to review timeline and update Trust Board **May 2019** On track to be completed by July 2019	**GREEN**
TB070/19	Apr 2019	**Chief Executive's Report**	IT implementation to be reported to Board in May 2019.	**DoF**	May 2019	May 2019	**May 2019** April 2019 FP&I Committee considered the subject which would be further expanded upon and presented at the June Board.	**GREEN**

Public Board Matters Arising Action Log
as at 1 May 2019

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB072/19	Apr 2019	**Assurance & Performance**	IPR: High level, relevant indicators to be brought to the June Board.	**DCEO**	Jun 2019	Jun 2019	**May Update** Due in June	**GREEN**
TB072/19	Apr 2019	**Assurance & Performance - IPR**	IPR should relate to the Trust's performance and include the explicit impact for system failure on the community, primary care, the third sector and the Walk-In Centres etc.	**DoF**	Jun 2019	Jun 2019	**May Update** Due in June	**GREEN**
TB075/19	Apr 2019	**Risk Management**	The Trust would state its Risk Appetite	**CoSec**	May 2019	May 2019	**May 2019 Update** A statement about key steps in this would be made and discussed at the BAF session after the Board	**GREEN**

Public Board Matters Arising Action Log
as at 1 May 2019

Southport and Ormskirk Hospital NHS Trust

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COMPLETED 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. **May 2019** Completed	**BLUE**

Public Board Matters Arising Action Log
as at 1 May 2019

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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 **May 2019** Completed	**BLUE**
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. **May 2019** Discussed at April FP&! Committee and agreed to take this forward and be monitored by FP&I.	**BLUE**

Public Board Matters Arising Action Log
as at 1 May 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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	**May 2019** The action plan has now been signed off and progress reported to the Board monthly in the monthly Mortality report	**BLUE**
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 **May 2019** Completed	**BLUE**

Complaints & Compliments

March 2019

1.0 Introduction

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

2.0 Compliments

The compliments received across the Trust related to the quality of care received by Patients, Communications with relatives & patients, staff behaviour, attitude, availability & competence, also related to Privacy & dignity.

We are pleased to report the Planned Care Business Unit received the most compliments with 101 in total and eye clinic receiving 33 compliments in the month.

The Urgent Care Business Unit received 23 Compliments, with the physiotherapy receiving the highest number (9).

The Women & Children's Business Unit received 37 compliments, 18 were related to Paediatric & Neonatal care.

2.1 Complaints

The complaints data has been split in to low level concerns (known as PALS) and formal complaints graded 3 or 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 (7) followed by the Planned Care Business Unit who received 6, the Women & Children's Business unit received 3, Clinical Support services Business Unit received 1 & Integrated Governance Business Unit received 1 complaint.

The following themes were identified:

- Complaints about staff attitude, 3 complaints mixed across all clinical Business units
- Clinical treatment featured in 8 Complaints received, these included
    - alleged wrong treatment/diagnosis
    - Poor nursing care,
    - Lack of continuity,
    - Lack of pain management
    - An alleged error in performing a procedure.
- Communications featured in 2 complaints regarding lack of clear explanations to both patients & families & patients not verbally being told things.
- Admissions/Transfers/Discharge procedure featured in 2 complaints received in March, One relating to Discharge destination & the other relating to a delay in internal transfer (Ward to ward).
- Basic Care was a feature in 1 complaint received, relating to Mobilising of a patient.

- Cleanliness/Laundry was the subject of 1 complaint received this relating to the general cleanliness of a ward area (Ward 11A).
- Patient Privacy/Dignity was a subject of one complaint received, relating to a patients human rights.

2.2 Concerns

There have been a total number of 34 concerns raised this month. The breakdown of concerns this month relate to Unacceptable time wait for an appointment with 5 concerns being raised. 4 concerns have been received relating to staff attitude which has seen an improvement from last month.

3.0 Conclusion

The Planned Care Business Unit received the most compliments again this month, thus demonstrating that patients consider this to be a quality service.

As clinical care does feature monthly in the complaints received by the Trust a breakdown will be considered as part of this monthly report.

	End of Life Care	Parking ticket	Process for making Outpatient Appointments	Request for Advice/Information	Support After Discharge	Poor nursing care	Treatment postponed	Face to face	Telephone	Appointment date continues to be rescheduled	Unacceptable time to wait for appointment	Lost property	Smoking	Inappropriate comment	Staff attitude	Treatment of patient (not clinical treatment)	Shortage of staff	Transport not turning up	Total
End of Life	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Request for Advice/Information	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Admissions/transfers/discharge procedure	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Clinical treatment	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2
Communication (oral)	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	3
Date for appointment	0	0	0	0	0	0	0	0	0	2	5	0	0	0	0	0	0	0	7
Outpatient and other clinics	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Patient property/expenses	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Premises/Car parking	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2
Staff attitude/behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	1	0	0	6
Staff availability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
Transport	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Total	2	1	2	3	2	1	1	1	2	2	5	2	1	1	4	1	2	1	34

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

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NHS Trust

Board Visibility – project update

23 April 2019

Executive breakfast events

This event is an open, informal relax opportunity for staff to speak to members of the executive team. The first event was held in Russet's Restaurant at Southport hospital from 10.30-12noon. Several dozen staff took the opportunity to speak to either the Chief Executive, Deputy Chief Executive or Director of Finance

The event was planned to coincide with staff breaks and this helped to ensure good numbers in attendance. Tea, coffee, pastries and fruit were provided. All issues were captured and followed up by the relevant people. On May 7, the event will be repeated at Ormskirk hospital, using the same mechanic.

Back to the Floor

Staff have been asked to invite Executive team members to join them for a shift, to see what challenges they face daily. Completed to date:

- Director of HR and OD: 12-hour shift in ED
- Director of Finance: observation in theatre with orthopaedic team Deputy Chief Executive: Paediatrics day shift
- Director of Medicine: day shift as ward healthcare assistant

Planned:

- Chief Executive healthcare assistant on Ward 7A at Southport hospital (April)
- Deputy Chief Executive in Catering (April)
- Director of HR and OD: ENT (May)
- Chief Operating Officer: night shift with the bed managers (May)

Each visiting Executive feeds back to staff through corporate communications channels in words and pictures.

Thanks a Bunch

Thanks a Bunch has been a monthly event since September 2018. We invite staff to nominate their peers, or their team to win an award. Charitable funds allow staff to be given either flowers, chocolates or a voucher, plus a thank you card.

The thank you gift is delivered by an Executive and picture captured and shared in Trust News and the Meeting Place, the staff Facebook page. Each month we pick two winners, aiming to cover both hospitals with a spread between clinical and non-clinical. This has become a very popular mechanism to thank staff with typically more than 10 nominations being received each month.

Straight to Silas

We set up an email inbox, “Straight to Silas”, which staff can use to raise concerns with the Chief Executive. Concerns are investigated with the staff members receiving a response direct from the Chief Executive, who will sometimes meet the staff member to further discuss the issues.

Inquiries are recorded in the quarterly Freedom to Speak Up reported to Board.

Fifteen Steps

The 15 Steps Challenge is a toolkit with a series of questions and prompts which help guide the first impressions of a ward/department. The challenge helps gain an understanding of how patients feel about care. The tool can also help trusts understand and identify the key components of high quality care that are important to patients and carers from their first contact with a ward.

The challenge strongly aligns with a range of strategic initiatives including supporting improvements to quality, safety and patient experience, and is sponsored by the trust senior leaders. The feedback template is completed under the following four headings:

- Welcoming
- Safe
- Caring and involving
- Well organised and calm

This month the Deputy Chief Executive and a Non-Executive member of the Board visited wards 14a and 15b. Themes recognised for improvement on the visits were current staffing levels impacting on morale, adequate equipment storage and areas used for escalation impacting on the delivery of therapy. The visit also demonstrated positive areas of strong leadership, patient experience and involvement in their care.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB091/19**	**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

- Estates and Facilities restructure
- Nursing establishment review
- Preparations for Care Quality inspection
- Sharing our operational plan with staff
- £260,000 Trust sexual health clinic opens

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2019/20)*

	Strategic Objective	Principal Risk
✓	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
✓	**SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
✓	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
✓	**SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓	**SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
✓	**SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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

CQC KLOEs	**GOVERNANCE**
✓ Caring	☐ Statutory Requirement

✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	☐ 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	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

CHIEF EXECUTIVE'S REPORT TO BOARD – MAY 2019

Estates and Facilities restructure

The Estates and Facilities departments are undergoing a programme of organisational change. The purpose of the change is to bring functions together into a merged Facilities Management structure that will focus on the provision of quality, patient-focussed services, responsiveness and compliance.

A new senior Associate Director role has been developed to lead the function which drew a very strong field of applicants when advertised. An interview assessment centre was held on 24th April.

Once in post, the Associate Director of Facilities Management will complete the restructure programme which features some new roles and brings together previously separate teams.

A significant piece of work ongoing in the department is work to declutter ward areas on the Southport site and to improve storage availability.

Plans have been drawn up which use existing general storage, linen, sluice and toilet areas to exploit the ward layouts to better improve the working and clinical environment of each ward.

We have also developed a ward equipment checklist to ensure that each ward area has the appropriate level of equipment for patients.

The significant sum of £600,000 has been allocated from this year's capital programme to support the work. We have advertised a six-month matron appointment to support the Estates team to implement this improvement programme.

Nursing establishment review

An extensive nurse staffing review has been underway this year which will inform an increase in the number of clinical staff on the wards to improve our patient care.

It will be among the largest workforce investments the Trust has seen for a number of years. It is also an opportunity to promote the Trust as an organisation that supports its staff and is focused on patient safety, experience and high standards of care.

As part of this work a Standard Operating Procedure detailing how to undertake a staffing establishment review has been prepared and was ratified at Hospital Management Board in April 2019.

Preparations for Care Quality (CQC) inspection

The Trust received notification from the CQC on Wednesday 10th April of the Provider Information Request (PIR). As set out in CQC's guidance for NHS trusts, within six months of the date of the letter, the CQC will carry out an inspection of how well-led the Trust is along with an inspection of at least one core service. The CQC will use the information in our

response to decide on their inspection approach, and they will use this to determine key lines of inquiry for the forthcoming inspections.

Teams across the Trust are currently completing aspects of the PIR and forwarding for Executive lead to sign off prior to Board sign off.

The Trust quality team has been enhanced to ensure it can provide greater support to both the corporate teams and clinical teams.

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

The Quality Improvement Delivery Group has recently been re-established and has already met to understand the progress of the must and should dos in addition to identifying the risks and areas where a shared approach is needed to ensure progress against actions.

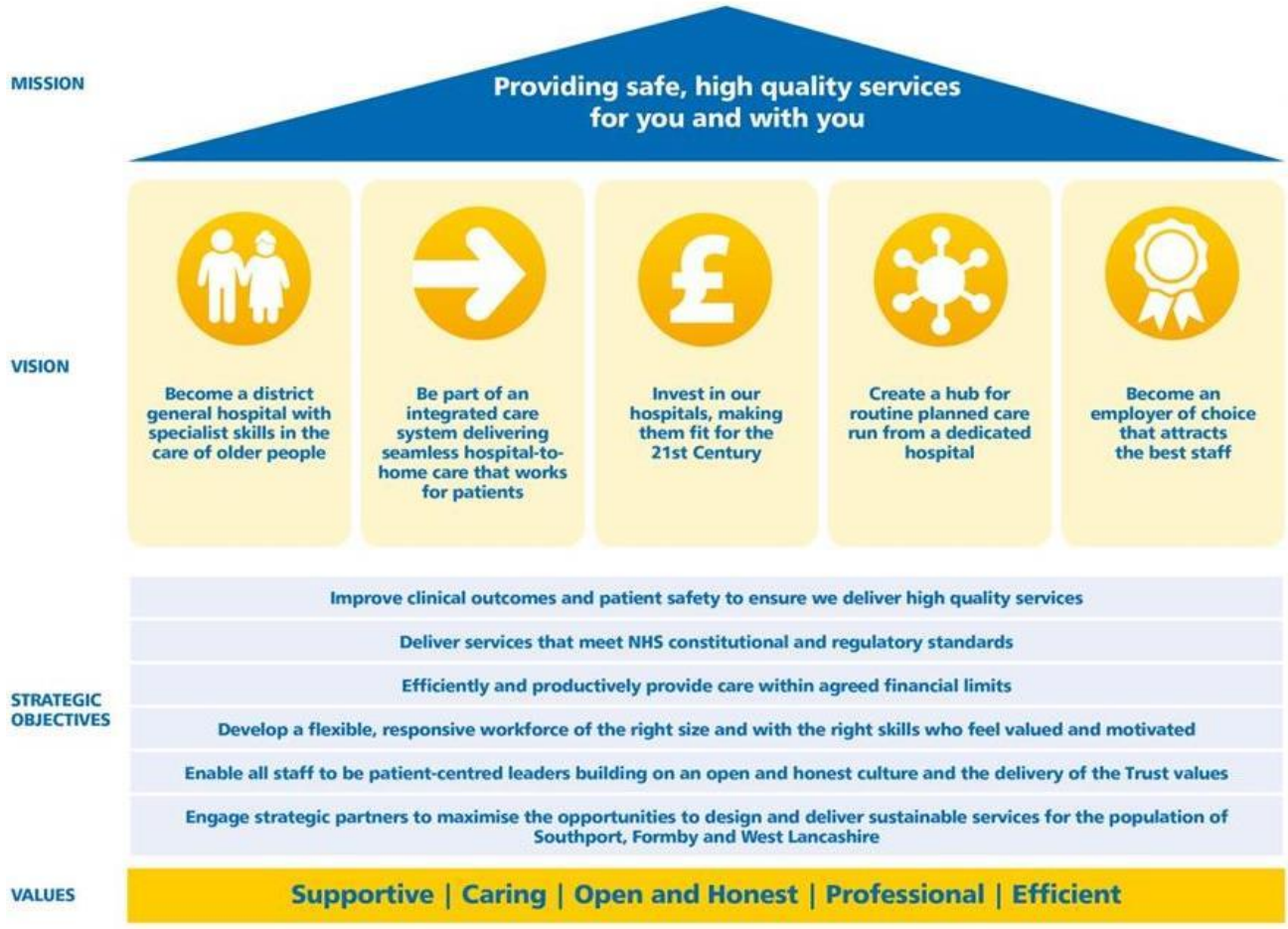
Sharing our operational plan with staff

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

There were four themes at the heart of Vision 2020 to which we have added a fifth: “become an employer of choice that attracts the best staff”. These are shown below with the Trust’s refreshed strategic objectives:

Briefings were held for senior managers at the end of March and beginning of April. This included information about the Trust’s Single Improvement Plan which sets out how we will deliver Vision 2020 this financial year.

“Town hall” style meetings and individual visits by members of the Executive to teams get underway on 18 April.



£260,000 Trust sexual health clinic opens

The Trust's Sefton Sexual Health Service opened a new community clinic in Bootle in the first week of April.

The £260,000 clinic is on the fifth floor of St Hugh's House in Stanley Road, Bootle, and incorporates services previously available at the nearby May Logan Centre and the PACE service for under 19 year-olds at Bootle Health Centre.

The opening coincides with the relaunch of Sefton Sexual Health website. As well as a feature that help users quickly find the service they need, it contains information on all contraception methods, STI testing and treatments.

In brief …

Equality and diversity. Network groups are being established for our black, Asian and minority ethnic (BAME), Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) and disabled staff led by Trust Equality Lead Bob Davies. The groups will aim to provide a forum for networking opportunities with the aim of improving staff experiences across the Trust.

Exit interviews. We have streamlined and improved the process of exit interviews for colleagues who are moving on. Analysis will be completed quarterly and shared with senior managers. Departments will be asked to put action plans in place that demonstrate a listening and learning culture.

Cultural change. Visiting Fellow at the King's Fund, Prof Michael West, gave a presentation organised by the Trust to more than 100 mostly staff and guests in Southport on compassionate leadership and cultural change. It was part of the Trust's on-going organisational development work, which over the next few years will help create a culture of improved well-being, innovation, collaboration and compassion.

NHS
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NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB092/19a**	**Report Title**	**Monthly Mortality Report Quarterly Learning from Deaths Report**
Executive Lead	Dr Terry Hankin, Medical Director		
Lead Officer	Dr. Chris Goddard, Associate Medical Director of Patient Safety Rachel Flood-Jones**,** Project Delivery Manager Richard Boydell, Deputy 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.

1.0 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 November 2018
- Disease-Specific Mortality Ratios – November 2018

2.0 Learning from Deaths Quarterly Update

The Trust is committed to improving mortality and in turn mortality ratios through the 'Reducing Avoidable Mortality' (RAM) Project which has the overriding aim of reducing avoidable mortality by to sit within statistical norms by April 2019.

The Trust is currently embedding the Royal College of Physicians Structured Judgement Review method to review in-hospital deaths, the findings from which will feed into the Learning from Deaths processes and outputs in line with national guidance.

3.0 Mortality Improvement Project Activity, Governance & Reporting External Mortality

Updates are provided appertaining to:

- Changes to the reporting and governance of the Reducing Avoidable Mortality Project and mortality improvement activity
- Current mortality improvement activity
- The latest version of the External Mortality Action Plan (including 7 RCA Cases) – Board Progress Assurance Report* (EMBAR).

4.0 Appendices
Appendix 1: Mortality Dashboard.
Appendix 2: Distribution Performance Graph, November 2018.

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 2019/20)*

	Strategic Objective	Principal Risk
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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	☐ Policy

If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)	☐ 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 is now incorporated into the Mortality Report.	
Previously Presented at:	
☐ Audit Committee	✓ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

1.0 Measuring Mortality

1.1 Executive Summary

- High level indicators show slow improvement, while in-month this has plateaued.
- From an information perspective, the importance of accurate diagnosis and documentation is emphasised.
- Interventions to improve performance in AKI have been implemented as of April 2019.
- Further evaluation of LRTI / Bronchitis is underway.
- Work is ongoing to improve mortality screening rates and to formalise the process for Structured Judgement Review governance.

1.2 Key National and Local Mortality Indicators

	2017/18	2018/19											Target
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Rolling 12 Month HSMR	123.4	121.2	120.6	118.3	117.5	116.0	114.8	111.9	110.8				*100.0*
Monthly HSMR	124.7	105.0	125.6	98.9	123.5	96.1	99.1	72.8	85.6				*100.0*
SHMI	118.0			115.5			113.2						*100.0*
Local HSMR Bronchitis	165.9	154.5	161.6	154.5	169.7	157.8	152.8	135.4	134.9				*100.0*
Local HSMR LRTI	167.4	155.9	163.0	155.9	171.2	159.1	154.0	136.5	135.7				*100.0*
Local HSMR Pneumonia	144.5	142.5	135.9	133.0	135.8	126.2	128.8	121.1	121.7				*100.0*
Local HSMR Septicemia	88.4	93.8	92.5	90.1	87.1	87.3	87.7	89.7	89.1				*100.0*
Local HSMR Stroke	139.1	135.4	136.6	127.7	123.5	126.1	114.8	106.2	108.5				*100.0*
Local HSMR UTI	131.2	131.6	127.5	126.1	125.0	112.6	116.4	113.9	116.0				*100.0*
Local HSMR Acute Renal Failure	124.2	121.5	109.0	108.0	108.6	104.2	96.8	95.8	104.5				*100.0*
Mortality Screens - %	102.83%	106.76%	88.24%	90.77%	92.21%	72.73%	58.90%	53.45%	58.82%	50.62%	63.44%	61.67%	*90.00%*
SJRs							33	21	13	7	13	4	*0*
2nd Review							0	2	2	0	2	0	*0*
In Hospital Deaths	106	74	85	65	77	66	72	59	69	81	94	61	*77*
In Hospital Deaths Crude Rate	41.4	30.4	29.0	22.2	26.6	21.1	22.2	17.4	20.6	24.4	27.4	19.5	*31.0*
LD Deaths	1	0	1	1	0	1	0	0	0	0	0	0	*1*
Steis Incidents	3	7	5	9	4	8	1	10	2	3	4	6	*5*

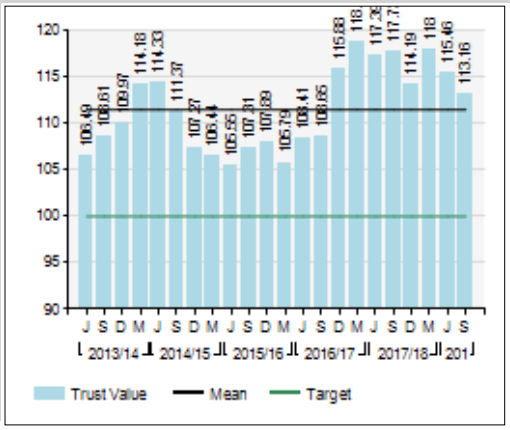
Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

- The high level indicators of SHMI and HSMR show a slowly improving trend.
- Disease specific HSMR highlights respiratory infective illness as the area for further investigation and this is ongoing.
- Pneumonia, AKI and sepsis are all monitored as part of the rolling AQ programme. The trust uses their indictors of clinical quality as the basis for pathway improvement and we are fully engaged with the AQ projects I this area including Hospital Acquired

Pneumonia.

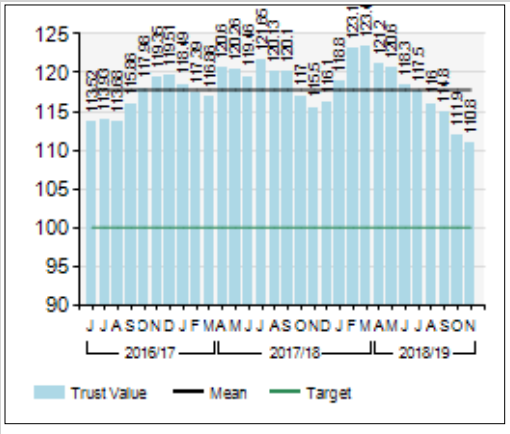
- Work around UTI is ongoing through the IP&C team, this will be monitored and supported as required.

SHMI - Summary Hospital Level Mortality Indicator



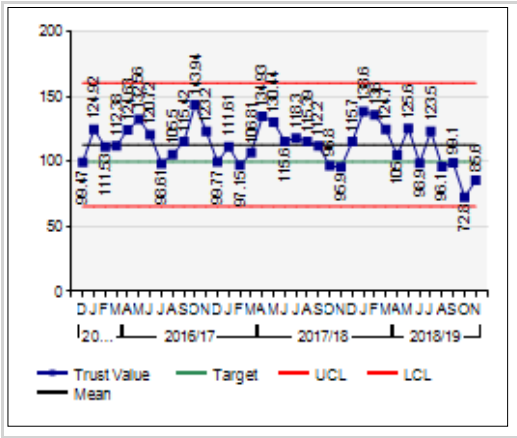
The last reported quarterly SHMI is 113.16. This is on an improving trajectory and is the lowest since 2016. This is most likely being driven by better identification of co-morbidities and conditions treated in our patient population. This work continues; the next area to examine is to reduce 'R' coding. This happens when admission diagnoses are based on 'signs and symptoms' rather than a diagnosis of a condition. The trust has high levels of 'R' coding. R codes are assigned lower mortality risks in the SHMI model than formal diagnoses as one does not die from 'breathlessness' or 'collapse ?cause'.

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



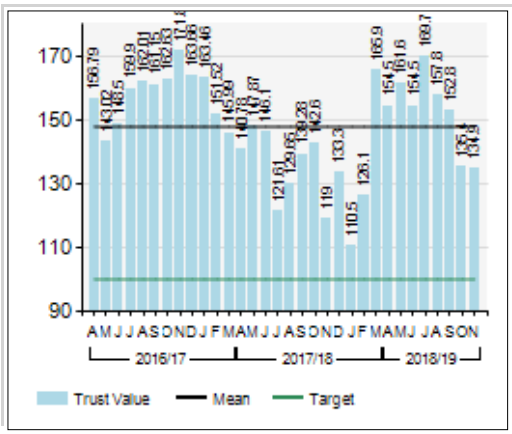
The HSMR continues to reduce and currently stands at 110.8. The likely drivers are similar to the SHMI, although as HSMR excludes patients receiving specialist palliative care input and palliative care coding has seen an increase in the past few months; it is likely that this is also an important element. As this is a 12 month rolling figure and the monthly HSMRs have been acceptable it is likely that this rolling figure will continue to improve.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



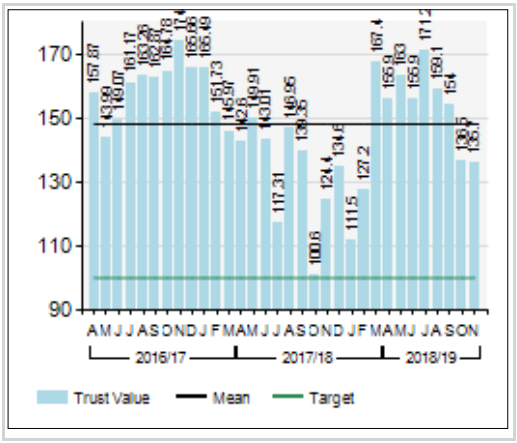
The last monthly HSMR for November 2018 is 85.6. This is within tolerance. The factors behind this from an information perspective are listed above. From the point of view of in-month clinical performance, it can be seen that ED flow was maintained in November, which shows a consistent relationship with mortality rates. Medical sickness absence is also showing an improved position on previous.

Local HSMR Bronchitis



The improved position from last month's report has been largely maintained, but LRTI and Bronchitis remain areas of significant interest and a focus for improvement. These conditions are often diagnosed when other diagnostic tests are normal, rather than there being a test which indicates their presence. It is likely that the raised SMR indicates either an underlying advanced frailty syndrome – which there is not a code for and is therefore unmeasured – or a misdiagnosis. A deep dive in this area is ongoing.

Local HSMR Lower Respiratory Tract Infection



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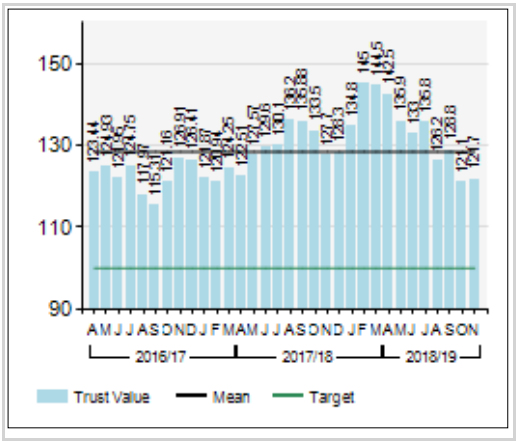
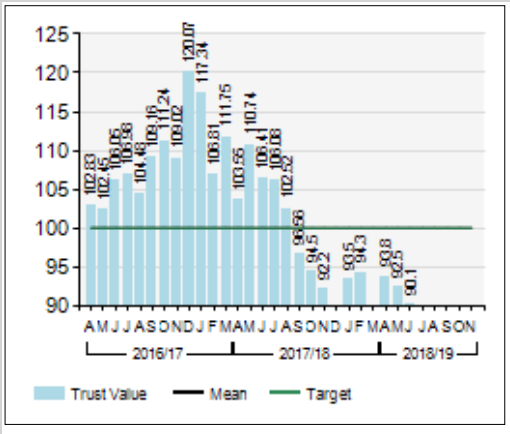
Local HSMR Pneumonia



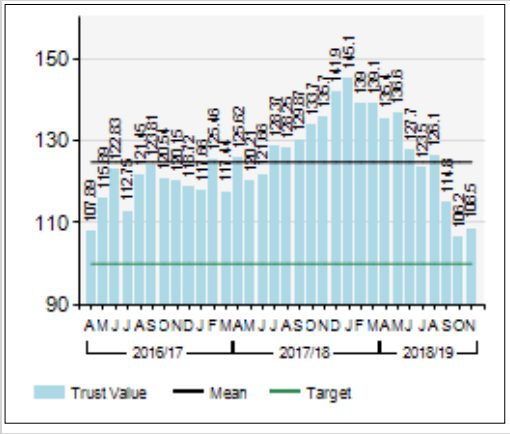
The SMR for pneumonia remains above the expected level. The trust pneumonia pathway has been introduced in order to guide and standardise the investigation and treatment of pneumonia with guidance on appropriate escalation of levels of care as required.
AQ continually audit the quality of pneumonia care delivered. Data up to December 2018 demonstrates the areas of challenge are delivering antibiotics within 4 hours of hospital arrival (78.9%) and performing CURB-65 risk assessments (66.5%). The AQ standards are met 88% of the time ranking us second of the participating trusts.

Local HSMR Septicemia



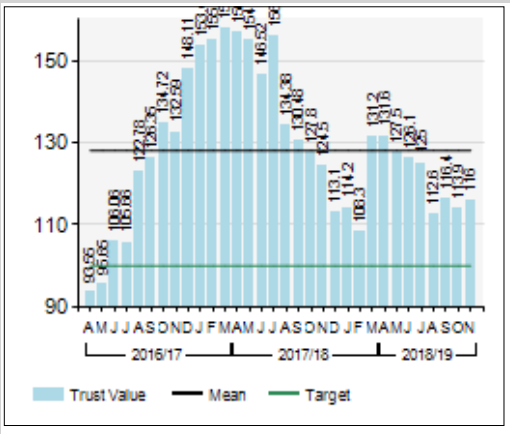
The sepsis SMR remains within target. Quality of care for patients with sepsis remains an area of focus as variation in practice still remains. Compliance with pathways of care is a key focus and this has been redesigned to aid completion. Clinical processes of care are monitored by AQ. The areas of challenge are performance of blood cultures within the first hour (68.3%) and senior review within 2 hours of diagnosis (45.8%). The first of these is likely a documentation issue, both can be addressed by pathway adherence. Our overall performance is 76.3% compliance ranking us second of the participating trusts.

Local HSMR Stroke



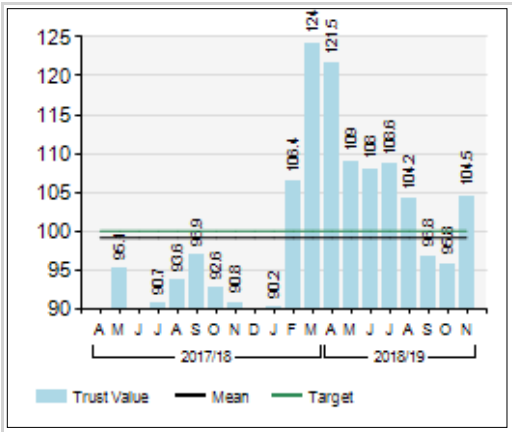
The SMR for stroke has generally improved in line with the improvements in data collection around co-morbidity and palliative care. As this process has largely been targeted at patients in their 7th and 8th decades, it is likely that stroke patients are well represented in this process. A working group on assisted nutrition is ongoing. Part of the terms of reference for this group is to look at the governance of naso-gastric feeding. As aspiration can be an issue following stoke it is anticipated that this work could have an impact in reducing aspiration pneumonitis.

Local HSMR Urinary Tract Infection



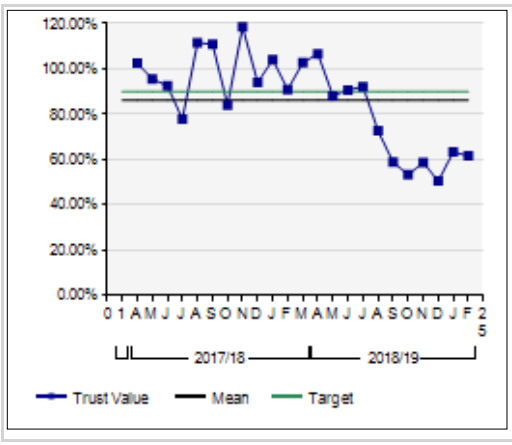
The SMR for UTI is above tolerance, work is ongoing to reduce the impact of urinary infection through reduced catheterisation and the promotion of continence. It is likely that deaths attributable to UTI are either a misdiagnosis, a contributory factor to an advance frailty syndrome or actually due to sepsis of urinary origin which has a different code to UTI. A review will take place to ascertain.

Local HSMR Acute Renal Failure



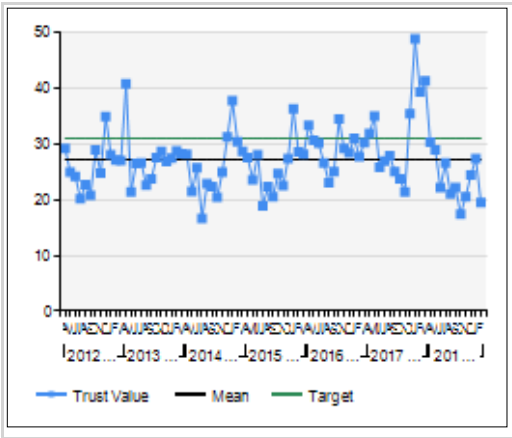
After 2 months of improved performance the SMR for AKI has deteriorated to 104.5. AKI is subject to continual review and improvement using AQ data. This is monitored by the AKI steering group. Areas of concern are urinalysis within 24 hours (46.9%) and nephrology or critical care review within 12 hours of AKI 3 (20.3%). The overall compliance is 53.4% placing the Trust 6th out of 9 Trusts. Actions taken include the development and refinement of a pathway to guide investigation and treatment, the development of a 12 hourly e-mail alert of new AKI biochemical results and the development of IV fluid guidance. The e-mail alert is received by pharmacy and by the 24/7 critical care outreach team (CCOT) as of the 1st of April 2019. CCOT review all AKI 3 patients and provide the AKI list to the AM medical handover on EAU.

Mortality Screens - % Deaths Screened



The mortality screening rate remains between 60-70%. This is lower than the aim of 100% of deaths screened. Education is provided at induction to make staff aware of the need to complete this, further sessions are planned to re-inforce and individual compliance will be provided to departments so they can monitor and improve their own performance.

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



Data for crude mortality rate is available up to February 2019. This is non-standardised data and is subject to monthly variation. That said, the crude rate has stayed largely below the trusts average for the past few months.

2.0 Learning from Deaths

The Trust is committed to improving mortality and in turn mortality ratios through the 'Reducing Avoidable Mortality' (RAM) Project which has the overriding aim of reducing avoidable mortality by to sit within statistical norms by April 2019.

The Trust is currently embedding the Royal College of Physicians Structured Judgement Review method to review in-hospital deaths, the findings from which will feed into the Learning from Deaths processes and outputs in line with national guidance.

2.1 Structured Judgement Review (SJR)

The Royal College of Physician's Structured Judgement Review (SJR) method went live in the Trust on 2nd July 2018, with a phased switch over completed in November 2018. Methodology and process have been outlined previously.

This month the new Structured Judgement Review activity is reported below. The two sets of data will continue to be reported in tandem in the Quarter Two Learning from Deaths Report (March/April 2019), after which time all reported data will be based solely upon the Structured Judgement Review method.

Table 1. Mortality Screening

Month	No of Deaths	No of Deaths Screened	% Screened	No. Triggering SJR Review	% Triggering for Review
July	77	30	39.0%	18	60%
August	66	39	59.1%	26	67%
September	72	43	59.7%	33	77%
October	59	31	52.5%	22	71%
November*	68	40	58.8%	13	33%
December	81	41	50.6%	7	17%
January	94	60	63.8%	13	22%
February	61	38	62.3%	4	11%

*change of criteria for review

Table 2. Screening by Specialty

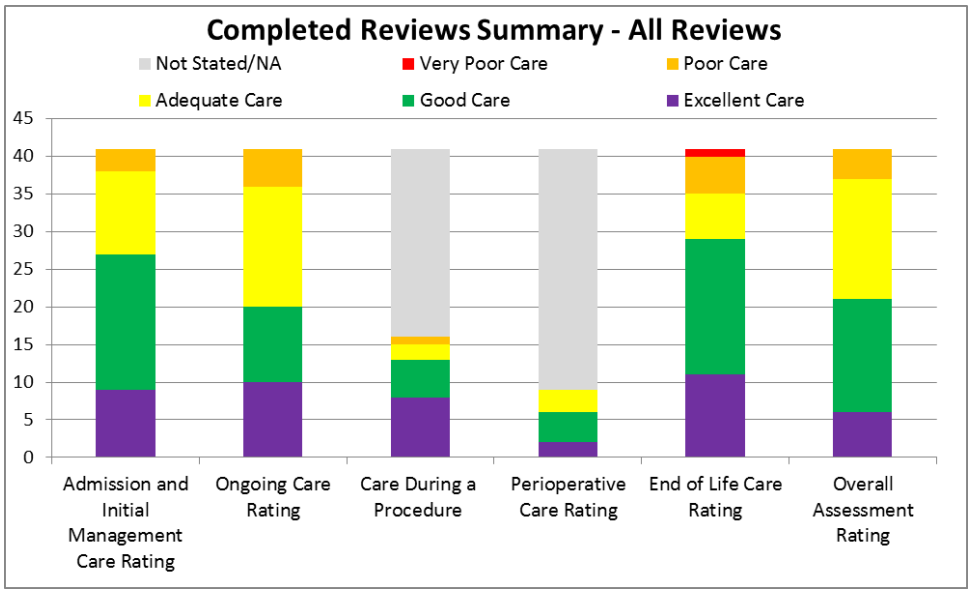
Screening Rates by Specialty (last 3 months)

	December			January			February		
	No of Deaths	No of Deaths Screened	Screening Rate	No of Deaths	No of Deaths Screened	Screening Rate	No of Deaths	No of Deaths Screened	Screening Rate
General Medicine	52	21	40%	58	38	66%	40	25	63%
Frail Elderly Medicine	8	4	50%	21	15	71%	11	8	73%
Cardiology	1	0	0%	1		0%	0	0	N/A
General Surgery	2	2	100%	4	1	25%	2	1	50%
Trauma & Orthopaedics	2	1	50%	2	2	100%	2	0	0%
Stroke Medicine	8	7	88%	3	2	67%	4	3	75%
Gastroenterology	5	5	100%	0	0	N/A	1	1	100%
Accident & Emergency	1	1	100%	1	0	0%	0	0	N/A
Urology	0	0	N/A	1	1	100%	1	0	0%
Gynaecology	0	0	N/A	1	0	0%	0	0	N/A
Respiratory Medicine	0	0	N/A	1	0	0%	0	0	N/A
Well Babies	0	0	N/A	0	0	N/A	0	0	N/A
Rehabilitation	1		0%	1	1	100%	0	0	N/A
Spinal Injuries	0	0	N/A	0	0	N/A	0	0	N/A
SCBU	1	0	0%	0	0	N/A	0	0	N/A
Grand Total	**81**	**41**	**51%**	**94**	**60**	**64%**	**61**	**38**	**62%**

Completed First Structured Judgement Reviews

Speciality	No of Reviews
General Medicine	11
Geriatric Medicine	11
Intensive Care/Coronary Care/High Dependency	8
Trauma & Orthopaedics	3

Chart 1. Trust – Wide SJR results



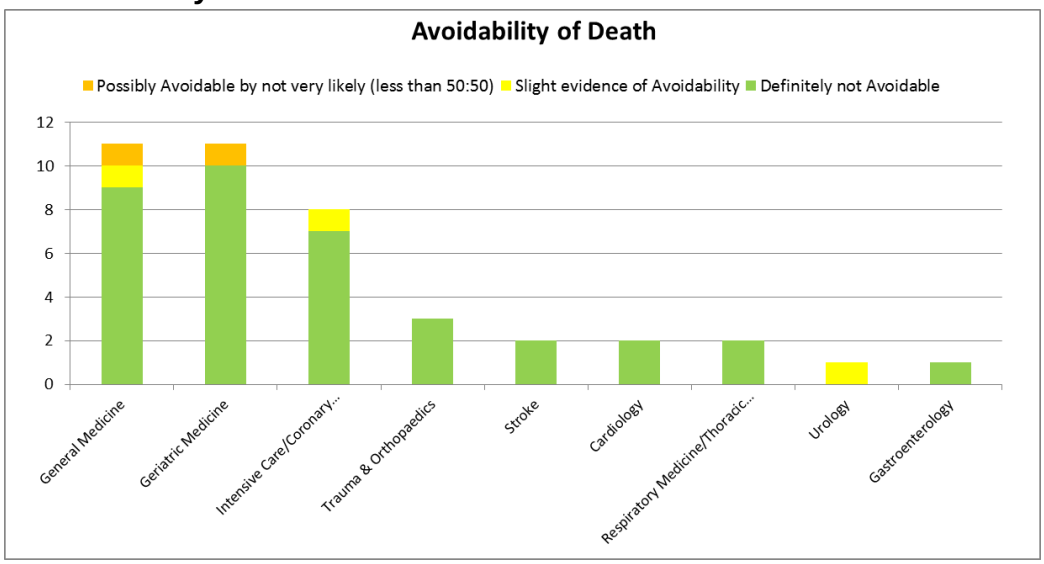
To date there has been no 'Very Poor' overall care identified. Two cases of overall 'Poor' care are being reviewed by the CBUs. Case one from T&O has been used as evidence for ongoing

revision of the fractured neck of femur pathway. This episode was rated 'poor' overall due to the patient waiting over 36 hours for surgery.

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

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

Table 3. Avoidability of Death



No definitely avoidable deaths have been found to date. 4 patients have been classified with some evidence of avoidability, but none greater than the 'more likely than not' cut off.

3.0 Mortality Improvement Project Activity, Governance & Reporting

3.1 External Mortality Review Action Plan

From May 2019, The External Mortality Review Action Plan Board Assurance Report or EMBAR (as shown below) will be submitted to the Quality and Safety Committee and the Trust Board each month as part of the Mortality Report. As its title confirms, the report provides assurance of progress against the 2018 External Mortality Review Action Plan detailing updates against a number of Trust Progammes of work (The Patient Flow Improvement Programme, Older Peoples Care Programme, Reducing Avoidable Mortality Project and the Documentation Programme).

The version of EMBAR (provided below) was first presented to the April Trust Board as an additional paper discussed as part of the Mortality Report agenda item. The next update will be submitted to the May 2019 Quality and Safety Committee and June 2019 Trust Board.

The Reducing Avoidable Mortality Project (Phase 2) will now report by exception into the Mortality Operational Group (which in turn reports into the Quality and Safety Committee).

3.2 Reducing Avoidable Mortality Project

Current project activity:

Future Care Planning:
A meeting was held on 5th April to discuss the division of the scope of work to be undertaken for Future Care Planning by the RAM Project and the Older Peoples Care Programme. The session was attended by the clinical and Programme Office leads of both projects alongside representatives Queenscourt Hospice, the Transform Team and Trust Frailty Practitioners. The main areas of focus for 2019/20 are: Advance Care Planning, Anticipatory Clinical Management Planning, documentation, training and roles and collaboration in End of Life care.

Correct Care Pathways:
Members of the Trust will be attending the biannual Advancing Quality Alliance (AQUA) Collaboratives in the North West: AKI on 26th April, Pneumonia on 21st May and the Sepsis on 10th June. AQUA continue to support the Trust and Clinical Audit with comparative compliance reports for the treatment of Sepsis, Pneumonia and AKI alongside best practice and membership to the Collaborative Network.

Appropriate Escalation / Senior Ownership:
The pilot of the electronic Board Round is to be tested on Wards 11B and 14A. The date of this pilot is to be arranged due to staff sickness. Input from the Clinical Ward Leads has greatly supported progress of the inhouse development of the bespoke software.

Documentation:
The initiation phase of the Documentation project will run over the first quarter of the financial year. Dedicated Programme Office support has been allocated to faclitate the Programme which is currently being led by the Deputy Director of Nursing. The requirement for the review and revision of Trust documentation is a common theme across the Trust quaility portfolio and as such, close collaborative work will be required with projects such as RAM to this end.

3.3 External Mortality Action Plan (including 7 RCA Cases) – Board Progress Assurance Report (EMBAR)

EMBAR
External Mortality Action Plan (Including 7 RCA Cases) Board Progress Assurance Report 2019/21

Blue	Activity completed
Red	Significantly delayed and/or of high risk - not expected to recover
Amber	Slightly delayed and / or of low risk - can be recovered
Green	Progressing on schedule

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Status Update 29th March 2019
Patient Flow	EMR Action 1	Improve Patient Flow	Improve patient flow so that patients requiring admission do not have to wait for an appropriate bed and are not nursed on corridors. Focusing on:	Patient Flow Improvement Programme (Feeding into RAM 2 'Appropriate Assessment & Admission')	Executive Lead: Chief Operating Officer	Nov-18	Mar-20	Tbc once Workstreams have been revised April 2019	G	This is the objective of the Patient Flow Improvement Programme Board (delivered by Length of Stay Work Streams).
		a. Alternative to admission	Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams						G	The objective of Work Stream 1 of the Length of Stay (LOS) Project 'Emergency Admission, Triage and Assessment Units' is to find ways of managing A&E attendances with increased efficiency at the point of arrival with: a trial of a senior nurse at the font door, enhanced triage, a review of the ambulatory care modelling by season and plans for in-reach provision into A&E for COPD and Diabetes.
		b. Criteria led discharge	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.							Clarification of the specific activity and work streams under which they will be delivered will be confirmed under the rescoping of the Patient Flow Improvement Programme in April 2019. A further update will be available for next month's report.
		c. Proactive escalation planning	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.							
		d. Multi-Specialty Team Working	Team working to improve patient management through the pathway including in-reach to emergency department and critical care outreach to all areas.							
Correct Pathways of Care	RCA Action 1	Improve Delivery of Pathways of Care	Ensure that pathways of care for key causes of clinical deterioration are; up to date, available, clear and used across the organisation. These must include Sepsis, Pneumonia and AKI. Training gaps on these processes for doctors and nurses must be identified and closed organisation-wide, to include the basic investigative and therapeutic strategies for the first hours of care and criteria for referral.	Reducing Avoidable Mortality 2 'Correct Pathways of Care'	Associate Medical Director of Patient Safety	Mar-18	Ongoing until end of project March 2020	Milestones to be confirmed within scope of RAM 2	G	A workshop to scope QI activity for the management of Respiratory Failure took place on 21st March with a subsequent session to be organised for the management of Pneumonia as a symptom of Heart Failure. The RAM project is linking into the Trust's new AKI Steering Group on key activity to support improved care and the Trust's Infection Prevention and Control Lead regarding cathetarisation, UTIs and sepsis. Meetings are to be set up to scope activity in both of these areas.
	EMR Action 2	Improve awareness of Sepsis	Improve awareness of Sepsis 6 guidelines and monitor adherence.			Apr-18	Jul-18	100%	B	The Sepsis Pathway was revised & relaunched in June 2018 and is held on a Deteriorating Patient Trolley located on each ward.
		Improve compliance with Sepsis 6 Guidelines / Monitor Complaince With Sepsis Pathway					Mar-20	60%	G	Compliance with Sepsis 6 is reported through the AQ Sepsis Audit which is now reported through the Mortality Report to the Board. During 2018 the Trust participated in advancing quality monthly Sepsis benchmarking data collection.Our composite quality score target (% of measures achieved) Jan –Dec 2018 was 75%, which we achieved with our final score for the year being 75.6%
	EMR Action 3	Establish Pneumonia Pathway	Review and/or establish a pneumonia pathway to ensure that it meets national guidelines.	RAM 1		Nov-18	May-19	90%	G	New Pneumonia Pathways are now on all wards as part of the new Deteriorating Patient Trolleys. Training will be rolled out by Critical Care Outreach Team.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Status Update 29th March 2019	
Senior Ownership	EMR Action 4	Doctors' Rotas to be Reviewed (to ensure sufficient daily senior cover & junior doctor support)	Review doctors' rotas to ensure sufficient daily senior cover and that junior doctors are not unsupported or working beyond their capabilities.	RAM 2 ('Senior Ownership')	AMDs of Clinical Business Units	Mar-19	Mar-20	5%	G	An audit of Ward Cover has been undertaken provising a baseline to inform the required review.	
	RCA Action 2	Clear Senior Clinical Lead	Ensure that it is clear to every patient, family and staff member which consultant team is the lead provider of care for every patient, including when care is shared between teams and specialisms. Departmental policies and working practices must promote and support consultant leadership of patient care and consistent handover of care of patients between shifts		AMD of Patient Safety with AMDs of Clinical Business Units	Apr-19	Mar-20	5%	G	Board Rounds are to be documented on the new Electronic Board Round proforma (initial pilot diarised for go-live, May 2019). This will require confirmation of the consultant and will provide clear consultant ownership of each patient. In the meantime, the Trust PAS, Medway must be kept up to date with the patients consultant documented.	
Documentation & Observations	EMR Action 5	Review Standards of Documentation	Review standards of documentation to ensure that staff always sign and date their entries and that handover of care is clearly documented including the responsible Consultant.	Documentation' Project (May 2019) Feeding into RAM 2 ('Observations & Documentation')	Deputy Director of Nursing	Apr-19	Tbc	0%		The Trust's Documentation Programme sits within the Quality Improvement Portfolio for 2019/20. Preliminary scoping work commenced on 1st April supported by dedicated Progamme Office Support.	
	RCA Action 3	Clinical Documentation Audits	Publish and regularly audit against agreed standards for clinical documentation; to include the completion of pathways of care for key medical conditions and legible prescribing. This should form part of structured feedback to medical staff.				Tbc	0%		Best practice will be based upon GMC Professional Standards for doctors and NMC standards and guidelines for nursing staff. The project will contribute to improved patient safety, efficiency and quality assurance while laying the foundations for the eventual full transition to digital records.	
	EMR Action 6	Review Nursing and AHP Documentation	Review nursing and AHP documentation to ensure that it is fit for purpose in focusing and promoting essential care, particularly fluid balance and nutritional needs.				Tbc	0%			
	EMR Action 7	Ensure Prescribing is legible, clearly signed and in line with national existing guidelines for care.	Ensure prescribing is legible, clearly signed and in line with national existing guidelines for care. Focus initially on opiate prescribing in line with recent Gosport report.				Tbc	0%			
	RCA Action 4	Ongoing audit of physiological observation compliance and fluid balance completion	Ongoing audit of physiological observation compliance and fluid balance completion must be reported to CBU and centrally. All CBUs must clearly demonstrate how they will improve observation compliance and fluid balance completion on their wards and demonstrate that this is occurring.			Jan-19	Ongoing	0%		Audits of NEWS and fluid balance are undertaken by the Critical Care Outreach Team; the results from which are fed back to individual ward managers for action. The VitalPAC system provides a monthly audit of observations compliance against the protocol and the number of patients taken off the protocol. This info is fed to Ward Managers, Matrons and the Heads of Nursing.	
Appropirate Escalation	EMR Action 8	Review Escalation and Ceilings of Care Policies	Review escalation and ceilings of care policies to include timely access to critical care and end of life care. Include a focus on training of all staff in accurate calculations of Early Warning Scores (EWS), interpretation and contextualisation of EWS and a shared understanding of when to escalate care and consider a structured communication approach such as Situation, Background, Assessment, Recommendation (SBAR).	RAM 2 ('Appropriate Escalation')	Associate Medical Director of Patient Safety	Jan-19	Jun-19	80%	G	The Trust's National Early Warning Score 2 (NEWS 2) Track and Trigger System Operational Policy (Clin Corp 81) has been revised and defined escalation plans have been added to this policy. Education on the amendments have been ongoing as part of the NEWS2 launch led by the Critical Care Outreach Team. the policy will be submitted to the April Clinical Effectiveness Committee for approval. (The SOP on Respiratory Variance to support NEWS2 has also been updated and published 21st March).	
	RCA Action 5	Physiological Monitoring Process	Implement the RCP/NICE NEWS2 physiological monitoring process, with clear pathways for the monitoring and escalation of elevated scores to senior decision makers. This must include a regular senior review of the appropriateness of escalation plans for every inpatient as an integral part of every ward and board round. All clinical staff should be aware of the NEWS 2 score for escalation, who to, and what should be expected from the senior decision maker.			Jan-19	Jun-19	80%	G	On Tuesday 26 March, the Trust moved to the NEWS2 observations model. Throughout March, the VitalPAC Business Change Development Team had rolled out training across the Trust. (Over 300 staff have now been trained). NEWS2 is a physiological monitoring process, with clear pathways for the monitoring and escalation of elevated scores to senior decision makers. The electronic Board Round (the pilot for which is due May 2019) will further support senior review and a standardised approach to appropriate and timely escalation.	

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Status Update 29th March 2019
Future Care Planning	EMR Action 9	Review End of Life Policy	Review end of life policy to ensure that doctors of appropriate seniority complete DNACPR forms, with confirmation by consultant at the earliest opportunity if less senior initial decision maker, and that senior doctors have end of life discussions with families and patients.	RAM 1 & RAM 2 ('Future Care Planning')	Medical & Education Director, Queenscourt Hospice	2018	2018	100%	B	The policy was updated in 2018 an continues to be relevant and fit for purpose
	EMR Action 10	Ensure prompt commencement of well documented individual end of life care plans	Ensure that individual end of life care plans are commenced promptly and that the care plans are well documented including preferred place of care. Consider wider use of Emergency Health Care Plans to prevent readmission for patients approaching the end of their life.			2018	Mar-21	30%	G	Work is ongoing to embed Advance Care Planning and the practice of setting EOL patients up with Anticipatory Clinical Management Plans. 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. 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.
Learning from Deaths	EMR Action 11	Robust mortality review process with central reporting with a focus of disemination of learning from deaths.	Ensure development of a more robust mortality review process with central reporting. There should be an emphasis on dissemination of learning from deaths across all specialties with involvement from medical, nursing and allied healthcare professionals. and including colleagues from Primary Care.	RAM 2 ('Future Care Planning')	Associate Medical Director of Patient Safety with Associate Director of Integrated Governance	Jul-18	Mar-20	50%	G	The Trust launched the Structured Judgement Review method in July 2018. SJR Reviews are undertaken through the DATIX system; the Trust has 38 trained SJR reviewers. There is ongoing work to improve both the numbers of deaths which are screened and the turnaround times for SJR reviews. A session is being held on 8th April to review the central reporting process.
	RCA Action 6	Mortality & Morbidity Reviews must occur in departments with evidence produced of agreed actions and improvement projects	Mortality and Morbidity review must occur in departments with evidence produced of agreed actions and improvement projects, as defined by the cases presented. These improvements, generated by clinical teams, must have evidence of review by CBU and senior management to demonstrate openly how change is supported.			Jul-18	Mar-20	50%	G	Process required for lessons learned in M&M to be reported to CBU Governance for review, approval and support. This then needs to be reported centrally for oversight and co-ordination. (This process is currently being devised). Serious Incidents picked up in Mortality and Morbidity Review Meetings are put through the DATIX system.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Status Update 29th March 2019	
Specialist Services	RCA Action 7	Management of Diabetes	Review and update the trusts policy and approach to the management of inpatient diabetes. Ensure available, clear guidance exists for the management of diabetic emergencies and that appropriate patients are identified and referred to the inpatient diabetic service. Resource and support this service to provide the necessary support to clinical teams.	Tbc	CD Medicine / AMD of Urgent Care	Apr-19	Mar-21	0%	G	Required activity identified as below; lead project, responsible owner and timeframes now to be confirmed. 1. Up to date and clear process and guidance for the management of hypoglycaemia, hyperglycaemia, perioperative fasting and DKA. 2. Clear referral criteria and process of referral to inpatient diabetes team. 3.Gap analysis and business plan to provide a diabetes service.	
	RCA Action 8	Acute Pain Services	Review and update the trusts approach to the provision of acute pain services, to include the available guidance to non-specialist doctors on a basic pharmacologic strategy, and how the ongoing support of a pain specialist can be obtained.	Tbc	Acute Pain Lead / CD Anaesthetics	Apr-19	Mar-21	0%	G	Required activity identified as below; lead project, responsible owner and timeframes now to be confirmed. 1. Clear analgesic guidance available for the non-specialist in prescribing basic analgesia to most patients. 2. Clear process and criteria for a referral to a pain specialist. 3. Gap analysis and options appraisal to be performed for the ability to provide acute pain specialist advice every day.	
Medicines Management	EMR Action 12	Review Antibiotic Guidelines	Review antibiotic guidelines to ensure that they meet recent national guidelines.	Medicines Management Project	Chief Pharmacist	May-18	Dec-18	100%	B	Antibiotic Guidelines were reviewed by the microbiology department in May 2018 and it was confirmed that we are meeting the required national standard (we are using the Mersey Micro App with St Helens and Knowsley NHS Trust). There is a point prevalence completed quarterly and a prescribing audit completed monthly to this end. Ros / Katherine can provide the data if needed. Andrew submits this data to the CCGs on a regular basis,	

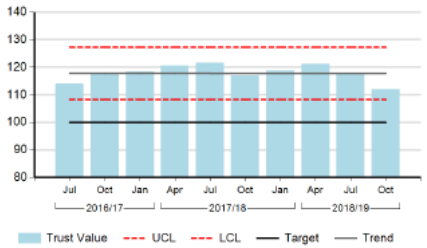
4.0 Appendices Appendix 1: Mortality Dashboard – April 2019

Southport & Ormskirk NHS Trust Mortality Dashboard April 2019

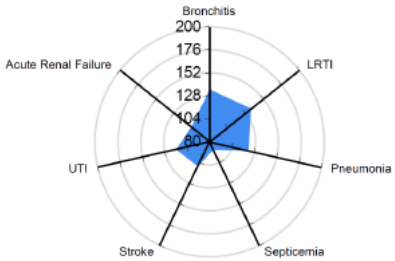
Southport & Ormskirk Hospital NHS

Dr Foster National Mortality Statistics

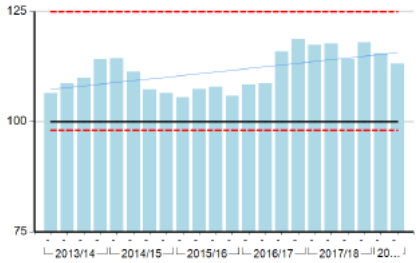
Rolling 12 Month HSMR



Local HSMR November 2018/19

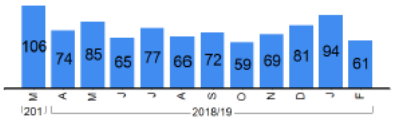


SHMI



Trust Mortality Statistics

In Hospital Deaths



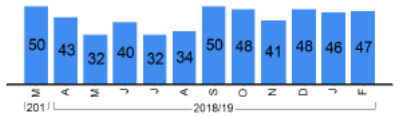
YTD Deaths of Patients with Learning Difficulties: 3

0.37% ▼

YTD Deaths of Patients with GSF Alert: 153

19.1% ▲

Deaths Post Discharge

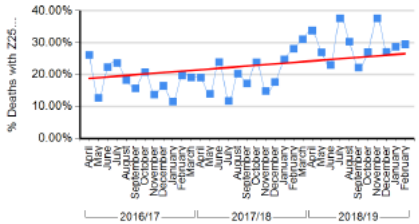


Avg Spell LOS whilst admitted: **16.8**

Avg Days to death post discharge: **13.2**

YTD Deaths of Patients with GSF Alert: 157 — **34.1%** ▲

Palliative Care Coding %



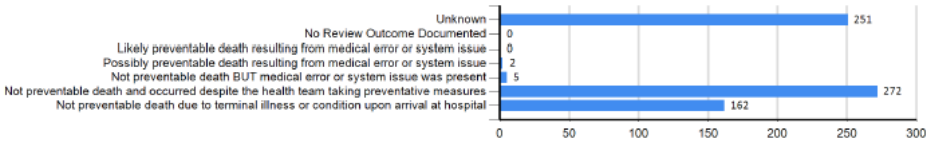
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Lobar pneumonia, unspecified	10	▼
Sepsis, unspecified	7	▼
Pneumonitis due to food and vomit	6	▼
Congestive heart failure	5	▲
Pneumonia, unspecified	4	▼

Mortality Reviews

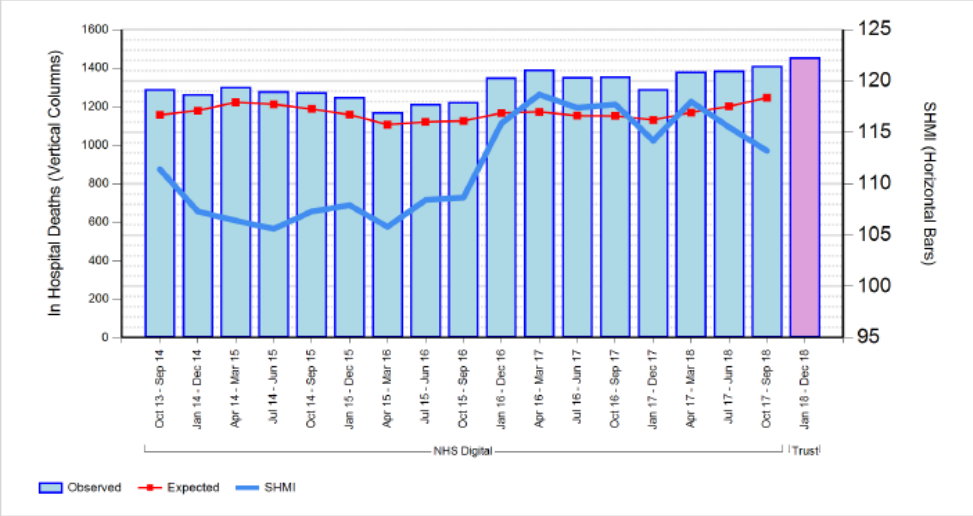
	2017/18	2018/19										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Screens Completed	109	79	75	59	71	48	43	31	40	41	59	37
Screens %	102.8%	106.8%	88.2%	90.8%	92.2%	72.7%	59.7%	52.5%	58.0%	50.6%	62.8%	60.7%

Mortality Review Outcomes - Last 12 Months



SHMI Breakdown

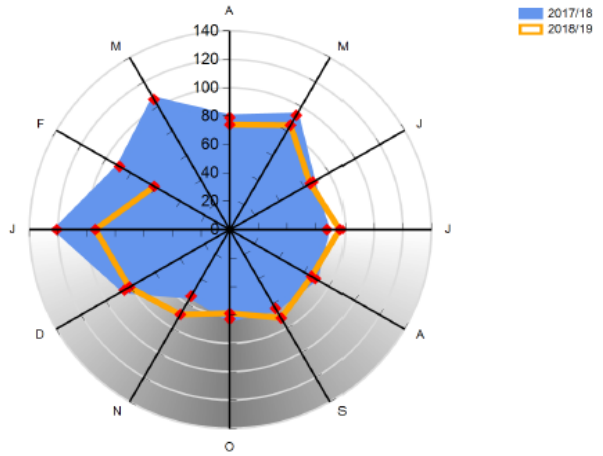
Southport & Ormskirk Hospital NHS
NHS Trust



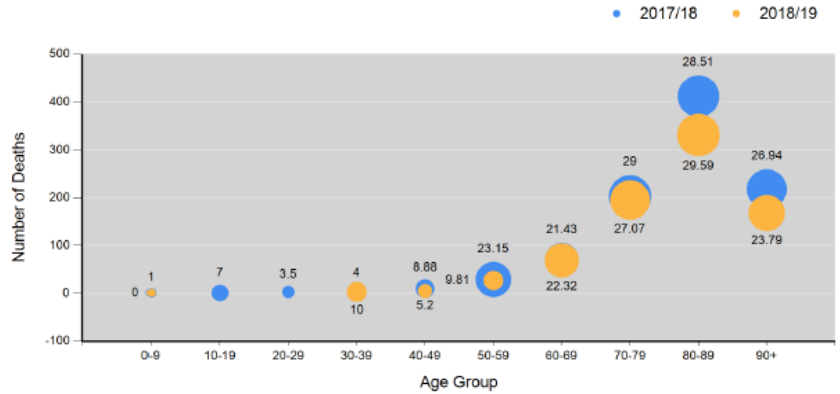
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

This should give an indication of the SHMI although the number of expected deaths for the recent periods is unknown.

In Hospital Deaths Seasonality Distribution



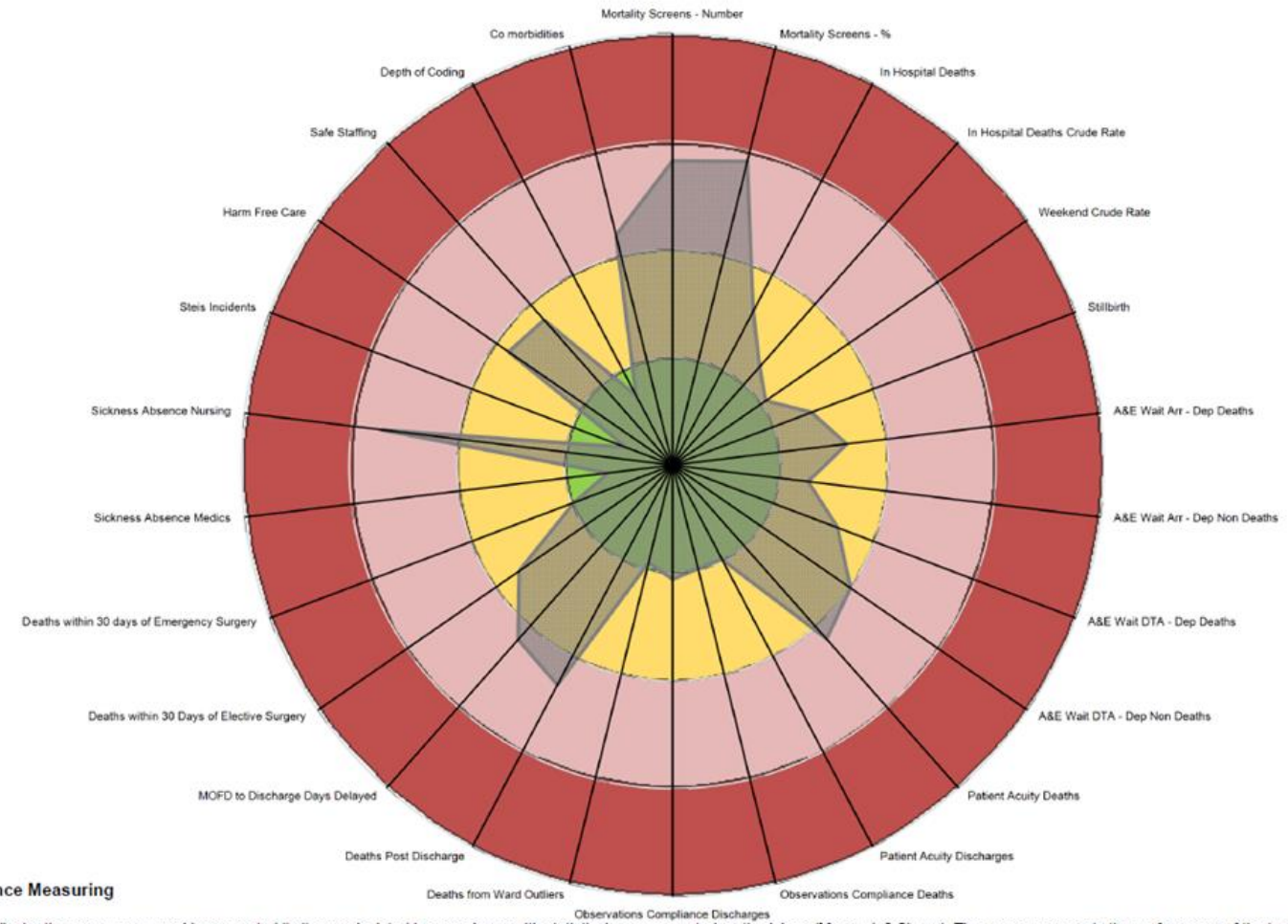
In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



The above chart shows the distribution of in-hospital deaths by age group in 2017/18 compared to 2018/19. The relative size of the bubble represents the average length of stay of the spell.

Appendix 2: Performance Distribution, November 2018

Performance Distribution for November 2018/19
HSMR Value in Month: 85.6



Performance Measuring

For each indicator the mean, upper and lower control limit are calculated in accordance with statistical process control methodology (Mean +/- 3 Sigma). The gauge represents the performance of the trust value being displayed within these parameters (green = lower control limit, red = upper control limit).
If the indicator is nearer to the green this means that performance is **better** compared to usual, if the indicator is nearer to the red it means performance is **worse** compared to usual.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB092/19b**	**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

The Board is asked discuss progress identified in this report in relation to the Quality Improvement and progress made in relation to the must and should dos and the continuation of the Assurance Panels to monitor progress and assurance processes in place.

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 2019/20)*

Strategic Objective	Principal Risk
☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
☐ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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 plan will be continuously reviewed and updated as necessary.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE MAY 2019

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on the progress 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 and the Core Service Review (CSR) in December 2018.

2. QUALITY IMPROVEMENT

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. Programme governance of the plan is managed through the Quality and Safety Group (QSG). Day to day management is delivered through the work streams.
- Reports 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
- Quality Priorities will also be reported through the annual Quality Account.

This was discussed and assurance given around the process in the March 2019 Quality and Safety Committee. This is operationally monitored through the Quality and Safety group in line with the agreed Trust Quality Priorities of:

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

Documentation is also an overarching priority cross cutting across nursing, medicine and therapy. A multidisciplinary task and finish group has been established with Programme Management Office (PMO) Support to process map existing clinical documentation and process map and develop future clinical documentation needs.

The Quality Priorities were identified through the CQC Must & Should Do recommendations and themes emerging from Serious Incidents, Complaints and CSR, the Quality Priorities were consulted on in Quality Week, feedback has been received from doctors, nursing staff, therapists and the corporate teams.

A plan on a page has been developed relating to these areas and how these are linked to Vision 2020 and the CQC must and should do's (a draft version can be found at Appendix). A highlight report is being developed, where KPIs are not currently reported in the Integrated Performance Report, these are in the process of being included.

Progress against Quality Priorities and Metrics

Priority	Care of Deteriorating Patients (escalation)	Care of Elderly Patients	Infection Prevention and Control	Medicines Management
Progress	• In March, the Trust moved to the NEWS2 observations model. • Throughout March, the VitalPAC Team rolled out training across the Trust. (Over 300 staff have now been trained).	• The new Dementia Strategy has been developed and is due for Board sign off May 2019 • End of Life, Continence and Enabling Environment Project continue to be rolled out	• New door signage rolled out across Trust to highlight isolation areas • Heightened hand hygiene training and ward presence by the Infection Prevention Control Team	• Ambient temperature monitoring is now in place across the Trust and will be audited as part of our weekly top-up service and as part of the Safe, Secure Handling of medicines audits. • Pharmacy are involved in the checklist projects which is currently taking place across the Trust.
Metrics	% Fractured Neck of Femur operated on within 36 Hrs of admission Proportion of stroke patients who have 90% of their hospital stay on dedicated stroke ward Identification and Treatment of Sepsis within 1 hr of diagnosis	Dementia Screening (FAIR – Find, Assess, Investigate, Refer) Adult patients to be risk assessed the whole Trust using an appropriate tool. % patients identified as at risk of falling to have a care plan in place across the Trust	Hand Hygine Training Compliance Zero tolerance of MRSA MRSA Screening (of eligible patients) Minimise rates of Clostridium difficile Monitor rates E-Coli	Medication Related Incidents Medicines in Date Fridge Temperature Compliance

3. TRUST PROGRESS AGAINST MUST & SHOULD DOs

A review in relation to the accountability framework is underway in order to realign responsibility between the operational, nursing and medical management. The framework, will enable clear lines of accountability for the 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 as part of the assurance panel process to review their evidence and confirm RAG status of the must and should do's.

Assurance Panels for the North West Regional Spinal Unit and Urgent and Emergency Care took place in March 2019, and a panel for Surgery has taken place in early April 2019, the result of which have recommended mandatory training compliance and compliance with duty of candour policy move to Blue (embedded and sustained), whilst cleanliness of equipment, checking of resuscitation trolley, compliance with national audits and sufficient staffing numbers of staff to assist with patients dietary needs. Further assurance panels are planned throughout May 2019.

In March and April 2019 with the increased focus on these areas there has been greater progression through the BRAG ratings and it is anticipated that further movement will be seen. The areas currently still identified as Red (No progress / Not progressing to Plan) have been placed on the risk register by the relevant CBU.

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	7	1	8
Action Completed	41	35	76
On track to deliver	8	10	18
No progress / Not progressing to Plan	6	6	12
TOTAL	62	52	114

Our expected forward trajectory is – Trust wide

Rating	Current position 12.04.19	Forecast May 2019	Forecast June 2019
Delivered and Sustained	8	12	22
Action Completed	74	88	85

On track to deliver	18	8	4
No progress / Not progressing to Plan	12	6	3

4. CQC PREPARATION

The Trust received notification from the CQC on Wednesday 10th April of the Provider Information Request (RPIR). As set out in CQC's guidance for NHS trusts, within six months of the date of the letter the CQC will carry out an inspection of well-led at the trust-wide level, along with an inspection of at least one core service. The CQC will use the information in our response to decide on their inspection approach, and they will use this to determine key lines of enquiry (KLOE) for the forthcoming inspections.

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.

The Quality team has been enhanced and now has support from an interim regulatory consultant, an interim programme manager and interim support officer. This will ensure the team can provide greater support to both the corporate teams and clinical teams.

A communications strategy has also been developed to ensure that key messages and information in relation about what to expect from a quality inspection are shared with the staff from across the organisation. The communications strategy includes booklets and dedicated intranet page to share relevant information during the preparation phase.

The Quality Improvement Delivery Group (QID) has recently been re-established and has already met to understand the progress of the must and should dos in addition to identifying the risks and areas where a shared approach is needed to ensure progress against actions

5. CQC ENGAEMENT MEETING MARCH 2019

Our last CQC engagement visit was Tuesday 19th March 2019, Corporate Staff based at the Ormskirk Site were invited to focus groups in the morning. Positive feedback was provided regarding improved communications from senior leadership and Executives, improved communications regarding Vision 2020, however staff at the Ormskirk site still fell 'not as engaged' compared to Southport site and there is a perceived lack of 'Board' visibility at the Ormskirk site. This has been fed back to Executives and the Communications Team and the Board 'walk arounds' have been relaunched. The CQC were particularly pleased to hear from the Research Team and their achievements through the year.

The next engagement visit is scheduled for Friday 10th May 2019 when they will meet focus groups from Urgent Care and Medicine (including older people), there will also be an opportunity for both core services to feedback on their progress since the last inspections.

6. RECOMENDATIONS

The Board is asked to **receive** the progress identified in this report in relation to the Quality Improvement and progress made in relation to the must and should dos and the continuation of the Assurance Panels to monitor progress and assurance processes in place.

VISION 2020

CQC to Good 2020/'Leader in Elderly Care'

S C O P E

TRUST VALUES -

NHS Southport and Ormskirk Hospital NHS Trust

CARE OF DETERIORATING PATIENTS (ESCALATION)	*CARE OF ELDERLY PATIENTS*	INFECTION PREVENTION AND CONTROL	MEDICINES MANAGEMENT
NEWS2/ Vital pac implantation & roll out including: - Frequency of observations -Changes to Observation policy and monitoring Implementation and usage of ward checklists Monthly Lessons learnt newsletters	- roll out red2green systems and ensure consistency - dementia training plan implemented - implement dementia & Delirium screening tools - recruitment of Admiral Nurse - implement falls prevention strategy and continence strategy	Review of polices including: - hand hygiene - Personal Protective Equipment - Aseptic Non-touch Technique - Outbreak policy - Training programme	-implement checklists - recruit to ward based pharmacy technician pilot - develop task and finish re TTOs (To Take Out) linked to ED -develop and implement criteria led discharge -increase attendance at meds management course

Clinical Business Unit *Mortality +Morbidity* *LEARNING FROM DEATHS* *Mortality Overview Group*

Strategic Judgement Review

Reducing Avoidable Mortality *TUMOR GROUP* *MEDICATION IMPROVEMENT GROUP* *Quality Improvement Plan*

DEMENTIA CARE *STEIS* *PROJECT HIGHLIGHT REPORT* *Quality + Safety GROUP WORKSHOP*

VISION

PRIORITIES

DRIVERS

ASSURANCE

Appendix 1

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB092/19c**	**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 Committee 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 March 2019.

- **Alert** – There has been a decrease in the number of 'red flag events' that have been recorded in March 2019, no patient harm have been caused due to insufficient staffing levels.
- **Advise** – Against the previous gap analysis of the NHS Improvement 2018 paper 'Developing workforce safeguards' non -compliant actions have been updated and are incorporated within the Safe Staffing Improvement plan.
  The Trust welcomes its first Nursing Associates to the workforce in March 2019
- **Assure** – For the month of March 2019 the Trust reports safe staffing against the national average (90%) at 92.8%.
  There has been a positive decrease in approx. 5 wte to the number of Nursing & Midwifery vacancies across the Trust for both registered and non -registered posts.
  Trust vacancy rate for nurses and midwives is 9% which is the lowest reported against comparative data reporting back to April 2017.

Recommendation:

The Board is asked to **receive** the report, noting due to the timing of workforce data availability within the trust, the data presented is unlikely to change however verbal updates will be given against the paper to the Board.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2019/20)*

	Strategic Objective	Principal Risk
☐	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
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☐	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial*

	resources the sustainability of services will be in question.
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
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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)*

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

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB092/19e1**	**Report Title**	**Guardian of Safe Working Report to Board for Period: 1 November 2018 - 31 January 2019**
Executive Lead	Dr Terry Hankin, Medical Director		
Lead Officer	Dr Sharryn Gardner, Guardian of Safe Working (GoSW)		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The report outlines:

- Dr Gardner was substantively appointed as the Guardian of Safe Working in March 2019
- A new Director of Medical Education was appointed in March 2019
- An inspection by Health Education North West (HENW) took place in March 2019
- No GoSW fines have been levied in the last two quarters
- All Trust rotas are 2016 compliant

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 2019/20)*

	Strategic Objective	Principal Risk
☐	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
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☐	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
✓	**SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
☐	**SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐	**SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to*

Southport, Formby and West Lancashire	*declining clinical standards.*

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)*

Ongoing monitoring and management of the process

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB092/19d**	**Report Title**	**Bi-annual Nurse Staffing Review**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery &Therapies		
Lead Officer	Fiona Barnes, Deputy Director of Nursing		
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 National Health Service Improvement guidance.

Advise:

- This report provides an overview of the Nurse Staffing Establishment Review that has been undertaken using Safe Nursing Care Tool audit and professional judgement.
- The report provides recommendations in regards to safe staffing establishments across the wards & departments that participated in the review and an estimated financial budget to support the recommendations.
- The report acknowledges that the investment will be implemented through-out the year due to the recruitment timeline and the size of the investment.
- To provide the ward/departments with minimum safe staffing there is a requirement for additional :
  RN – 54.53 w.t.e.
  HCA – 59.28 w.t.e.
  Ward Clerks – 3.27 w.t.e.

Assure:

- This report summarises the professional rationale for the recommendations and the recommendation to undertake an annual establishment review in line with national guidance.
- The Trust Board is advised the current nurse staffing risk reports as extreme (RR16) via the risk register (ID1862). Following the aforementioned activities this risk will be further reviewed.

Alert:

- The report provides the rationale as to why there may be further changes to the final number of w.t.e. and the implementation plan. The report identifies the need to undertake a further QIA with an external Chief Nurse to support the proposed establishment.

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 2019/20)*

Strategic Objective	Principal Risk
☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
✓ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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

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

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

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

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

In line with 'Developing workforce safeguards' (NHS I 2018) the Director of Nursing & Medical Director are required to confirm that they are satisfied with the outcome of this establishment review.

This report will form part of the Trust annual governance statement in regards to staffing governance processes.

This report will form part of the future Clinical Workforce Plan that will be presented at Trust Board.

The Board is asked to support the implementation of the Nurse Staffing Review.

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

1.0 Introduction

The purpose of this report is to provide a summary of the Nurse Staffing Establishment Review that has been undertaken in line with National Quality Board, National Institute of Health & Care Excellence and National Health Service Improvement guidance.

2.0 Background

In 2013 The National Quality Board[1] (NQB) issued guidance relating to the optimisation of staffing capacity and capability for Registered Nurses and Nursing Assistants. The Care Quality Commission and NHS England subsequently produced additional guidance on the delivery of publishing staffing data as part of a 'Hard Truths Commitments' paper[2] (March 2014).

In addition, the Department of Health and NHS England commissioned the National Institute of Health and Care Excellence (NICE) to develop evidence based guidelines on safe staffing, with a particular focus on nurse staffing[3]. The guidance was published in July 2014 and made recommendations for safe staffing for nursing in adult inpatient wards in acute hospitals. The guideline identifies the organisational and managerial factors that are required to support safe staffing for nursing.

It was clear from these papers that Trust Boards are expected to take full responsibility for the quality of care provided to patients and, as a key determinant of quality; take full responsibility for nurse/midwife staffing capacity and capability.

In July 2016 the NQB[4] published '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'; that led on from the Carter report[5] promoting an improvement in workforce efficiency that was beneficial for patient care. The NQB (2016) report[4] focuses on 'right care, doing the right thing, first time; minimising avoidable harm, a relentless focus on quality; and maximising the value of available resources, providing high quality care to everyone who uses the healthcare'.

In light of national guidance Trust Boards should be:

- Managing nurse staffing capacity and capability by agreeing staffing establishments
- Considering the impact of wider initiatives (such as cost improvement plans) on staffing
- Monitoring staffing (nurse) capacity and capability through regular and frequent reports on the actual staff on duty on a shift by shift basis versus planned staffing levels
- Examining trends in the context of key quality and outcome measures
- Ask about the recruitment, training, skills and experience, and management of nurses, and giving authority to the Director of Nursing to oversee and report on this at Trust Board level

A gap analysis of the Trust current position against the NQB 2016 guidance has been completed and reported to Workforce Committee and Trust Board. Currently the Trust is partially compliant.

In October 2018 the NHS Improvement published 'Developing workforce safeguards – supporting providers to deliver high quality care through safe and effective staffing'. An initial gap analysis against the 14 recommendations for nursing and midwifery was undertaken in December 2018 and shared with Trust Board. A full gap analysis has been undertaken in March 2019 and presented at Workforce Committee and Trust Board. The Trust remains non-compliant due to the previously identified partial compliance with NQB guidance of 2016.

This nurse staffing establishment review reflects the principles of NQB 2016 and NHS I 2018 recommendations.

3.0 Historical Nurse Staffing Establishment Reviews

Southport and Ormskirk Hospital NHS Trust have historically undertaken bi-annual patient acuity and dependency studies, however, the previous establishment reviews were undertaken in October 2015 and October 2017. Therefore, a comprehensive staffing review has been

completed in accordance with NQB guidance[4], including a systematic review of all inpatient ward areas using formalised methodology and professional judgement.

This establishment review is the first annual review for the Trust that forms part of the long-term clinical workforce plan for nursing. Therefore, the recommendations from the review do not meet all the national recommendations however, through this process the senior nursing team are in agreement that by using professional judgment the allocation of additional staff has been prioritised appropriately. Each annual establishment review will enable the Trust to move towards the national recommendations.

This Nurse Establishment Review does not cover: Theatres, Outpatients, Midwifery and adult Accident & Emergency as these areas have recently or will be undertaking a separate review of establishments based on changing services.

4.0 Nurse Staffing Establishment Review Process:

Evidence-based tool – for this review the Safer Nursing Care Tool (SNCT) has been used, endorsed by NICE to facilitate a systematic approach to determining nurse staff requirements based on the acuity & dependency of patients. Over a period a month a daily point prevalence audit was completed on each ward of all the patients that considered the patient acuity & dependency and need or additional clinical support (i.e. enhanced levels of care). This data is then summarised and using a validated tool provides a recommended number / skill mix of staff within the ward/department. See appendix 1.

Professional judgment – a Professional Judgement Template has been shared with all Ward/department Managers to provide a structured view by the ward team of the clinical staffing requirements of their patients based on case mix and work load. The outcome of the professional judgement review has been incorporated into the triangulation of data with the SNCT & current ward/unit budgeted establishment. See appendix 1.

A 'Confirm & Challenge' meeting was then undertaken with each Ward Manager, Matron Assistant Director of Workforce and Deputy Director of Nursing to provide professional scrutiny before the final recommendations have been reviewed by Heads of Nursing/Midwifery and agreed by Director of Nursing. A standard Operating Procedure has been developed to support the overall Nurse & Midwifery Establishment Review process which will be ratified in April 2019.

Compare staffing with peers - a comparison of the wards establishments has been undertaken as recommended by the national guidance. However, the comparison is limited due to the national data being out of date, in some areas by over a year. Reviewing the data that was available it can be seen that apart from Paediatric Services, all other wards are below our 'peer' group & national average. See section 7 and appendix 2.

Mandatory training, development and education - compliance against the Trust mandatory training is 86%. However, through a number of clinical incidents it has been identified that our non registered workforce (HCA) and junior staff nurses (B5) require re-training in a number of clinical & non clinical practices. Therefore as part of the Nursing Establishment review this will be considered as part of the 'uplift', see section 5.

Multi-professional team working – As part of the Trust Vision 2020 our future workforce will, in some areas, become more multi-professional. Through this Review there has been an opportunity to not only consider new ways of working but new roles, such as nursing associates (NA), assistant practitioners (AP), advanced nurse practitioners, (ANP) and non nursing roles such as assistant therapists (physio & occupational therapists) AT. As there are not many NA, AP & AT that are currently trained across the region this has been identified as a key area of focus as part of our nursing establishment review and future clinical workforce strategy.

Recruitment & Retention – This has been a key area of focus for the Trust over the years. In the last 9 months the Trust has been supported by NHS Improvement focusing on retention of staff. Through this work there has been some key steps made and now the Trust is working on an improvement plan that is both retention & recruitment focused. Since September 2018 there has been a 2% reduction in vacancies. It is recognised that the Trust has significant vacancies for registered staff that the HR recruitment Team will continue to support and proactively manage internal & external recruitment events with a marketing campaign.

Productive working and eliminating waste – Through the national guidance there is recognition that the implementation of the Productive Ward Series (NHS Improvement) could support all clinical areas to be more effective and efficient. However, the Trust does not have an identified lead with the relevant knowledge and skills to undertake this structured support. This is currently an action as part of the Trust overarching nurse staffing improvement plan.

Efficient deployment and flexibility – The implementation of the E-Roster system within the Trust occurred four years ago. At the time there was training for the ward staff but there has been a reduction of skills and competence in managing the E-roster system at ward level as staff have left. As part of the Trust efficiency programme an external company has supported the Ward Managers to understand & review their E-roster efficiencies and challenge the current practice. This work is on-going and will support all the Ward Managers to understand and produce effective rosters. As part of this work there is an E-roster 'dash board' that is monitored by the Associate Director of Work force and managed by the Heads of Nursing/Midwifery.

Efficient employment and minimising agency - On a daily basis the Trust has a 'Safe Staffing Huddle' with Matrons, NHSp, E-roster co-ordinator and is chaired by Assistant Director of Nursing (workforce) or Head of Nursing/Midwifery. Through these meetings the staffing levels across the Trust are monitored and risk assessed for requiring further staff (through NHSp or if critical to patient safety, through an agency). This is monitored on a daily basis and only authorised through Head of Nursing/Midwifery, Associate Director Workforce or Deputy Director of Nursing.

As part of the improvement plan for workforce governance within nursing & midwifery a Standard Operating Procedure (SOP) has been developed to reflect the 'Nurse/Midwifery Staffing Escalation Process' this provides a flowchart by which ward based staff can highlight and raise concerns regarding staffing levels within their clinical area both in & out of hours. This S.O.P. will be ratified in May 2019.

5.0 Allowance for planned and unplanned leave

Key to establishing safe staffing levels is a comprehensive understanding of all ward establishments and allowances for planned and unplanned leave. The current position with regard to establishment uplift is as follows:

- There is an overall 22.5% uplift. This is added to the budget of every ward/department covering the base establishment and including cover for annual, sick and study leave
- Of this, 16 % is allocated for Annual Leave, 3.5% is allocated for sickness and is allocated 3% for study leave.

Currently our sickness for RN is 6-8 % and for our HCA is 8-10%. This in itself creates a challenge for the services and highlights the need for focused work by Senior Nursing/Midwifery supported by H.R. staff to support individuals in their wellbeing to promote a 'healthy & happy' workforce.

Historically the allocated study leave has not been used for study leave due to the high sickness. However, it has been identified that additional training is required for our HCA in regards to key clinical tasks and later in the year there will be a focus on B5 clinical skills which will need to be supported through the current budgeted establishment.

6.0 Skill Mix / Ratio

As part of the Establishment Review the skill mix and ratio of the workforce has been considered. The skill mix refers to the number of registered nurses within the establishment compared to the unregistered workforce. Royal College of Nursing guidance (2012) suggests a ratio of 65:35. This means that 65% of the establishment is registered nurses and 35% of the establishment is unregistered staff.

Through the Establishment Review and recommended increase in number of staff there would be a number of wards that remain below 65:35. It is acknowledged that the skill mix is, on some wards, well below the 65:35 (appendix 3). Through comprehensive discussions with the senior nursing team, triangulation of the data and professional judgement it is recognised that although the skill mix is not currently at the recommended level there is a greater need to increase the number of staff who can provide fundamental nursing care (non registered staff) under the supervision of the registered staff and Ward Manager.

It is important to acknowledge that as part of the changing workforce profile (see section 11) the future 'band 4' roles are recorded as 'un-registered' until the indiviudal achieves their competencies. Therefore, the skill mix for the next 2 years reflects these workforce changes.

It must be emphasised that this nursing establishment review is the first step of the nursing & midwifery workforce plan and needs to be considered as part of the long term plan for our ward establishments to meet national requirements. In regards to the governance process for the establishment review a detailed Quality Impact Assessment (QIA) will be undertaken by an external Chief Nurse to support the transparency of the review. This may require future changes to the proposed recommendations.

More recent national guidance considers a ratio of 1 nurse to 8 patients to be a *minimum* which has been incorporated as part of the triangulation of data, see appendix 4. This triangulation shows the different between our current position and that following the proposed investment, which demonstrates a positive improvement in 1:8 ratio. Since 2018 many organisations use Care Hours per Patient Day as criteria for establishment reviews (see below).

7.0 Care Hours per Patient Day & Model Hospital data

Care Hours per Patient Day (CHpPD) Guidance for Acute and Acute Specialist Trusts[6] (NHS Improvement, June, 2018) : This publication by NHS Improvement clarified that from September 2018 the Trust monthly CHPPD data will be published at a trust and ward level on 'My NHS & NHS Choices'. The Trust continues to comply with the requirements to upload and publish the aggregated monthly average nursing and care assistant staffing data for inpatient areas. Average shift fill rates identify the actual staffing levels in place against what was planned and the Trust has remained above 90% since July 2018.

The CHpPD data, that is available through Model Hospital, has been used as part of the triangulation of information when considering recommendations of establishments for the wards/departments, see appendix 2. However, due to the national Model Hospital data being 'out of date' the same methodology to calculate the CHpPD has been applied to our data from our current and proposed establishment budgets to demonstrate the changes from the planned investment see appendix 4.

8.0 Red flagged incidents & Clinical Metrics:

In line with NQB report[4] the nurse staffing red flags are currently reported via the Trust incident reporting Datix system. This has only recently been implemented across the Trust (January 2019) and is reported through the monthly Nursing & Midwifery Workforce Safe Staffing report. As part of this establishment review it has not been possible to use the 'red flag events' data to provide detailed themes or clinical areas of concern. However, other clinical metrics are reviewed and the senior nursing team are currently developing a Quality Care Indicators

dashboard that brings both quantitative and qualitative metrics together. In the meantime there is a clinical metrics dashboard that covers staffing, Incidents, Harms, Complaints, FFT, sickness and Vitalpac data that is shared with the Workforce Committee & Trust Board on a monthly basis, in line with NHS I guidance. Enclosed is the current clinical dashboard for March 2019, see appendix 5.

9.0 Ward Manager – Supervisory time

Since 2012 there has been a recommendation from the RCN that Ward Managers are supervisory within the ward establishment.
Within the Trust there is considerable variation in regards to supervisory time and the role undertaken when supervisory. Fundamentally the Ward Manager should have dedicated time to:

- Provide professional leadership for the Ward
- Provide clinical expertise as part of the team
- Educate, train and support staff & students
- Provide management for the Ward /staff

Currently much of the time allocated by the Ward Manager to be 'office based' is taken by needing to work clinically as part of the 'numbers' to support the patient acuity & dependency due to vacancies, sickness and acuity/dependency of patients.

Following discussion with the Ward Managers and Director of Nursing it has been agreed that the Ward Manager will be supervisory full time. Therefore this has been incorporated as part of the proposed budgeted establishment. It is acknowledged that due to the current recruitment timeline the Ward Managers will only be 'supervisory' when the ward establishments can support this step change.

10.0 Ward Clerk:

The role of the ward clerk is critical to ensure that the 'administration' of the ward is proactively managed. Some of the wards do not have full time ward clerks, therefore there has been a review of the current w.t.e. and a summary of the additional ward clerk hours to ensure full time or improve efficiency of the role have been included as part of this review. (See section 13).

13.0 New roles:

As part of the Establishment Review consideration has been given to the opportunity of new roles, such as Nursing Assocaites. This is inline with the NHS Long Term Plan and workforce projections for the future. Acknowledging the changing profile of the clincial workforce the Trust is supporting the development of new roles.

In line with national guidance any new role will require a full Quality Impact Assessment (QIA). On behalf of the Trust the Director of Nursing & Medical Director currently undertake the QIA process and will review all schemes that could effect our workforce. Therefore, moving forward there will be a QIA for all new roles, including any that are implemented from the Establishment Review.

14.0 Nursing & Midwifery Workforce Governance

As part of the N&M workforce governance a draft summary of the Nurse Establishemnt Review was shared with the Executive Team to provide an overview of the project in February 2019. A summary of the Review has also been shared with the Workforce Committee and Finance, Performance & Investment (F,P & I Comm.) Committee in March 2019.

As part of the initial business case to support the Review a summary report has been shared with Business Development Investment Sub-Committee and Hospital Management Board & F, P & I Comm. Following these meetings the financial summary has been prepared and a comprehesive

business case has been developed as part of the Trust business cycle process. The Nurse Establishment Review has had a full QIA and a further QIA wil be undertaken for those wards that have a reduced skill mix ration with an external Chief Nurse.

The indicative expenditure for the increase in staff is between £1 – 2 million and will be finalised and ratified by Trust Board in May 2019. The agreed investment will be invested over the year based on clinical priorities. It must be noted that there may be changes to the estalbishemnt following the external QIA review.

13.0 Nurse Staffing Establishment Findings:

To ensure that each ward /service has the appropriate staffing (registered and un-registered) workforce the current nurse establishment, the SNCT establishment & professional judgement tool establishment was collated. A proposed 'off-duty' based on professional judgement, supported by the SNCT data was produced to support the Confirm & Challenge meeting with the Ward Managers and Matrons. See appendix 1.

Based on the business case the increased w.t.e. requirements are:

Role	**W.T.E.**
Registered Nurse	54.53
HCA	59.28
Ward Clerk	3.27

there may be further changes to these numbers due to a number of reasons that are described through the report

A summary of the changes is presented below.

Planned Care:

Across the Planned Care services there are some wards that require very little additional establishment / financial changes or do not require the full establishment that was allocated. There are other wards that do require further investment or have reduced their establishment

- Spinal Unit – original professional judgement suggested a significant uplift of staff however, this was considerable different to the SNCT. Therefore, further professional review with the Matron has supported additional staffing but not to the original request.
- F Ward – to increase from 8hr shifts to 12 hr shifts to allow for an increase in Day Case capacity without requiring 'overnight' stay.
- Ward 14A – there are clinical concerns regarding the care provided on the ward and therefore it is recommended that an increase in establishment is supported.
- G & H Ward – to increase 5.5 day opening to its current 7/7 day opening

Paediatric Services:

Within the Paediatric Services the budgets have historically been allocated across a number of clinical services although from an operational perspective the Matron utilises the staffing based on clinical demand and national guidelines. Therefore, the financial data provided has been re-aligned as part of the implementation plan for the NER. Across the Paediatric services the main change has been to align the establishment for the Paed. Ward and identified budget for Assessment unit and A&E that reflects national guidance.

Urgent Care:

Across the ten wards & Medical Day Case Unit there are increased requirements in all the services to support the acuity & dependency of our patient case mix.

- Rehabilitation Ward - Open to 26 beds but only budgeted establishment for 16 beds

- Medical Day Case – An increase in the number of patients the unit treats & the complexity of those treatments
- Observation ward – Based on national 'assessment unit' ratio
- Short Stay Unit –Change in skill mix within the establishment
- Ward 14B, Respiratory – to support the increase in acuity / specialist respiratory patients based on national guidance for respiratory patient.
- Ward 15A – to support Frail & Elderly patient pathway. This includes the complex older persons care that requires an increase in HCA workforce that will be trained to care for patients with Dementia.
- ACU & CDU – Neither area have a funded establishment and therefore have been a 'cost pressure' over the years.

14.0 Summary:

Through an in-depth nurse establishment reivew, that reflects the national NQB 2016 guidance, there is a significant investment in staff required to address the shortage of staff within many ward establishments that will:

- provide the fundamental clinical needs of patients
- reflect Safer Nursing Care Tool data
- reflect Professional Judgement review
- address the supervisory time for Ward Managers
- reflect the changing national workforce profile
- reflect the opportunties to consider new roles
- reflect professional view, and review, of the senior nursing team in regards to proposed establishment
- re-establishment of ward budgets that have not previously been addressed through services changes
- commence the strategic planning of the clinical workforce needs of the Trust
- support the annual establishment review
- support investment through out the year

	Funded WTE (based on March 2019)	NER Investment w.t.e.	Increase in w.t.e. / percentage	Overall Vacancies w.t.e.
Registered nursing staff	864.12	54.53	6.3 %	138.11
Non-registered staff	381.63	59.28	15%	73.33
Total	1,245.75	113.81	9.1%	211.44

It must be acknowleged that the proposed increase in establishment demonstrates an increase in CHPpD and ratio of 1:8 however, the skill mix for a number of wards is less than national recommendations which may require further changes to the final estalbishment.

15.0 Implementation Plan

Following the final decision at Trust Board for the investment there will be an extensive programme to implement the Review findings. This will require a detailed plan that schedules the recruitment and investment against the key performance indicators (KPI). The implementation will be 'fluid' due to the nature of recruitment however the KPI will be based on run rate expenditure, improved roster efficiency and reduction in sickness, all of which are interlinked. There will also be quality indicators that will be monitored on a monthly basis.

Fundamental to the success of the implementation plan will be the recruitment, training and introduction of new staff to the Trust. The Associate Director of Nursing Workforce has been working closely with Human Resources Team to ensure that the Recruitment Team are prepared for the proposed increase in marketing campaigns, recruitment events and staff recruitment. As

part of the recruitment campaign there will also be recruiting Healthcare Assistants to support the enhanced care needs of the patients. This will be monitored through the Nursing & Midwifery Recruitment & Retention Group.

16.0 Conclusion:

In line with 'Developing workforce safeguards' (NHS I 2018) the Director of Nursing & Medical Director are required to confirm that they are satisfied with the outcome of this establishment review.

This report will form part of the Trust annual governance statement in regards to staffing governance processes.

This report will form part of the future Clinical Workforce Plan that will be presented at Trust Board.

The Trust Board is asked to review the enclosed report, ratify the methodology and findings of the Review and support the implementation of the proposed increase in staffing.

References:

1. The National Quality Board (2013) - How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time http://www.england.nhs.uk/.pdf
2. Hard Truths Commitments Regarding the Publishing of Staffing Data (2014) http://www.england.nhs.uk.pdf
3. National Institute for Health and Care Excellence (NICE 2014) - Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals http://www.nice.org.uk/guidance/sg1
4. National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – July 2016
5. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (Carter report) – 2016
6. NHS Improvement - Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts, June, 2018
7. NHS Improvement - Developing workforce safeguards – Supporting providers to deliver high quality care through safe and effective staffing, 2018
8. Royal College of Nursing – Mandatory Nurse Staffing Levels, 2012

Appendix 1

Establishment Review Summary

This table demonstrates the current establishment, the proposed establishment and the Safer Nursing Care Tool by ward/department that have been part of the Establishment Review.

Ward Staffing Summary

CBU	Ward	Bed	Current Budgeted WTE			Professional Judgement WTE			SNCT WTE		
		Numbers	Reg WTE	Unreg WTE	Total WTE	Reg WTE	Unreg WTE	Total WTE	Reg	Unreg	Total
Planned Care	11A Surgical Ward	18	14.36	10.50	24.86	14.72	10.97	25.69	16.00	8.70	24.70
	F Ward Surgical day case	12	6.65	3.15	9.80	8.08	4.74	12.82			0.00
	Short Stay Surgical 10B	16	15.90	13.89	29.79	15.94	13.72	29.66	17.10	7.30	24.40
	Spinal Injuries Unit	43	50.05	38.75	88.80	52.37	37.72	90.09	65.30	15.70	81.00
	ITU	15	62.89	14.59	77.48	62.56	10.97	73.53			0.00
	Ward 14A	30	19.55	17.29	36.84	22.95	24.89	47.84	28.10	15.10	43.20
	Ward G plus H	30	21.00	10.18	31.18	25.03	13.72	38.75			0.00
	Total Planned	164	190.40	108.35	298.75	201.65	116.73	318.38			
Specialist	Paeds	21	44.02	17.29	61.31	31.82	14.89	46.71			0.00
	Neonates	10	18.97	2.80	21.77	17.86	2.74	20.60			0.00
	Paeds A&E	0	0.00	0.00	0.00	19.15	5.49	24.64			0.00
	Total	31	62.99	20.09	83.08	68.83	23.12	91.95			
Urgent Care	A&E Obs ward	7	10.84	5.80	19.23	11.97	5.49	17.46	12.40	5.40	17.80
	Emergency Assessment U	18	24.57	14.50	39.07	27.67	18.57	46.24	25.70	11.00	36.70
	CDU	8	3.70	0.00	3.70	10.97	5.49	16.46			0.00
	FESS Ward	28	21.37	12.90	34.27	20.89	17.15	38.04	25.20	13.50	38.70
	Medical Day Unit	34	9.01	2.60	11.61	8.77	4.65	13.42			0.00
	Rehabilitation Ward ODG	27	13.10	10.40	23.50	20.20	19.20	39.40	25.80	13.90	39.70
	Short Stay Unit (b)	29	16.68	14.50	31.18	20.89	20.21	41.10	25.70	13.80	39.50
	Stroke Ward	20	19.38	13.60	32.98	18.93	16.46	35.39	21.50	11.50	33.00
	Ward 11B	27	17.08	17.70	34.78	20.20	18.17	38.37	24.20	13.10	37.30
	Ward 14B	30	21.51	16.62	38.13	24.66	19.20	43.86	31.20	16.80	48.00
	Ward 15A - General Medi	24	15.58	13.40	28.98	21.58	20.92	42.50	23.70	12.80	36.50
	Ward 7A	28	16.67	14.80	31.47	20.20	19.18	39.38	25.60	13.80	39.40
	Total	272	189.49	136.82	328.90	226.93	184.69	411.62			0.00
	Totals	**467**	**442.88**	**265.26**	**710.73**	**497.41**	**324.54**	**821.95**			

Appendix 2

Model Hospital data

The following tables demonstrate the information that is available on the Model Hospital webiste. Under 'Money & Resources' it can be noted that the Model Hospital records the Trusts CHpPd as an overall figure of 8.3. However this can be viewed at ward level which is shown on the next page.

This table show the Trust data taken from the national Model Hospital data base for each of the Trust wards compared to our 'peers' and 'national' benchmarking however some of the information is out of date.

Caring:

Caring	Data period	Trust value	Peer median	National median	Chart	Actions
Recommend to friends & family (Staff)	Q2 2018/19	70.8%	N/A	N/A		
Recommend to friends & family (Patients) - Inpatient	Nov 2018	97.7%	N/A	N/A		
Recommend to friends & family (Patients) - Outpatient	Nov 2018	93.9%	N/A	N/A		
Recommend to friends & family (Patients) - Maternity Antenatal Care	Nov 2018	100.0%	N/A	N/A		
Recommend to friends & family (Patients) - Maternity Birth Setting	Oct 2018	80.0%	N/A	N/A		
Recommend to friends & family (Patients) - Maternity Postnatal Ward	Nov 2018	100.0%	N/A	N/A		
Recommend to friends & family (Patients) - Community	Nov 2018	97.0%	N/A	N/A		

Money & Resources:

Money & Resources	Data period	Trust value	Peer median	National median	Chart	Actions
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£845	£754	£710		
Total Nursing & Midwifery FTE	2017/18	1,066.9	1,219.1	2,096.6		
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Nov 2018	8.3	7.7	8.0		
Cost per Care Hour - Total Nursing & Midwifery Staff	Oct 2018	£29.48	£26.28	£25.85		
Cost per Patient Day - Total Nursing & Midwifery Staff	Oct 2018	£243.48	£205.86	£207.25		
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£39,149	£35,357	£35,334		

People, Management and Culture – Well Led

People, Management & Culture: Well-led	Data period	Trust value	Peer median	National median	Chart	Actions
Sickness Absence Rate - Nursing & Health Visitors	Sep 2018	6.2%	4.4%	4.2%		
Sickness Absence Rate - Midwifery	Sep 2018	3.6%	4.6%	4.5%		
Sickness Absence Rate - Healthcare Support Workers	Sep 2018	9.1%	5.6%	6.2%		
Staff Retention Rate - Nursing & Health Visitors	Oct 2018	87.9%	87.4%	87.8%		
Staff Retention Rate - Midwifery	Oct 2018	92.6%	88.5%	89.1%		
Staff Retention Rate - Healthcare Support Workers	Oct 2018	90.6%	82.0%	83.3%		
Staff Survey (Nurses - Adult/General) - Recommend as place to work or receive treatment	2016	3.3	3.7	3.8		
Staff Survey (Nurses - Children) - Recommend as place to work or receive treatment	2016	3.7	3.8	3.8		
Staff Survey (Nurses - Midwives) - Recommend as place to work or receive treatment	2016	3.6	3.7	3.7		
Staff Survey (Nursing Assistants) - Recommend as place to work or receive treatment	2016	3.7	3.8	3.9		
Recommend as a place to work (All Staff)	Q2 2018/19	64.8%	64.4%	N/A		

Safe:

Safe	Data period	Trust value	Peer median	National median	Chart	Actions
Proportion of Patients with Harm Free Care	Dec 2018	90.3%	93.0%	94.3%		

Care Hours per Patient Day from the national Model Hospital data

Ward	S & O	Model Hospital Peer	Model Hospital National	Date	Comments
11A Surgical Ward	6.71	6.37	6.81	Jan. '18	
F Ward Surgical day case					No data available
Short Stay Surgical 10B	4.72	6.37	6.81	Jan. '18	
Spinal Injuries Unit					No data available
Surgical Assessment Unit					No data available
ITU					No data available
Ward 14A	5.67	6.66	7.19	Oct. '18	
Ward G					No data available
Paeds	16.93	10.75	10.75	Nov. '18	Includes A&E
Paeds clinics					No data available
Neonates	16.11	11.54	11.72	Oct. '18	
A&E Obs ward					No data available
Emergency Assessment Unit	7.2	7.47	7.48	Oct. '18	
FESS Ward	5.08	6.63	7.28	Dec. '16	
Medical Day Unit					No data available
Rehabilitation Ward	6.30	6.21	6.68	Nov. '18	
Short Stay Unit	5.35	7.47	7.48	Oct. '18	
Stroke Ward	5.92	6.61	6.89	Jan. '18	
Ward 11B	5.03	6.61	6.89	Jan. '18	
Ward 14B	5.21	7.47	7.48	Oct. '18	
Ward 15A - General Med	5.71	6.61	6.89	Jan. '18	
Ward 7A	5.46	7.21	7.32	Nov. '18	

Appendix 3

Skill Mix

These tables demonstrate the skill mix (ratio of registered to unregistered staff) by ward for the current and proposed establishment.

With the proposed increase in registered and unregistered staff to our establishment the skill mix on a number of wards has reduced. Due to this a QIA will be undertaken by an external Chief Nurse to review the process undertaken.

Sum of Current funded establishment	% Reg	% Non reg
11A Surgical Ward	57.8%	42.2%
A&E ward	66.3%	33.7%
CDU	100.0%	0.0%
Emergency Assessment Unit	62.9%	37.1%
F WARD SURGICAL DAYCASE ODGH	67.9%	32.1%
FESS Ward	62.4%	37.6%
ITU CCU	81.2%	18.8%
Medical Day Unit	77.6%	22.4%
Neonatal Ward	87.1%	12.9%
Paediatric A&E	0.0%	0.0%
Paediatric Unit	71.8%	28.2%
Rehabilitation Ward ODGH	55.7%	44.3%
Short Stay Surgical 10B	53.4%	46.6%
Short Stay Unit	53.5%	46.5%
Spinal Injuries Unit	56.4%	43.6%
Stroke Ward	51.3%	48.7%
Ward 11B	49.1%	50.9%
Ward 14A	53.1%	46.9%
Ward 14B	56.4%	43.6%
Ward 15A - General Medicine	53.8%	46.2%
Ward 7A	53.0%	47.0%
Ward G	67.4%	32.6%

Sum of Proposed funded establishment	% Reg	% Non reg
11A Surgical Ward	57.3%	42.7%
A&E ward	68.6%	31.4%
CDU	66.7%	33.3%
Emergency Assessment Unit	59.8%	40.2%
F WARD SURGICAL DAYCASE ODGH	63.1%	36.9%
FESS Ward	54.9%	45.1%
ITU CCU	85.1%	14.9%
Medical Day Unit	65.3%	34.7%
Neonatal Ward	86.7%	13.3%
Paediatric A&E	77.7%	22.3%
Paediatric Unit	68.1%	31.9%
Rehabilitation Ward ODGH	51.3%	48.7%
Short Stay Surgical 10B	53.8%	46.2%
Short Stay Unit	50.8%	49.2%
Spinal Injuries Unit	58.1%	41.9%
Stroke Ward	53.5%	46.5%
Ward 11B	52.6%	47.4%
Ward 14A	48.0%	52.0%
Ward 14B	56.2%	43.8%
Ward 15A - General Medicine	50.8%	49.2%
Ward 7A	51.3%	48.7%
Ward G	64.6%	35.4%

Appendix 4

Nurse:Pateint ratio and Care Hours per Pateint Day (CHpPD)

This table demonstrates the current and proposed CHpPD and nurse:patient ratio by ward/departments based on 'our' data from the review process. It can be seen that with the proposed changes that the 1:8 ratio has increased and many of the CHpPD have also improved.

CBU	Ward	Pt.No.	National Pt. ratio	Current CHPpD	Current Pt ratio			Proposed CHPpD	Proposed Pt ratio			Comments on proposed establishment
					E	L	N		E	L	N	
PC	11A Surgical Ward	18	1:8	6.8	G	G	A	6.0	G	G	A	Ward Manager agreed with professional judgement with night ratio
	F ward Surgical Day Case	12		3.8	G	G		6.3	G	G		
	10B Short Stay Surgery	16	1:8	7.2	G	G	G	8.0	G	G	G	
	Spinal Injuries Unit	43	1:2 / 1:8	8.6	A	A	A	8.9	G	G	A	Ward Manager agreed with professional judgement with night ratio
	ITU/HDU/CCU	15	1:1 / 1:2	16.0	G	G	G	17.6	G	G	G	
	Ward 14A	30	1:8	5.3	G	A	A	6.7	G	G	A	Ward Manager agreed with professional judgement with night ratio
	Ward H	16	1:8	6.0	G	G	G	4.5	G	G	G	
	Ward G	14	1:8	6.5	G	G	G	6.9	G	G	G	
Spec	Paediatric Ward	21	1:2 / 1:4	9.3	A	A	A	9.0	A	A	A	Ward Manager agreed with professional judgement with ratio based on flexibility with Paediatric A&E and Assessment Unit
	Paediatric A&E		1:2 / 1:4		R	R	R		G	G	G	Paed. A&E and Assessment Unit will flexibly cover boths areas depending on clinical need
	Paediatric Assessment	6	1:6	0.0	R	R	R	6.0	G	G	G	
	Neonates	10	1:3	9.6	G	G	G	8.4	G	G	G	
UC	A&E Obs. Ward	9	1:4	8.0	A	A	A	8.0	A	A	A	Ward Manager agreed with professional judgement with ratio based on flexibility with Assessment Unit & CDU
	Emergaency Assess. Unit	18	1:4	8.0	G	G	G	8.4	G	G	G	
	CDU	14	1:4	5.1	A	A	A	5.1	A	A	A	Ward Manager agreed with professional judgement with ratio based on flexibility with Assessment Unit & Obs. Ward
	9A - FESS	28	1:8	5.4	G	G	A	6.0	G	G	A	Ward Manager agreed with professional judgement with night ratio
	Medical Day Unit	16		4.5				5.3				
	7B - Rehabilitation Ward	26	1:8	4.7	G	A	R	6.5	G	G	A	Ward Manager agreed with professional judgement with night ratio
	10A Short Stay Medicine	29	1:8	5.0	G	G	A	5.8	G	G	A	Ward Manager agreed with professional judgement with night ratio
	15B Stroke Ward	20	1:8	6.8	G	G	G	7.2	G	G	A	Ward Manager agreed with professional judgement with night ratio
	Ward 11B General Medicine	27	1:8	5.6	G	A	A	6.1	G	G	A	Ward Manager agreed with professional judgement with night ratio
	Ward 14B Respiratory Ward	30	1:6/1:8	5.5	A	A	R	6.4	G	G	G	
	Ward 15A Acute Elderly Care	24	1:8	5.3	G	G	R	7.3	G	G	G	
	Ward 7A Cardiology	28	1:8	4.8	G	A	R	6.3	G	G	A	Ward Manager agreed with professional judgement with night ratio

E	Early shift
L	Late shift
N	Night shift - there is no national guidance in regards to ratio
G	Green - compliant with 1:8 ratio (minimum)
A	Amber - partially compliant with ratio
R	Red - non compliant with 1:8 ratio

Appendix 5

Clinical Dashboard

This dashbaord demonstrates the Trust clinical metrics that is currently being developed.

Mar-19	Staffing													Incidents		Harms					Complaints			FFT	Sickness		VitalPac	Training	
	Realtime Staffing - Overall	Realtime Staffing - Registered (Day)	Realtime Staffing - Non Registered (Day)	Realtime Staffing - Registered (Night)	Realtime Staffing - Non Registered (Night)	CHPPD - Registered	CHPPD - Non Registered	% Temp Staffing of Nursing in post - Registered	% Temp Staffing of Nursing in post - Non Registered	Vacancies - Registered	% Vacancies - Registered	Vacancies - Non-Registered	% Vacancies - Non-Registered	Staffing related Incidents	Medication - Missed Doses	Post Fall # Neck of Femurs	Falls	Pressure Ulcers	Bed Occupancy	VTE Risk Assessments *	Total (from Levels)	Relating to clinical treatment	Relating to attitude	FFT - % recommended	Sickness - Registered *	Sickness - Non Registered *	% of Obs that were late	Mandatory Training - Registered	Mandatory Training - Non-Registered
Trust	**92.80%**	**85.67%**	**93.69%**	**95.36%**	**105.81%**	**4.8**	**3.4**	**20.03%**	**35.21%**					**33**	**24**	**0**	**73**	**9**	**83.06%**	**96.54%**	**18**	**11**	**4**	**95.48%**	**4.54%**	**8.38%**	**19.51%**	**87.89%**	**87.83%**
Urgent Care	**95.16%**	**85.50%**	**97.49%**	**97.20%**	**109.22%**	**6.7**	**3.7**	**40.56%**	**46.20%**					**9**	**11**	0	**56**	**7**	**96.60%**	**96.31%**	**7**	**6**	**1**	**93.08%**	**4.62%**	**9.71%**	**18.76%**	**85.75%**	**84.76%**
7A	76.92%	78.32%	63.31%	90.05%	97.83%	2.6	2.7	76.36%	73.39%					1	1	0	3	1	95.97%	88.24%	1	1	0	90.00%	9.38%	34.54%	33.59%	80.67%	70.24%
9B - FESS	92.19%	66.90%	108.38%	95.94%	110.85%	2.5	2.7	38.08%	68.20%					1	4	0	6	1	97.12%	88.89%	0	0	0	75.00%	0.26%	6.54%	13.27%	96.77%	97.50%
11B	93.27%	83.79%	110.00%	68.79%	121.02%	2.4	2.7	19.62%	44.84%					0	1	0	3	0	96.42%	88.00%	1	0	0	100.00%	1.31%	15.69%	17.75%	82.72%	75.64%
14B	100.62%	99.39%	103.77%	98.91%	100.00%	2.9	2.3	20.70%	8.71%					0	0	0	6	0	99.68%	84.62%	1	0	0	90.91%	2.55%	5.90%	17.61%	80.00%	89.04%
15A	122.38%	101.79%	157.56%	97.55%	149.36%	3	3.3	45.76%	0.00%					0	1	0	11	1	99.46%	92.11%	0	0	0	92.31%	0.00%	0.66%	24.44%	85.81%	93.59%
15B - Stroke Unit	101.68%	95.68%	114.26%	97.80%	98.30%	3.9	3.4	28.34%	25.55%					0	0	0	8	0	96.29%	84.00%	0	0	0	53.85%	6.17%	7.54%	4.37%	80.62%	86.11%
ACU	74.89%	67.26%	78.90%	152.06%	7.94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	50.00%	100.00%	0	0	0	100.00%	N/A	N/A	7.41%	N/A	N/A
EAU	88.45%	86.52%	83.03%	94.37%	95.36%	4.3	3.4	48.37%	48.93%					0	1	0	8	2	82.84%	91.30%	0	0	0	100.00%	0.55%	2.91%	19.38%	90.74%	84.09%
SSU	87.20%	73.82%	90.44%	95.57%	92.36%	2.5	3	38.74%	29.02%					0	0	0	0	2	95.55%	100.00%	0	0	0	91.67%	2.94%	9.68%	19.21%	80.92%	70.00%
A&E	95.17%	88.98%	84.68%	105.72%	110.83%	N/A	N/A	49.32%	39.58%					0	0	0	1	0	N/A	N/A	1	1	0	95.45%	12.25%	6.54%	N/A	82.19%	83.33%
Obs	98.48%	94.91%	102.02%	101.75%	95.92%	5.6	2.8	77.42%	20.07%					0	1	0	2	0	92.47%	86.42%	0	0	0	89.29%	0.00%	17.61%	11.02%	94.05%	76.39%
7B / Rehab	109.96%	79.75%	125.29%	100.00%	149.71%	2.5	3.7	24.75%	86.41%					5	2	0	5	0	156.85%	84.62%	0	0	0	94.74%	0.27%	4.87%	17.99%	98.06%	98.61%
Women & Childrens	**95.77%**	**92.98%**	**92.21%**	**96.75%**	**111.56%**	**5.4**	**4**	**6.23%**	**12.19%**					**9**	**2**	**0**	**0**	**0**	**47.45%**	**94.92%**	**4**	**3**	**1**	**94.56%**	**4.37%**	**11.98%**	**N/A**	**91.71%**	**92.32%**
G Ward- Gynaecology	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A
Maternity	98.34%	94.07%	90.46%	99.17%	122.96%	14.98	6.2	5.09%	22.15%					2	0	0	0	0	47.16%	94.92%	1	1	0	98.41%	3.65%	9.14%	N/A	91.93%	91.67%
NNU	97.30%	98.36%	100.57%	95.61%	N/A	10.6	0.7	9.15%	N/A					0	0	0	0	0	65.16%	N/A	0	0	0	N/A	7.11%	53.75%	N/A	93.50%	97.37%
Paediatric Unit	92.29%	90.24%	93.54%	94.09%	95.35%	13.7	4.7	12.95%	8.61%					6	2	0	0	0	71.77%	N/A	0	0	0	97.73%	3.79%	9.04%	N/A	92.13%	92.98%
PAB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	29.03%	N/A	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A
Radiology	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A	1	1	0	N/A	36.55%	N/A	N/A	91.67%	N/A
Planned Care	**88.33%**	**81.65%**	**88.74%**	**92.26%**	**98.67%**	**5.5**	**3.7**	**13.33%**	**29.01%**					**11**	**4**	**0**	**17**	**2**	**78.19%**	**97.01%**	**6**	**2**	**2**	**97.94%**	**4.68%**	**5.75%**	**20.92%**	**86.86%**	**89.01%**
10B - SSS / SAU	86.10%	70.41%	71.74%	101.72%	197.26%	4.1	4.1	25.92%	41.42%					0	0	0	2	0	95.36%	96.50%	0	0	0	97.78%	5.10%	0.84%	36.23%	84.72%	90.97%
11A - General Surgery	85.19%	83.69%	92.04%	96.80%	66.04%	3.5	2.9	21.04%	38.17%					0	0	0	0	0	87.44%	93.02%	1	0	1	100.00%	0.50%	5.77%	15.91%	92.95%	83.33%
14A	131.25%	95.67%	127.37%	148.01%	190.32%	2.7	4.1	58.40%	93.50%					3	2	0	4	0	98.71%	79.55%	1	0	1	72.73%	0.45%	5.50%	20.72%	83.77%	79.17%
Critical Care	84.52%	85.67%	88.29%	84.67%	74.89%	20.3	5.0	25.06%	10.36%					0	0	0	0	0	81.08%	77.41%	0	0	0	N/A	6.64%	3.36%	12.90%	90.47%	90.63%
G Ward - Urology	58.41%	46.64%	62.79%	72.01%	60.70%	4.5	3.1	11.29%	46.57%					1	1	0	1	0	52.10%	98.90%	0	0	0	100.00%	6.92%	7.84%	15.63%	88.89%	89.81%
H Ward - Orthopaedics	68.83%	87.67%	52.76%	76.25%	48.04%	11.4	5.3	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	31.38%	100.00%	0	0	0	80.00%	N/A	N/A	5.69%	N/A	N/A
Spinal Unit	91.66%	89.27%	91.70%	96.12%	88.93%	5.4	4.1	9.15%	20.66%					0	1	0	9	2	87.02%	25.00%	1	0	0	100.00%	0.43%	9.56%	32.99%	88.70%	90.44%
Theatre	N/A	N/A	N/A	N/A	N/A	N/A	N/A	34.94%	N/A					2	0	0	0	0	N/A	N/A	1	0	0	N/A	12.29%	N/A	N/A	70.10%	N/A
Treatment Centre	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A					1	0	0	0	0	N/A	100.00%	1	1	0	100.00%	9.05%	0.00%	N/A	87.80%	83.33%
Red	<90%	<90%	<90%	<90%	<90%	N/A	N/A	15%>	15%>	5>		5>		1>	1>	1>	1>	1>	93%>	<94%	N/A	1>	1>	<80%	7%>	7%>	15%>	<80%	<80%
Amber	90-95%	90-95%	90-95%	90-95%	90-95%	N/A	N/A	10-15%	10-15%	1 -4'		1 -4		1	1	1	1	1	85-93%	94%-95%	N/A	1	1	80-94%	4-7%	4-7%	10-15%	80-89%	80-89%
Green	95%>	95%>	95%>	95%>	95%>	N/A	N/A	<10%	<10%	0		0		0	0	0	0	0	<85%	95%>	N/A	0	0	94%>	<4%	<4%	<10%	90%>	90%>

NB. All Trust & CBU totals relate to all wards and departments within these groups. The numbers in brackets relate to the total of the areas shown in this report.

* Figures subject to change

THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT

1 November 2018 – 31January 2019

Introduction

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

1. EXCEPTION REPORT OVERVIEW (1 November 2018 – 31 January 2019)

	1/11/2018 -31/01/19	**1/11/17 – 31/01/18**
Exception Reports ERs	3	95
Completed ERs	3	103
Trainees	2	15
Episodes	3	103
Review Interview Held	3/3	72/103
A&E	0	0
Medicine	0	88
Surgery	1	3+1 dup
T & O	2	2
Anaesthetics	0	0
Ophthalmology	0	0
Paediatrics	0	2
Obs & Gynae	0	0
GP	0	0

See Appendix A for Exception Report Breakdown

It has been possible for Time Off In Lieu (TOIL) rather than payment to be given for more Exception Reports (a situation supported as ideal by the BMA representative attending Trainee Doctor Forum). Pressures during winter meant that TOIL often wasn't feasible in a reasonable timeframe.

There is room for improvement in completion rate and efficiency in Review Meetings and reminders are being sent.

An Exception Report SOP has been ratified by the Workforce Committee on 24th October 2018.

ACTION: Look at ways to increase completion of Exception Report meetings / outcomes (GoSW)

2. MEDICINE

5 new Clinical Fellow posts were approved. 4 are in post and the 5th is completing pre-employment checks.
During winter locum shifts were approved at short notice to support the service (often filled internally) and this was felt to have a significant positive impact. Medicine at all levels is felt to be better placed than 12 months ago and this is reflected in the reduction in ERs.

3. PAYMENT AND FINES

There have been no GoSW fines levied in either of the last two quarters.

4. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

All Trust Rotas are 2016 compliant.

There were no Work schedule reviews during this period (potentially one is being initiated currently).

5. DOCTORS NOT ON THE NEW CONTRACT

Medical Staffing identified the 20 doctors not on 2016 contract in the last quarter. No concerns about safe working from non-trainee doctors have been escalated to the GoSW.

Medical HR will identify any trainee not on 2016 contract quarterly and GoSW will continue to monitor these trainees.

6. DOUBLE/TRIPLE BLEEP CARRYING

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

There have been no further reported episodes of Double Bleep carrying.

7. VACANCIES (as of 1st April 2019) See Appendix B

SOHT are actively recruiting and therefore vacancy rates are changing frequently, so I cannot guarantee complete accuracy. Doctors are also leaving often out of sync with normal staff changeover dates.
Medical staffing and HR has been relocated within the Trust and this is expected to be a positive change.

8. MIAA REPORT

The Mersey Internal Audit Agency Report on Junior Doctors Contracts was positively rated as Significant Assurance. A SOP for the Exception Reports dealing with safety issues, processing overtime payments resulting from exception reports and training has been written.

This has been ratified by Workforce Committee on 24th October 2018. Terms of Reference for the Trainee Doctors' Forum have been written and sent to the Medical Education Committee. These have been reviewed 6 months ahead of planned routine review as the process for payments and been improved and streamlined.

These updates have been provided for the latest MIAA report and thus far, no feedback has been received.

9. TRAINEE CONCERNS

The Trainee Doctor Forum continues to meet monthly. Trainee attendance is variable, but trainees continue to email their concerns to the GOSW and representatives raise concerns forwarded to them. From February 2019 a change of day and time has been instigated as a new GoSW has been appointed with a different job plan. There is a dedicated IPad for trainee use in the Education department at Ormskirk so that trainees from both sites can link into Trainee Doctors Forum.

Datix Reports involving trainees should be sent to GOSW. None were available at the last bi-monthly review at the Trainee Doctor's Forum.

ACTION: Check that Datix reports involving Trainees are being forwarded to the GoSW (Lynn Jones)

9.1 Medicine

Once the additional Clinical Fellows are in post, the effect on trainee workload and training can be assessed and this is planned within the department already. Some concerns that some doctors appointed at this level have no previous NHS experience and have required support from F1s.

Weekend day shifts are felt to be overly onerous. Launching FRIDAYS checklist (BMJ Quality initiative) to help prepare for weekends. Support from Director of Nursing and Deputy Medical Director.

ACTION*:* EMD meeting F1 doctors weekly
ACTION: HR now relocated to Southport and Ormskirk and Induction Programme being developed by Education Department
ACTION: Launch FRIDAYS checklist

9.2 Surgery

The Surgery rota has 3 unfilled posts in an 8 person rota (posts removed after HENW decided that they should stop on calls as they were losing training time in daytime roles outside surgery such as Psychiatry).

The EMD has given assurance this will not result in Double Bleep carrying. Instead the Registrars and Consultants will act down.

This has however led to instances of shortages in daytime cover and on call teams covering multiple wards. This issue was raised at the April TDF and the Medical Director is currently meeting F1 doctors weekly about a number of operational issues including escalation.

ACTION: GOSW and EMD will continue to monitor Surgery closely.
ACTION: EMD imitating meetings with F1 doctors

9.3 Facilities

Significant upgrades / improvements have been made to the doctors' mess at Southport (and some at Ormskirk). Following a period of relative disruption while improvements were delivered there is a real sense of this making a real difference to junior Doctors as a group.

10. ADDITIONAL GOSW CONCERNS

There have been a few incidents of limited junior staffing on isolated days across Surgery and Urology. One of these was raised as an immediate safety Concern. This had not been raised at the time to senior clinical staff and the junior doctor had not felt unsafe or that patients were at risk.

This was discussed with the individual, and then discussed at the Trainee Doctor's forum. The EMD has subsequently started meeting F1s weekly around a number of issues including escalation.

11. GOSW ROLE

A new GoSW was appointed as an interim 1st February 19 and as a substantive in March 2019 (Dr Sharryn Gardner Paediatric Emergency Consultant). They have been contacted by the GMC Local Liaison Officer and the Freedom to Speak up Guardian for introductions. They have also chaired 2 Trainee Doctors Forums to date.

A new Director of Medical Education was appointed in March 2019 and the Trust has since has an inspection by HENW (Health Education North West)

ACTION: GoSW / EMD / DME to look at setting up joint meetings as team have changed

Dr Sharryn Gardner
Guardian of Safe Working
15th April 2019

Appendix A

EXCEPTION REPORT OVERVIEW (1November 2018 – 31 January 2019)

Exception Reports

3 by 3 trainees
0 Medicine
2 Trauma & Orthopaedics
3/3 Completed on system
3 Episodes

Exception Episodes

Medicine 0 Episodes
0 Extra Hours Episodes
0 Service Support
0 Training Episodes

Extra Hours 0/0 Episodes Completed
0/0 Episode interviews have taken place
0/0 Episode Interviews within 14 days*
0/0 awaiting trainee sign off
0.00 Extra hours worked
0.00 hours TOIL agreed
0.00 hours Overtime pay agreed
0 Episodes overdue
0 days overdue

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

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

**not yet overdue

Trauma & Orthopaedics 2 Episodes
2 Extra Hours Episodes
0 Service Support
0 Training

Service Support 2/2 Episodes Completed
0/2 Episode interviews have taken place
0/2 Episode Interviews within 14 days
2/2 awaiting trainee sign off

2 Episodes overdue

Appendix B

VACANCIES AS OF 1st NOVEMBER 2018

AED

Consultant	0.2 vacancies in 11 posts (1 SAS acting up)
SAS	1 vacancy in 10 posts
>ST3	0 vacancies in 2 posts
FY2 – ST2	0 vacancies in 9 posts (1 sick, 1 parental leave)
Clinical fellow	1 vacancy in 4 posts
FY1	0 vacancies in 2 posts

Anaesthetics

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

Dermatology

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

GP Practice

FY2 – ST2	1 vacancy in 9 posts

Medicine

Consultant	5 vacancies in 20 posts (4 locums in post) 0 vacancies in 11 person rota (2 SAS acting up)
SAS	1 vacancy in 7 posts (1 locum in post)
ST3 and above	2.4 vacancy in 10 posts (1 on Parental leave) (1 locum in post)
FY2 – ST2	2.6 vacancies in 16 posts (1 on Parental leave) (2 locums)
FY1	0 vacancies in 16 posts

Obstetrics and Gynaecology

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

FY2 – ST2	0 vacancies in 8 posts

Ophthalmology

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

Orthopaedics

Consultant	1 vacancies in 9 posts (1 SAS doctor acting up)
SAS	2 vacancy in 7 posts (2 locum in post)
ST3	0 vacancy in 2 posts (2 locums in post)
FY2 – ST2	3 vacancies in 8 (3 locums in post)
FY1	0 vacancies in 3 posts

Paediatrics A&E

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

Paediatrics

Consultant	2 vacancy in 7 posts (1 appointed)
SAS	0 vacancies in 4 posts
ST3	0.4 vacancies in 4 posts
FY2 – ST2	0 vacancies in 8 posts
FY1	0 vacancies in 1 post

Psychiatry

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

Spinal Injuries

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

General Surgery

Consultant	0 vacancies in 7 posts
SAS	1 vacancies in 6 posts

ST3	2 vacancies in 5 posts	(2 Locum in short post)
FY2 – ST2	3 vacancies in 8 posts	(2 Locum in short post)
FY1*	0 vacancies in 5 posts	

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

Urology

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

NHS
Southport and Ormskirk Hospital
NHS Trust

GOSW Feb 19 Trust Board Report Action Log

Matters Arising Action Log

Apr-19

Status	
Red	Significantly delayed
Amber	Slightly delayed and/or
Green	Progressing on
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Owner	Original Deadline	Forecast Completion	Status Outcomes	Status
GOSW Nov Trust Board Report	Nov-17	**Exception Report Completion**	**Changes to ER process to ensure TOIL and payment only occur if trainee signs off report.**	GOSW	Feb-18	ongoing	Completion rate significantly improved. 3 trainees have received Payment via the new system	BLUE
GOSW Nov Trust Board Report	Nov-17	**Double/Triple Bleep Carrying**	GOSW has and will continue to forward all instances of double bleep carrying to EMD.	EMD/GOSW	Nov-18	ongoing	No episodes of Double Bleep carrying reported to GOSW in the last Quarter.	GREEN
GOSW Nov Trust Board Report	Feb-18	**Exception Report Overview**	GOSW has advised TOIL as default from 1st August.	GOSW/EMD	Aug-18	ongoing	Continued monitoring - currently roughly equal split TOIL / Payment and dependent on numbers in each specialty	GREEN
GOSW Nov Trust Board Report	Feb-18	**Southport Doctors' Mess**	Extension of Southport Mess Area agreed and refurbishment	GOSW/HR	Feb-18	Apr-19	Work completed - Trainees impressed with changes	GREEN
GOSW Nov Trust Board Report	Feb-18	**Medicine Workload**	EMD and AMD for medicine to determine safe medical staffing levels for each ward following the principles of safe nurse staffing	EMD/AMD Medicine/GOSW	Aug-18	May-19	5 Additional posts. 4 in post and 5th completing pre-employemnt checks. Doctors recruited from	AMBER
GOSW May Trust Board Report	May-18	**MIAA identified Terms of Reference for TDF**	GOSW to write Terms of Reference for Trainee Doctors Forum by June 2018	GOSW	Jun-18	Jun-18	ToR written and agreed by Medical Education Committee	BLUE
GOSW Sept Trust Board Report	Sep-18	**Ormskirk Mess Improvement**	Purchase of a microwave and enable trainees to lock doors	GOSW	Dec-18	Dec-18	Purchased by EMD	BILUE
GOSW Nov Trust Board Report	Jan-19	**Surgery Acting Down Policy**	RC to discuss with EMD completion of an Acting Down Policy in Surgery that does not include Double Bleep Carrying	EMD	Feb-19	Jun-19	RC discussed with EMD, EMD to ensure appropriate policy in place. Agreed policy in T&O. Not yet formalised in Surgery.	RED
GOSW May Trust Board Report	May-19	**F1 Concerns**	EMD meeting F1 doctors weekly around concerns	EMD	May-19	May-19	Meetings already taken place - escalation will be discussed	GREEN
GOSW May Trust Board Report	May-19	**FRIDAYS Checklist**	Checklist being introduced to reduce F1 weekend routine wo	GOSW	Jul-19	Jul-19	QI details completed - audit registered. Comms being developed	GREEN
GOSW May Trust Board Report	May-19	**Meeting with DME**	Plan to arrange regular meetings with DME	GOSW / DME	Jul-19	Jul-19	Datix reports go to DME & now copied to GOSW	AMBER

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB092/19d**	**Report Title**	**Freedom to Speak Up Annual Report 2018-2019**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Gill Murphy, Deputy Director of Nursing Midwifery & Therapies Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

This report identifies the number of concerns raised to the FTSU Guardian during quarter 4 2018/19. There has been an increase in month and a marked increase throughout the year which is a positive indication of staff speaking up.
This is further supported by the Mersey Internal audit of the Raising concerns policy during December 2018, which rated the compliance as **substantial assurance.**

The report identifies positive progress on the implementation and sustainability of actions following the NGO recommendations from September 2017.

Good progress has been made on compliance to the Freedom to Speak Up self-assessment tool for NHS trusts and foundation trusts completed in July 2018.

The board is asked to receive this report as a form of assurance that raising concerns across the organisation is improving and the appropriate systems and processes are in place for staff to do this safely and confidently that action will be taken.

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 2019/20)*

Strategic Objective	Principal Risk
☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
☐ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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

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

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

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

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

To receive the report and note progress made during 2018-2019.
To support future plans 2019 – 2020

Previously Presented at:

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

Freedom to Speak up Guardian Annual Report 2018-19

Purpose of the Report
To update the board on concerns raised to the Freedom to Speak up Guardian, to confirm actions completed to date against the action plan following the NGO visit in September 2017 and progress made following completion of the NHSI, FTSU self- assessment tool in July 2018.

1 Report on Submission to National Guardians Office

Quarter 4 1st January – 31st March 2019

Date to be submitted to NGO: 8th April 2019

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

Number of concerns raised: 30

1.1 During quarter 4, 30 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG). This is in addition to the 11 issues which were raised through the Speak Straight to Silas initiative.

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

Table 1: Concerns raised during Quarter 4

Month	No raised	Raised Anon*	Issues / Themes / Outcomes & Status	Staff Group Raising Concern
Jan	13	1	Three concerns raised about the breakdown of relationships within the same department with a lot of underlying issues and a lot of concerned staff. This concern is still open with independent support in place. Four concerns have been raised relating to bullying. These have all being closed with appropriate support offered and, where appropriate, ongoing support. One Difficult relationship hindering integration in a department. Closed after resolution. One issue relating to staff wellbeing and patient safety after a plan not to replace a staff member from a small department. After further review staff member to be replaced. Two concerns regarding bullying and people being treated differently. Closed as service is being reviewed with outside support invested in. Bank member of staff with a learning disability not invited for interview. Closed as minimum criteria met	Consultant 2 Admin worker 1 Matron 1 Therapy Assistant 1 Secretary 1 Dietician 1 Domestic 1 Maintenance 1 Stores 1 PA 1 A+E nurse 1 Anonymous 1

			and interview arranged. HR also gave the person coaching. Stress due to pressures of work. Person wanted it recorded and did not want to take it any further. Closed after support. Relationships in a Department – ongoing support. Concern over use of charitable money – ongoing external investigation.	
Feb	11	0	Concern that there is unfairness on ward in relation to staff support. Closed after advice and support given. EMIS not been completed at ward level so correct information not going to GP. Closed after better practice in place. Ongoing issues re support for person with disability within a department – outside support has been offered. Issues surrounding on call, lack of policy available on intranet and concern for people working most of the night and then expected to work the day. Ongoing. Reported that a character slur had been made by a staff member. Closed after conversation. No system for ordering basic essential equipment. Closed – system in place. Support to member of the public following mortality review. Ongoing. Ongoing issues re bullying. Support and plan in place. Concern raised by staff member that they have too many patients and this is a challenge to patient safety. Also concerned that the previous concerns raised have had no response. Closed after response from MD. Cages blocking doors in the sewing room/mortuary corridor which would prevent the corridor being used as a safe fire exit. Closed – signing in place and good practice encouraged. This has been a particular issue due to winter pressures.	Matron 2 Pharmacist 1 Stores 1 Consultant 2 Maintenance 1 Domestic 2 Domestic 1 member of the public 1
Mar	6	0	Staff member feels they are being treated differently with regard to special leave/sick leave. Closed – satisfactory conclusion and plan. The moving of a deceased patient down the main corridor from A+E to the mortuary may have caused distress to other patients or visitors. It was also	Consultant 2 HR 1 Medical Secretaries 1 ANP's 1 Catering 1

			expressed that the porters were wearing blue surgical gloves. Closed – action plan in place to use other corridors and not to use gloves for transportation. Concern raised about staff having to move office and the availability of WC's. Concern raised about medical support at ODGH for patient on sepsis pathway. Closed after conversation with manager. Concerns about the future of a department. Person feels they cannot get any answers. Closed after conversation with manager. Concern raised over the relationship between the Trust and a department within Lancashire Care.	

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

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

1.2 Feedback post raising concern

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

During quarter 4 feedback was received from 25 people. All of the feedback was positive, however, one reported feeling they were told off by their manager and another said that although they were pleased with the personal support the process took too long (HR). It has also been noted that other HR issues take a significant amount of time to come to resolution.

Given your experience, would you speak up again?

All answered yes apart from one who said they would not speak up again as the issue (not speaking up) has had a significant negative impact on their life.

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

No suggestions received

Some examples:

I just want to say a HUGE THANK YOU to you for raising my concerns to the Trust Board.

My manager says I was brave to have escalated the issue and change wouldn't have happened otherwise!
I'm so grateful to you for helping me to escalate the problem as I wouldn't have achieved this positive outcome without your input.

Given my experience I would most definitely speak up again. I had tried, unsuccessfully to resolve the situation prior to speaking to you and you were my last resort. Virtually within hours my problems were attempted to be resolved and there was a quick resolution.

The service offered by you was first class and thank you so much for your assistance.

Table 2 : Straight to Silas inquiries – Jan- March 2019

Month	Number	Themes	Staff group
Jan	2	Long service suggestion (1) Staff compliment (1)	Medical devices (1); Patient (1)
Feb	2	Staffing issue in estates (1) Car lease (1)	Spinal (1); Theatres (1)
March	7	Issue with urine pots and blood forms (1); staffing issues in estates (1); Waste (1); Phonebook issue (1); patient concern – relating to family member (1); Catering working conditions (1); Positive feedback about play team (1)	Outpatients (1); Estates (1); IT (1); Clinical engagement (1); Therapies (1); Catering (1);

Annual Review
During the year 2018/2019, 75 concerns were raised through Freedom to Speak Up.
Of these 12 are still open with plans in place to bring to a conclusion.

Table 3 : Annual Number of Concerns raised since April 2015
(Year runs 1st April – 31st March)

Period	Number
2015 / 2016	3
2016 / 2017	8
2017 / 2018	15
2018 / 2019	75

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

Establishing the role
In April 2018 the Trust appointed a permanent “Freedom to Speak Up” Guardian (FTSU).

Staff appear to have responded positively to the appointment of the FTSU Guardian. Data also indicates that since the appointment an increasing number of concerns (table 3) are being raised. This information suggests that staff may be more comfortable in raising concerns with the FTSU Guardian rather than their line manager. An analysis of this data has not yet identified any trends regarding the nature of concerns being raised at present; however following the case review it is clear that the culture requires immediate attention

The FTSU Guardian service appears to be utilised by all staff groups within the Trust, with no individual or stand-out groups of staff raising specific concerns at this stage.

It is pleasing to report that the majority of concerns were reportedly raised in an open manner, suggesting a changing environment where staff felt more confident to speak up about concerns.

There were however a smaller number of concerns which were raised in an anonymous or confidential manner. This suggests that further on-going support is needed to build a more open culture in relation to raising concerns.

A key focus of the FTSU Guardian, has been to develop a communication strategy, supported by the Trust's Communication Team.

This initiative has included using posters, pay slip inserts and the further development of the Trusts internet site. Information about the role of the FTSU Guardian is now included within the New Starter and Junior Doctor Induction.

In addition, a personalised approach has been taken to introducing the role to staff through regular attendance at team meetings, department walk arounds and senior management meetings.

The Guardian has also attended national meetings and training events and is supported by the Deputy Director of Nursing, and Associate Director of HR in delivering the agreed action plan.

During the last 12 months the recruitment of 10 FTSU champions has taken place, with specific training delivered to support their role.

The board of directors have also received FTSU training in Autumn 18

Another key recommendation from the NGO review was to develop an Equality and Diversity role for the Trust. This post was appointed to in September 18 and the post holder is working closely with the FTSU guardian. .

Mersey Internal Audit completed a review on the Raising concerns policy in December 2018 and rated compliance as significant assurance. This further supports that staff are confident to raise concerns supported by the increase in issues as described in table 3. MIAA cited two recommendations which have been implemented

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

Background

The committee is aware that in September 2017 the National Guardian's Office conducted a review of the "speaking up" processes, policies and culture at the Trust. This review was established due to information received regarding the Trusts process for supporting staff who raise concerns. It was felt that the current systems and processes where not in accordance with best practice.

In particular, the National Guardian's Office had received information which indicated that a bullying and discriminatory culture existed across the trust.

The purpose of the review was to evidence where the "speaking up" process, policies and culture did not meet with best practice and to make recommendations to remedy this. The Trust has fully supported the review and provided all necessary information for its completion

Findings
The review found evidence that the culture, policies and procedures of the Trust did not always support workers to speak up. There was also evidence of a reported bullying culture felt by staff within the Trust.

Many workers who spoke to the National Guardian's Office during the review expressed a belief that the Trust did not take their views or concerns seriously.

The review also found that the Trust did not appropriately support the needs of its black and ethnic minority workers, including a failure to respond to multiple and serious concerns raised by staff.

Response
An action plan was developed to support the 22 recommendations for the Trust.

This plan was approved at Trust board on the 7th February 2018 and has also had approval from NHSI. In addition quarterly updates of progress against the plan and the review recommendations are made to NHSI.

The Trust appointed a "Freedom to Speak Up" guardian to work through the required actions and support staff in raising concerns.

The trust has also identified the Director of Nursing as the Executive lead and appointed a Non –Executive lead, for Freedom to Speak Up.

Table 4 : NGO action plan - Progress to Date

Rating	Number	Comment
Delivered and Sustained	52	(improvement from 37)
Action Completed	15	
On track to deliver	3	(improvement from 8)
No progress / Not progressing to Plan	1	1 – Sharing of cultural review report delayed due to ongoing HR issue

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

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

Progress continues to complete actions identified with movement of nine recommendations to fully met since reporting in January 2019.

Current position is detailed below

Table 5 : self-assessment tool current position

Self-review indicator	Expectation being met	
	Partial	Full

Leaders are knowledgeable about FTSU	1	3
Leaders have a structured approach to FTSU		4
Leaders actively shape the speaking up culture	1	5
Leaders are clear about their role and responsibilities		3
Leaders are confident that wider concerns are identified and managed		2
Leaders receive assurance in varying forms	1	7
Leaders engage with all relevant stakeholders		8
Leaders are focused on learning and continual improvement	2	6
Individual responsibilities CEO and Chair		5
Individual responsibilities Executive lead(s)	1	8
Individual responsibilities Non-executive lead(s)		6
Individual responsibilities HR and OD directors	2	1
Individual responsibilities medical and nursing directors	1	2

Summary

The next step is to continue to ensure that the role and service is fully embedded across the Trust and to communicate any trends and lessons learned out to staff with further development of the website, recruiting of champions and developing lessons learned bulletins.

Recommendations

The board is asked to receive and note the information within this report.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB093/19**	**Report Title**	**Integrated Performance Report**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Anita Davenport, Interim Performance Manager		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

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

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

The report contained the following components:

- Performance Dashboard
- Executive Assurance
- KPI Graphs and Narrative

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

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2019/20)*

Strategic Objective	Principal Risk
☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*

✓ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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

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

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

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

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

To apprise the Board that controls and assurances are in place

Previously Presented at:

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

NHS
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Integrated Performance Report

Trust Board May 2019

NHS
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Board Report - March 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	1	12	1			
Never Events	0	0	2	0			
VTE Prophylaxis Assessments	95%	96.5%		159			
Harm Free (Safety Thermometer)	94.99%	97.6%	97.4%	9			
Falls - Moderate/Severe/Death	1	1	26	1			
Patient Safety Incidents - Low, Near Miss or No Harm		732	7365	732			
Safe Staffing	90%	92.8%	90.9%	N/A			
Fractured Neck of Femur	90%	89.3%	71.7%	25			

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	110.8	110.8	N/A			
WHO Checklist	99.9%	100%	100%	676			
Stroke - 90% Stay on Stroke Ward	80%	47.5%	71.4%	21			
Sepsis - Timely Identification	90%	100%	98.1%	N/A			
Sepsis - Timely Treatment	90%	92%	79.1%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	37	207	37			
Written Complaints	44	18	273	18			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	95.5%		33			

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

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Accident & Emergency - 4 Hour compliance	94.99%	84%	88.6%	1719			
Accident & Emergency - 12+ Hour trolley waits	1	2	59	2			
Ambulance Handovers <=15 Mins	99%	49.4%	45%	797			
Diagnostic waits	1.01%	2.7%	2.7%	90			
14 day GP referral to Outpatients	93%	98.2%	94.6%	14			
31 day treatment	96%	98.6%	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%	71.4%	77.7%	12			
62 day GP referral to treatment	85%	70.9%	78.7%	12.5			
Referral to treatment: on-going	92%	94.5%	94.5%	590			
Bed Occupancy - SDGH	93%	92.3%	94.9%	N/A			
Bed Occupancy - ODGH		46.6%	31.9%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	100%	83.8%	0			
Duty of Candour - Evidence of Letter	100%	100%	71.7%	0			
I&E surplus or deficit/total revenue	-1%	-17.2%	-19%	N/A			
Liquidity	-23	-65	-60	N/A			
Distance from Control Total	0%	0.6%	-7.9%	N/A			
Capital Service Capacity	-2.423	-2.798	-3.559	N/A			
% Agency Staff (cost)	5.6%	9.9%	6.5%	N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	66.3%	-5.6%	N/A			
Staff Turnover	0.76%	0.7%	6.8%	N/A			
Staff Turnover (Rolling)		10.8%		N/A			
Vacancy Rate - Medical		4.2%	4.2%	N/A			
Vacancy Rate - Nursing		8.1%	8.1%	N/A			
Sickness Rate	3.9%	5.1%	5.7%	N/A			
Personal Development Review	85%	75.8%	75.8%	N/A			
Mandatory Training	85%	86.6%	86.6%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.3	8.2	N/A			

Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month		61	55	61			
Length Of Stay		6.6	6.9	N/A			
New:Follow Up	2.64	2.5	2.5	N/A			
DNA (Did Not Attend) rate	8%	6.4%	7.2%	1410			
Cancelled Ops	0.61%	0.7%	0.3%	14			
Theatre Utilisation - SDGH	90%	52.6%	51%	N/A			
Theatre Utilisation - ODGH	90%	62.1%	60.8%	N/A			

Reporting Frequency is monthly except for SHMI which is quarterly.

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KPI Graphs and Update

Board Report - March 2019

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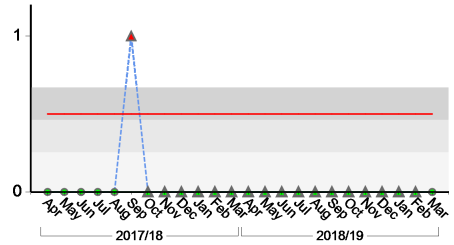
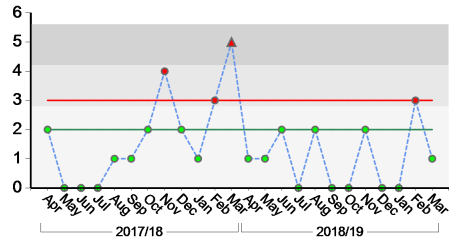
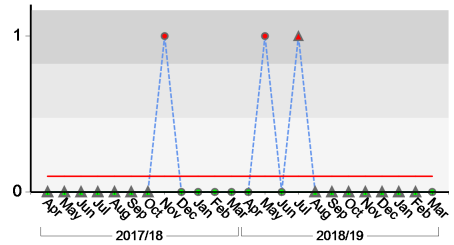
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	The Trust continues to be compliant. There has been zero MRSA Bacteraemia since September 2017 - The Trust is continuing to comply with the zero tolerance for MRSA bacteraemia. New employees who perform cannulation receive training which includes ANTT for that procedure. The Trust is in the process of adopting annual e-learning for ANTT for all staff doing these procedures. We now have stickers in the cannulation packs for whoever is placing the cannula to complete and place in the patient's notes. 2019/20 review of cannulation documentation will be part of the IPC team's ongoing monitoring/audit plan.	
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.	Annual Stretch Target achieved of less than 20 cases per year with total cases 12 for 2018/19 - 1 case of C. diff. in March with a total of 12 for 2018/19, hence below the stretch target of 20 for the year. A new target has been set by NHSI of no more than 16 cases for 2019/20; however the parameters have changed to include community cases who have been in the Trust within the last 4 weeks and the case definition for new admissions who are C. diff. positive will include patients who tested positive 2 days following admission as opposed 3 days which is what it was previously. Education is being provided through mandatory training and also information has gone out with the monthly IPC performance report.	
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 March - All incidents are screened to see if they meet the Never Events Criteria	

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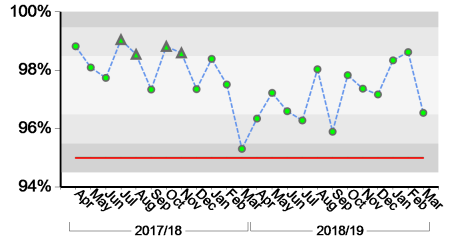
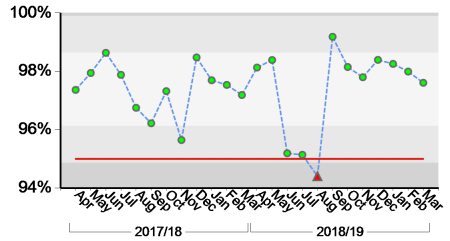
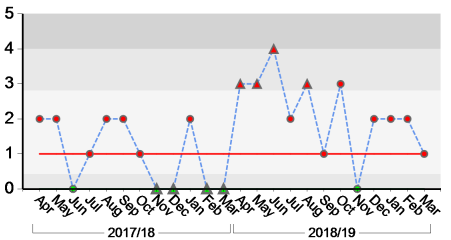
NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	Performance of 96.54% for March continues to be above required compliance level - There has been marginal dip in compliance since last month 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.	
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance of 97.61% in March 19 remains above the 95% threshold - The Trust reported a total of 9 new Harms during the census period comprising of 2 x new category 2 pressure ulcers (7a and Spinal) ,3 x Falls with low harm (14b, 15b & 10b) 1 x catheter associated UTI on Spinal and 3 x new VTE (9b,14a and critical care) All reported harms are reported on Datix and subject to local investigation within the 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	1 fall per 1000 bed days was reported in March - The trust falls multifactorial assessment is to be trialled on ward 9A with the intention (if successful) to roll out to all ward within the trust. this will be delivered along side an educational session to raise the profile of falls awareness and prevention to all nursing staff.	

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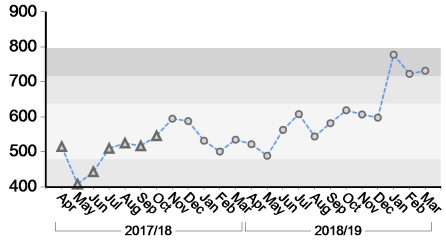
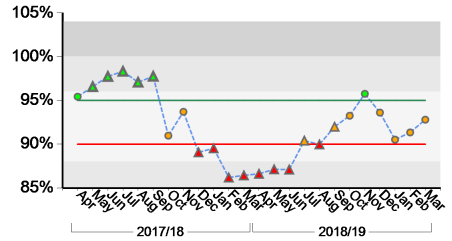
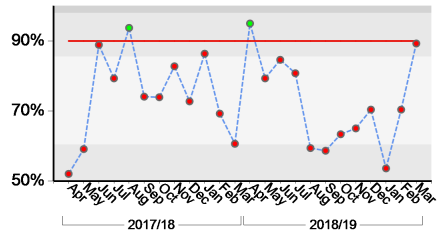
Safe

Indicator Name	Description	Narrative	Month Trend
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.	The reporting figures continue to show a good reporting culture - Reporting figures remain consistent with the previous month with just a very slight increase in incidents relating to admission and discharge. Bed Management and safeguarding continue to be the dominant categories being reported.	
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 has improved from February position - Monthly safe staffing is on a positive upward trajectory.	
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance improved significantly in March and almost achieved target. Consultant of the week now in place - Patients are being reviewed daily by a consultant, so patients are being prepared for surgery more efficiently. Bed pressures are also improving	

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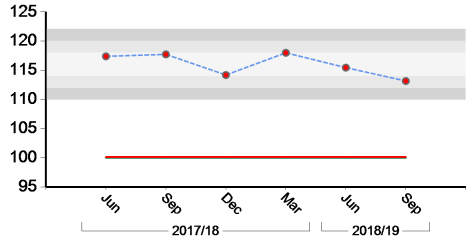
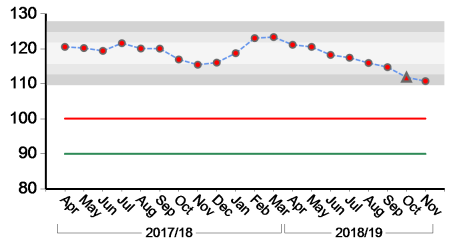
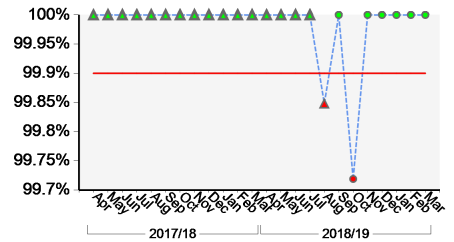
NHS Southport and Ormskirk Hospital NHS Trust

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.	Steady improvement towards target - The HSMR continues to reduce and currently stands at 110.8. The likely drivers are similar to the SHMI, although as HSMR excludes patients receiving specialist palliative care input and palliative care coding has seen an increase in the past few months; it is likely that this is also an important element. As this is a 12 month rolling figure and the monthly HSMRs have been acceptable it is likely that this rolling figure will continue to improve.	
WHO Checklist	WHO Checklist.	Performance remains at 100% compliance for March 2019 - Checklist audits continue	

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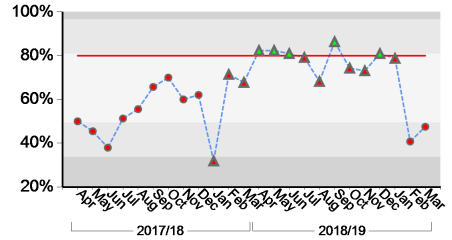
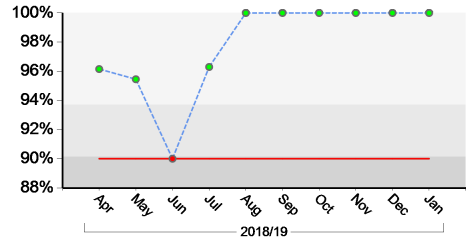
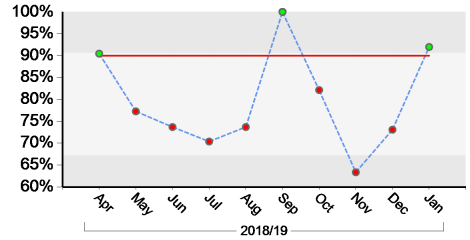
Effective

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.	Performance improved slightly from 40.74% in February to 47.5% but remains below target due to bed pressures - 19 out of 40 patients received their care on the stroke ward for 90% or more of their stay. Unfortunately bed pressures were high throughout March which continued to have a impact on available stroke beds due to no protected bed and the subsequent boarding of additional patients	
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.	Trust achieving 100% target - Information for this measure is collected monthly as part of advancing quality regional benchmarking. Our 100% achievement indicates potential sepsis is being picked up promptly.	
Sepsis - Timely Treatment	Sepsis Timely treatment for sepsis in emergency departments and acute inpatient settings- the rate of rapid administration of antibiotics within one hour of diagnosis of sepsis.	The Trust is compliant - 23 out of 25 patients received antibiotics within one houor of their diagnosis - For those patients who did not receive their antibiotics within the hour, they have had their notes further reviewed by 2 senior consultants	

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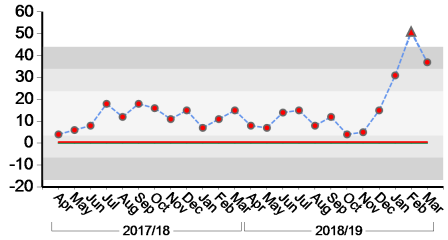
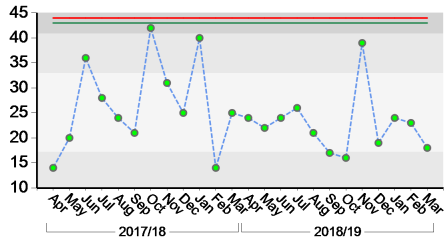
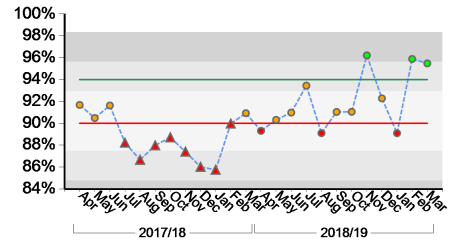
Caring

Indicator Name	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	A reduction was noted in March from 51 breaches in February to 37 in March - all breaches are in relation to critical care step down; all delays datixed by critical care; review of all patients for stepdown from critical care at all bed meetings and plan dependant on overall Trust position; critical care manager now attends 12:30 bed meeting daily	
Written Complaints	The total number of complaints received. A lower number is good.	In March there was a reduction in the number of formal complaints received - 18 complaints received in March which is 5 fewer than the previous month. Issues with clinical care remains the main reason for the complaints received in month, followed by staff attitude/behaviour. There are no themes in terms of the wards/departments to which the complaints relate. Further analysis into the complaints received January - March, including responsiveness, will be undertaken and included in the Integrated Governance report for Q4.	
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.	March saw a minor decrease in performance since last month. - but the trust remains above the compliance level of 95%. However, the number of FFT responses remains low at 6.29%. Planned workshops from Picker are planned for May-19 to support the review and action planning on the results of the 2018 National Inpatient Survey.	

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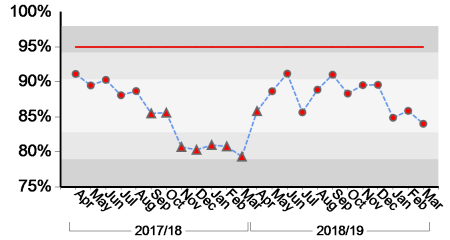
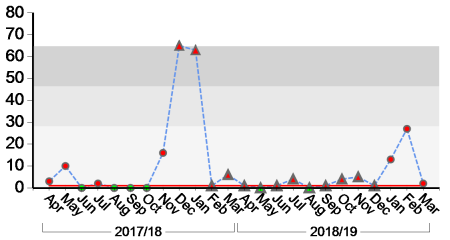
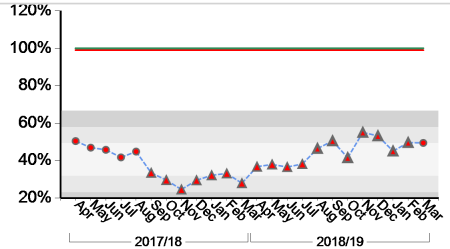
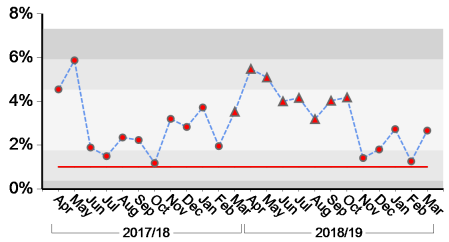
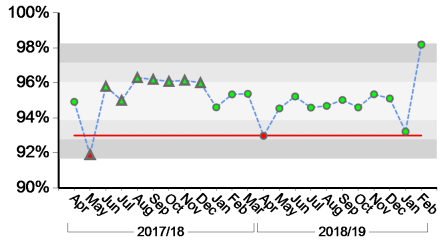
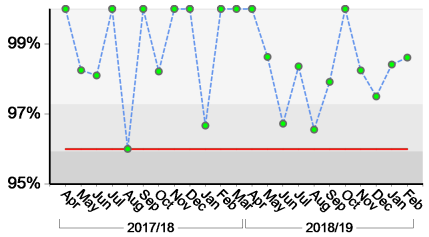
Responsive

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.	Trust 4-hour performance was 84.02%. - This was a just under a 5% improvement compared to March 18. On the Southport site, there was a 13.5% improvement in performance (397 fewer patients waited longer than 4-hours compared to March 2018). This was despite an 11.4% increase in attendances (additional 538 patients who were all majors category. Emergency care flow remains a challenge with significant blockages in timely bed release and unprecedented peaks in times of attendance. Specialty reviews routinely take place down in A&E to consider alternative pathways to admission as there is little capacity in the assessment areas, which contributes to delays in release of ED cubicle capacity. Pressures continue to be experienced for patients requiring admission to mental health beds, with patients routinely in the department in excess of 12 hours (from arrival time) whilst awaiting a bed. CDU and ACU continue to support ED in streaming appropriate patients, and there is further work to do to maximise opportunities to replicate this in SAU. The ED workforce model has little flex and remains vulnerable to deal with peaks in attendances, although the department has successfully recruited 4 new Physicians Associates who commenced at the end of March to support a longer term staffing model, and looks forward to welcoming 2 new substantive consultants in Summer 2019.	
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0.	Disappointingly, there were 2 reportable 12-hour breaches during March - 1 was due to a delay in securing a bed for an orthopaedic bed on a Monday following significant bed pressures from the weekend. The other was a delay awaiting a Merseycare mental health patient. With regards to acute bed pressures, there has been a continued reliance on escalation beds on a daily basis to support the shortfall of discharges compared to admissions. Unfortunately, corridor care was maintained across a number of days towards the end of March as demand for beds exceeded capacity, despite continued heightened specialty reviews to consider alternative pathways to admission, and daily discharge huddles taking place 7 days a week. Red to Green continues across the wards, and a further MADE review was held on 28 and 29 March, with some positive feedback from commissioners regarding visible grip on inpatient pathways and next steps required to support discharges. Regarding the mental health breach, extended delays in ED continue for patients awaiting admission to a mental health bed. Timelines have been completed and submitted for both 12-hour breaches	
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.	- March saw a challenging month against the 4-hour standard with an increase of 11.4% in attendances (538 patients). Although the % of ambulances handed over within 15 minutes for March was 49.4%, this is a huge improvement compared to March 18 performance when just 27.82% were handed over within 15 minutes. There has also been an improvement in ambulances handed over between 15 and 30 minutes - 1200 ambulances were handed over in March 2019 compared to just 700 in March 2018. Collectively, these improvements are enabling NWAS crews to attend to patients in the community faster. ED and NWAS continue to work together to reduce avoidable delays to handover.	

Board Report - March 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower.	Diagnostic performance for the Trust shows a deterioration from Feb'19 with March's figure reported as 2.67% - 90 patients out of 3375 breached. The breaches were in the following areas: Audiology 4 patients (2.2%), capacity, positions filled by May Cardiology - Echo 2pts (0.5%), patient cancellations Colonoscopy 1 patient (1%), patient DNA Computed Tomography 3 patients (4.5%), patient choice Dexa Scan 4pts, 2.2%,1 x patient choice, 1 x unable to contact patient, 2 x next available slot Non Obs Ultrasound 12 pts, 1%, 4 x hospital cancellations, 5 x unable to contact patient, 2 x patient choice, 1 x patient cancellation Urodynamics 41 pts, (41.8%) - 36 Urodynamics (treatment centre) nursing capacity, 2 - Urodynamics (Gyn) cancellation and DNA, 3 x Video Urodynamics (Urol) nursing capacity. Additional clinic and extra slots	
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.	Trust compliant against standard - The trust is compliant against this standard and it is anticipated that the compliance level will improve with the move to the 7 day pathway (improved capacity will mean patients are offered a variety of appointments within the 14 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 maintain it's excellent performance against the 31 day decision to treat to treatment standard. -	

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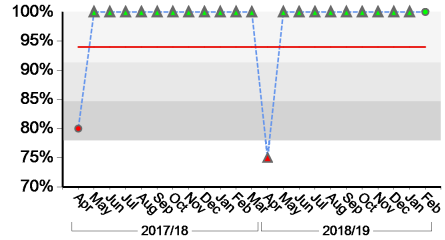
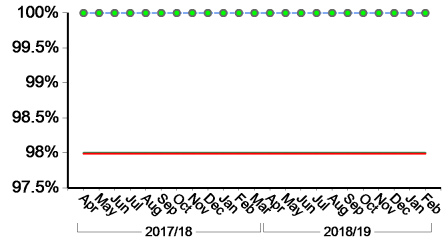
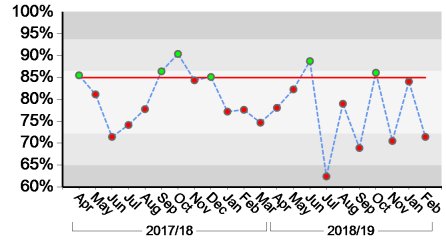
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
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 maintains compliance against standard - All patients treated in the last couple of months as a subsequent treatment, received it within 62 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').	Trust maintains compliance against standard. - The trust continues to achieve the100% target for its patients	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Performance against reallocation varies on a monthly basis. - Compliance post reallocation can very significantly between tumour groups. The improvement plans include looking at referring dates to tertiary centres, which are vital in hitting this target. Alongside that, the cancer team need to firm up their tracking procedures to ensure patients are being looked at, in timely manner.	

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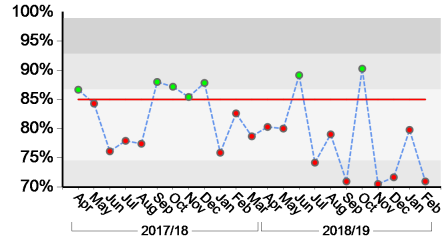
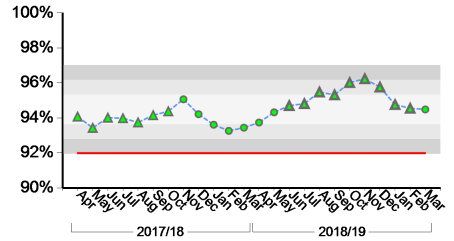
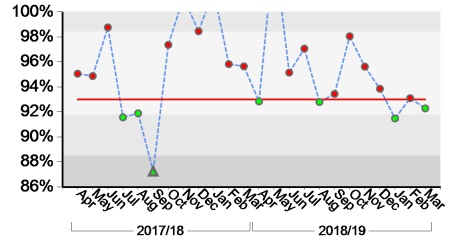
NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
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.	Continued underperformance has led to the creation of an improvement plan - Issues have been identified in nearly all the pathways causing patients to breach their pathways. Each directorate has produced a robust improvement plan to move their service to a 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 March's performance being recorded at 94.48% - however, this does not reflect that some specialities are facing challenges with compliance/performance. The following specialities are failing RTT Oral Surgery 87.3%, Respiratory 91.1% & Vascular 91%.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Occupancy remains high although there is a slight improvement within month - closure of ward 1 during March following phased reduction of use; the Trust has continued to feel the additional pressure of managing closed areas due to infection which has impacted on flow throughout those beds; daily discharge huddles continue with System partners; trusted assessment into both ICB and D2A beds for LCFT is supporting the reduction in superstranded; red2green rolled out throughout Trust; MADE with senior partners to support had positive feedback from CCGs and other system partners	

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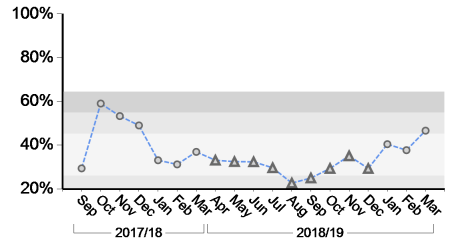
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site. A lower percentage is good. Threshold is 93%.	Performance continues to improve and is now at its highest since Jan 2018 -	

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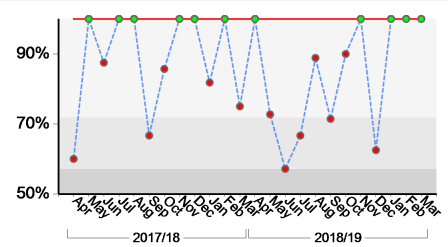
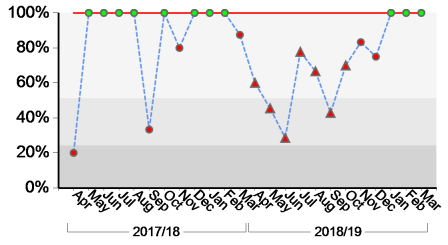
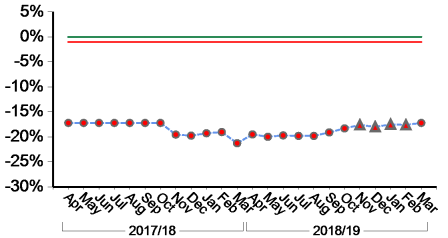
NHS Southport and Ormskirk Hospital NHS Trust

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.	Trust maintains 100% compliance for verbal Duty of Candour - The action taken in Q3 2018/19 to implement daily alerts and escalation has led to the Trust achieving 100% compliance against this indicator in January and February 2019.	
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.	100% compliance achieved for Duty of Candour - Letter sent within 10 days - The action taken in Q3 2018/19 to implement daily alerts and escalation has led to the Trust achieving 100% compliance against this indicator in January and February 2019.	
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Performance is relatively consistent across the last quarter - 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.	

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NHS
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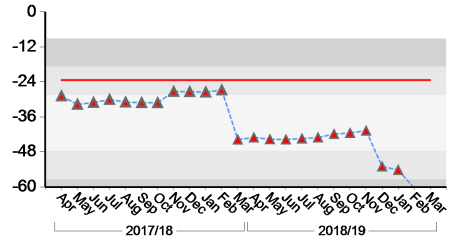
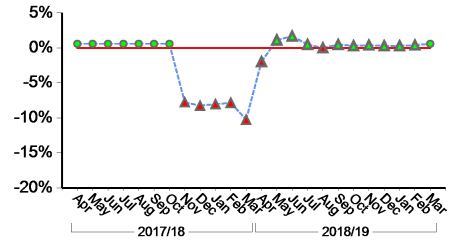
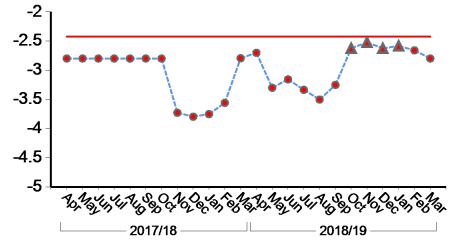
Well-Led

Indicator Name	Description	Narrative	Month Trend
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Downward trend on this metric - As highlighted in previous months, 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	
Distance from Control Total	Distance from Control Total.	The Trust is 0.6% ahead of plan - The Trust has delivered a higher I&E margin (-17.2%) than plan (-17.8%). Although the actual deficit is £143k worse than plan this is over a higher turnover (plan £161.9m; actual £167.9m).	
Capital Service Capacity	The level of debt the Trust is required to service. This indicator is 1 of 5 used to derive the 'Use of Resources (Finance)' score.	A gradual decline in this metric over the quarter - The reduction in the metric is due to the fact that the operating deficit (before financing costs are taken into consideration) is nearly £0.7m away from plan.	

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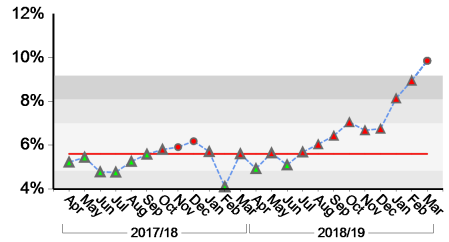
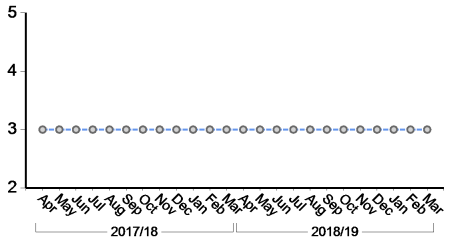
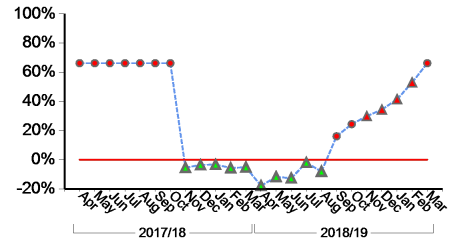
Well-Led

Indicator Name	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	There has been a significant increase in cost in March - The Trust spent £1,092,000 on agency staff in March (12.2% of the substantive payroll) and is across all staff groups, medical, nursing and other staff such as key senior manager and A&C posts.	
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) - No change to the metric at 3 (unrounded it is 3.4). The only individual metric within this score at 1 is the distance from plan.	
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	A futher deterioration in this metric. - The high level of agency spend in March (£1.092m) has contributed to the Trust being further away from the agency spend cap target.	

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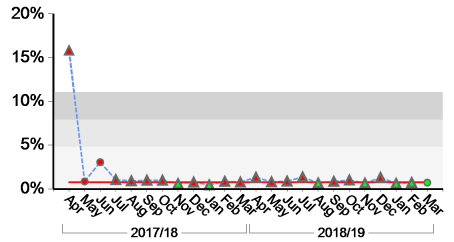
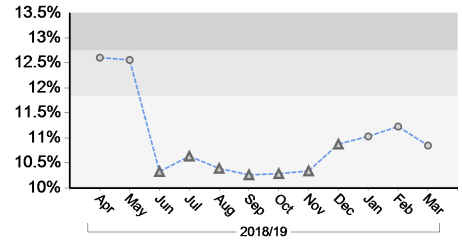
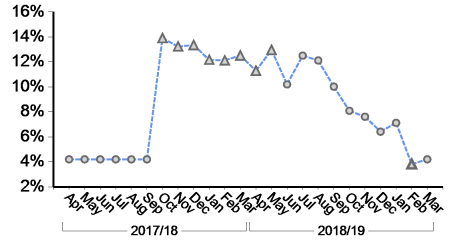
Well-Led

Indicator Name	Description	Narrative	Month Trend
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month.	Staff turnover has remained the same in month and remains on target - The Trust has established a Nursing Recruitment and Retention group which has recently met and established its terms of reference. Terms of reference were approved a workforce committee.	
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.	Staff turnover has decreased slightly in month and remains on target - The Trust has established a Nursing Recruitment and Retention group which has recently met and established its terms of reference. Terms of reference were approved a workforce committee. The trust target of 10% will be included in future reports	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The rate was slightly increased in March from 3.82% to 4.21% -	

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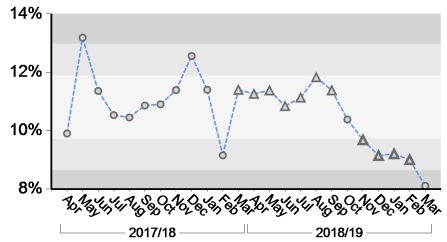
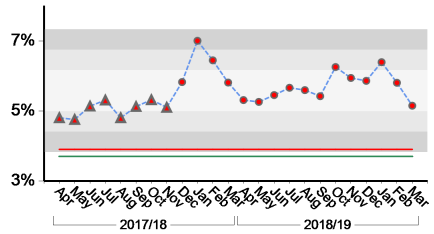
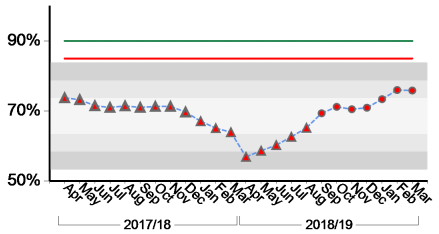
Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	9% showing a positive downward trajectory - Ongoing alignment to non registered vacancies from previous recruitment events continues with local registered nurse recruitment events ongoing. 11th May 2019 will host Trust next event aligned to International nurses day.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence reduced for the third month running in March and a significantly improvment was reported again in month to 5.15% - Sickness absence continues to be a concern for the Trust. Sickness spiked in January which was felt nationally however February and March saw a reduction in sickness absence to 5.15% the lowest levels since December 2017. 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. - PDR compliance is now at 75.98% for February 2019 and 75.83% in March which is nearly a 2% increase from January 2019 and is a 5% increase since December 2018. This is the fourth month of consecutive improvement however improvement is slow. However in March 2018 PDR compliance was 63.91% therefore compliance has increased by over 10% in less than 12 months. CBU's have revised their PDR improvement plans to meet 85% improvement target by June 2019.	

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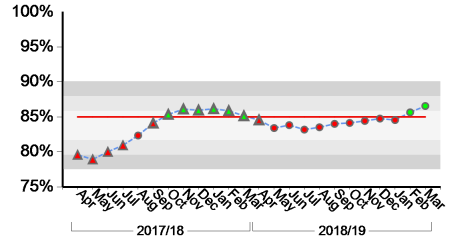
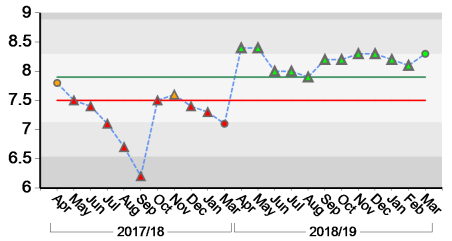
Well-Led

Indicator Name	Description	Narrative	Month Trend
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	The Trust has maintained its target of over 85% for the second month in a row, with all CBU's RAG rated as green. - The Head of E&T will present a paper to the Risk & Compliance group (April 2019) with proposals to further scrutinise the management & recording of core mandatory training data. The Trust was audited by MIAA in 2018 and received a 'significant assurance' rating around its processes and systems	
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 is stable - The overall CHPPD for the Trust remains above the target at 8.3 hours - and slightly above the national average, there are a number of wards that have a low CHpPD with the lowest at 5.1 hours - data cleansing is ongoing.	

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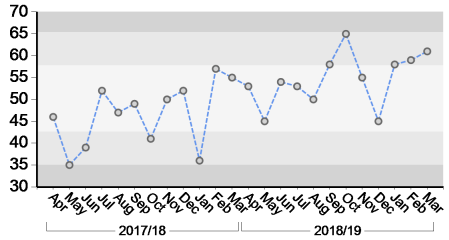
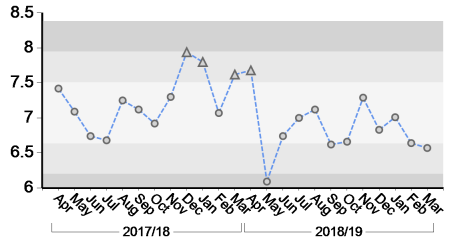
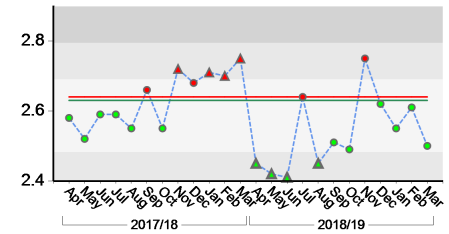
NHS Trust

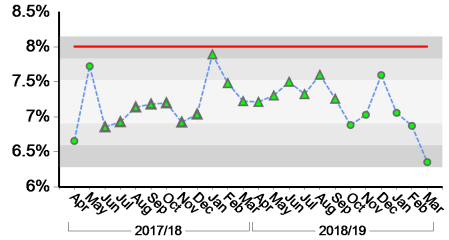
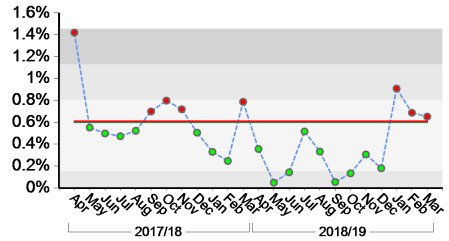
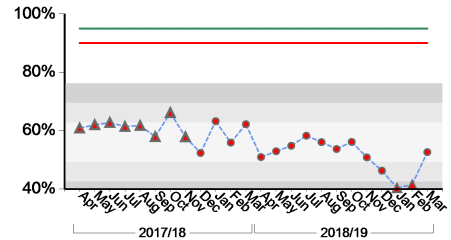
Efficiency

Indicator Name	Description	Narrative	Month Trend
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	Average Number of Daily Beds Lost In Month.Taken from A Daily Snapshot Of Patients Medically Fit For Discharge. Lower is better.	slight increase noted in March, continued infections within acute impacting on flow - 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 across the Trust; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements continued throughout March due to infection led to delays in discharge of MOFD patients to alternative care facilities; closure of ward 1; MADE with senior system partners	
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.	steady reduction in LOS continues - 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 and ODGH; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements continued through March due to infection led to delays in discharge of MOFD patients to alternative care facilities and increased LoS, impact of infection within both community homes and wider community setting has led to prolonged and repeated closures of ward areas. A Trust target is being set for length of stay at 0.5 fewer days than the average for March 2019 i.e. 6.07 days - this is effective from 1 April 2019	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	New:Fu Ratio in March has decreased to 2.5% and the Trust continues to maintain stable performance and is performing within threshold. -	

Board Report - March 2019

NHS Southport and Ormskirk Hospital NHS Trust

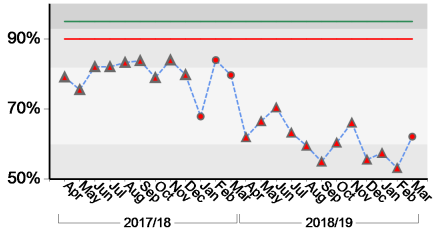
Efficiency

Indicator Name	Description	Narrative	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	The Trust is still performing under threshold with March's DNA Rate being recorded as 6.35% - Phoning ERS Patients to reduce DNA rates and short notice cancellations	
Cancelled Ops	Percentage of Operations Cancelled.	Performance improving - Whilst there is a slight improvement shown in performance, we are still experiencing bed pressures at SDGH and are trying to book clinically urgent and Target patients only. We continue to undertake procedures at ODGH wherever possible and have a plan from the end of May to have more senior support at ODGH to enable some additional cases to be moved across.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Despite the ongoing bed pressures leading to daily cancellations on the SDGH site, we have seen an 11% improvement in utilisation. This is the highest seen since Oct 2018. - The trust have recently enrolled in 2 pieces of work to support. SAEC – Surgical Ambulatory Emergency Care Programme Cohort 4 – Trust are enrolled in this programme that will assist in identifying and treating patients on the same day. This is a 12 month national project. National launch held 10.4.19 – 8 Trust employees attended. • NHSI and GIRFT Theatre Efficiency Programme – specific 6 month programme of work in the North of England with 5 other Trusts – S+O Trust KPIs around that programme are: o On the day cancellations – which will impact on under-utilised sessions (we currently run at 10% - KPI is <5%) and o The Golden patient - which will impact on late starts in theatres and allow more cases to be added to lists.	

Board Report - March 2019

NHS
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.	Utilisation has seen a marked increase in performance this month but still remains behind target of 85% - Work is currently focused on cleansing the data. e.g. we are currently including paediatric dental, which is a community service not managed by the trust, but still adversely impacts on our utilisation. There are other issues around utilisation from an obstetrics point of view in that the planned elective caesarean sections are currently being performed in obstetric theatre with the data not being captured on Galaxy as obstetrics run a different information system. On the flip side theatre sessions in main theatres are being opened for emergency obstetric cases which are rarely utilised (Utilisation 2.3%). Unless these non-utilised sessions are closed they highly impact utilisation figures. For example – if those non-utilised emergency obstetrics sessions were removed March utilisation would increase to 70%.	

NHS
Southport and Ormskirk Hospital
NHS Trust

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.

Following the Well Led Review the Programme is being revbised and led by the Deputy CEO via a vis Well Led

We are working with the Leadership Academy to roll out a Shadow Board geared at aspirant Board directors; this will now have its first meeting in September 2019.

Well Led Self-Assessment and Action Plan

AQuA led a discussion on next steps at the 3 April 2019 Board and will also do that at the 1 May Board

Board Governance

A new BAF model based on new and refreshed strategic objectives and principal risks will be discussed at the 1 May 2019 Board along with a discussion on risk appetite.

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 reviewed statutory instruments were discussed at the Audit Committee and approved. being reviewed as per good practice leading into 2019/20.

NHS
Southport and Ormskirk Hospital
NHS Trust

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

Overview

Vision 2020

Over the past month work has focused on enabling the delivery of Vision 2020 to deliver the short term to medium term objectives. This has culminated in the development of the Single Improvement Plan that supports the Trust's delivery of the 5 core themes. Alongside this work, the Acute Sustainability Programme is producing a development programme plan that will deliver short to medium term outcomes and is underway in scoping out a Pre Consultation Business Case that will outline the options for the future state (long term outcomes) for acute services. There has been an alignment of the objectives for Vision 2020 with those of the Acute Sustainability Programme. This alignment has segmented the programmes of work into three areas: stabilisation, optimisation and innovation to enable the full programmes of work to be viewed as one.

Assured/Most Improved

CLINICAL SCENARIOS
Final draft versions of the new models of care for Frailty, Urgent and Emergency Care, Maternity and Neonatal, Gynaecology and Sexual Health and Paediatric services have been produced alongside a roadmap for testing and refining these models. An all service fragility review is underway. A Strategic Partnership Framework is being developed upon which the clinical models can be used to work through the various delivery options.

ESTATES SOLUTIONS
The Strategic Estates Group have had several meetings and have defined the scope of work for the Sefton Estates Strategy. A key interdependency of this work is the refresh of the Southport & Ormskirk Estates strategy. Alongside this work, an initial clinical view of the configuration of services across the two sites has been undertaken with the Director of Nursing and the Medical Director. This work will be further refined in line with the emerging clinical models

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. Work has commenced to develop an options appraisal approach to the various organisational forms that could support delivery of the future state.

KEY ACHIEVEMENTS/PROGRESS IN MONTH
The new Acute Sustainability Programme Assurance and Oversight Group met on the 24th April 2019 which replaces the Acute Sustainability Programme Board and provides a greater level of scrutiny of the strategic objectives of the programme. The Vision and Design Principles of the programme have been reviewed by both Clinical Leadership Group and the Assurance and Oversight Group

Not Assured/Most Deteriorated

The delay of decision on the future site configuration of services due to the complexities of securing capital funding and robust capacity/demand modelling may hold up finalisation of clinical models which will impact on the PCBC timescales
The speed at which Primary Care Networks are able to evolve into functioning networks at the centre of integrated community care teams presents a risk to the Acute Sustainability work in relation to delivering the new models of care where there is a dependency upon transformation of community care delivery and integration of specialist care into a community hub setting.

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 rigor, 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 12

Month 12 financial performance resulted in a year end deficit of £28.961 million. Although marginally above the planned deficit this was within the limits deemed acceptable by NHSI.
Underlying expenditure levels increased on February levels with agency levels contributing.

Assured/Most Improved

- March in month deficit was in line with forecast discussed and agreed with NHSI.
- 2018/19 outturn position delivered despite significant penalties incurred (sanctions for operational performance and CQUIN).
- Elective income balanced to plan in quarter 4.
- Year end position has minimal risk relating to South Sefton CCG (£250,000)

Not Assured/Most Deteriorated

- Underlying expenditure levels increased on February levels with agency levels contributing.
- Agency spend of £1.1 million in March highest in 2018/19; it is imperative that these levels reduce significantly in order to achieve the 2019/20 plan.
- 2019/20 financial plan dependent on commissioner income which has not yet been agreed; contract negotiations ongoing.
- 2019/20 CIP plan dependent on £4.5 million expenditure reduction; schemes not yet fully developed/approved through the CIP governance framework.

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 110.8 for November
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 started 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
In hospital deaths fell in February to 61, below the target of 77
Interventions to improve performance in AKI have been implemented in April
Fractured neck of femur performance improved significantly in March with implementation of consultant of the week
.

Not Assured/Most Deteriorated

Mortality screening requires improvement.
LRTI and Bronchitis HSMR remains unacceptably high, diagnostic criteria remain unclear. Further evaluation underway

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 completed NHS I Pressure Ulcer collaborative and received an award for their improvement work

2c – Safe Staffing
Ward nurse establishment review completed. Approval paper to Trust Board in May 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 April 2019.

Operational Overview:
Safe Staffing is compliant with national average and further improved slightly in March 2019 (92.08%).
Performance in Harm Free Care (97.61%)
VTE - 96.54%

Assured/Most Improved

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

Not Assured/Most Deteriorated

Three incidents were referred to StEIS in March 2019

Eight grade 2 pressure ulcers have been reported in March 2019

Delivering single sex accommodation breaches have decreased to 37 pt. for March 2019, this was due to waits for beds from critical care environments

There has been one C. Diff. infections reported in March 2019

Patient falls still remains a concern. An action plan for improvement is being developed, drawing upon best practice both regionally and nationally. There was 1 pt fall in March being graded as moderate or above harm, this has been discussed at SIRG

Friends & Family Test (FFT) response rate continues to be low however the likely to recommend increased to over 95% in March 2019

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

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 March was 84.2%, March 2018 it was 79.2% so a 5% improvement on last year.
- This is mainly due to performance at Southport which has improved in the year from 53.0% to 65.9%, despite an increase in attendances of 368 patients in the month and the knock on effect to bed pressures throughout March. The Trust also experienced challenges in lost bed capacity due to prolonged norovirus outbreaks.
- This is the eighth consecutive month that performance has been better than last year and overall 2018/19 is showing a 2.7% improvement in performance on 2017/18.
- Unfortunately despite this improvement March 2019 failed to meet the trajectory target of 87% agreed with NHSI by 2.8%. The Trust was ranked 67th nationally out of 135

Ambulance Handover Times

- The Trust had 47 ambulance handovers greater than 1 hour in March 2019. In March 2018 this was 177 – an improvement of 73%.
- 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, this is mainly due to the new ambulance hand over bays at the front door of A&E which are helping to facilitate a more rapid turnaround.

18 Week RTT Performance

- March 18-week performance is not yet confirmed but early indications are it was 94.5% which maintains the February position and is still well above the 92% target.
- The ongoing waiting list is approximately 10,789, above the trajectory of 9000, however this is not impacting on the ongoing performance and within threshold.
- Despite this performance level there are still challenges in Community Paediatrics, Oral Surgery, Vascular Surgery, Respiratory Medicine and Ophthalmology.
- The improvement programme for Outpatients is now setup for 2018/19. The initial phase of this work will be to undertake a review of Access & Booking with a focus on reducing DNA rates, optimising funded clinic templates and reducing numbers of hospital cancellations – KPIs have been set and trajectories agreed.

Theatre efficiency

- The improvement programme is now setup for 2019/20 and KPIs confirmed with trajectories. The COO chairs the fortnightly meetings with the overall aim is to deliver an 85% theatre utilisation. As part of the in-month process of improvements the team have instigated a standard agenda for the Theatre Scheduling Meeting with focuses on
    - Late Starts / Early Finishes / Overruns / Number of Cases per list / On the day cancellations
    - Actions for improvement
    - Then the forward review takes place in the 6 4 2

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 6.7 days in March, with patients on assessment wards staying an average of 7 hours. This is comparable with previous months.
- Improved length of stay is also evident in the improvement made in the Stranded patients metric which shows that March has 7% fewer stranded patients and 8% fewer super stranded patients than March last year despite a slight increase from the February 2019 position.
- The improvement programme for reducing LoS is now setup for 2019/20 and KPIs confirmed with trajectories. The COO chairs the fortnightly meetings and the overall aim is to deliver a 0.5 day reduction in LoS.

Overdue Follow Ups Backlog

- The numbers of overdue follow up patients has stabilised throughout March with the current position slightly improved on the February position at 2196.
- In March 2018 this number had breached 3200 so the reduction seen this year is still being maintained.
- The risk stratification process is in place and being monitored at speciality level through the CBU leadership and governance arrangements

Not Assured/Most Deteriorated

Diagnostics

- Performance for March against the 6 week wait target was 2.67% a deterioration of 1.5% over the February position.
- Urodynamic is the area of most concern with 41 waiters over 6 weeks. This was due to short notice absence which has now resolved itself.

Cancer 62 Day

- Performance for February 2019 was 70.9%

- 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 in April / May 2019.
- The improvement programme is now setup for 2019/20 and KPIs confirmed with trajectories. The CCO chairs a fortnightly with the overall aim is to deliver an sustained improvement within the standard.

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 issue is related to patients with a place of residence in the West Lancashire area. The lack of access to mental health beds remains high risk for the Trust from a quality, safety and performance perspective and has been formally escalated to regulators and CCG.

MOFD

- The Trust now has accurate reporting of Medically Optimised for Discharge (MOFD) and confirms that 50 – 60 beds are occupied each day by patients classified as MOFD. The Trust is working with the system on tactical actions to support reducing figures (i.e. MADE events, daily system-wide huddles) however due to the acknowledged lack of community provision the system has commissioned an external consultancy to complete a whole-system capacity and demand review to determine gaps and to prioritise any recommendations to support winter planning for 2019/20.

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

Sickness Absence
Sickness absence has decreased in month again in March to 5.15% (the lowest rate since September 2017); 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.

Core Mandatory Training
Core mandatory training rates continue to steadily increase and improve each month. In March the overall Trust rate was 86.56%, this is the second time that the Trust has managed to achieve and maintain 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 has continued in March and there has been an increased requirement for temporary staffing. Agency spent hit over a £1m. Temporary staffing requirements within Nursing & Midwifery continue to be monitored on a daily basis. Off

framework utilisation through Thornbury Nursing Services remained high during March split by department and nursing/HCA 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 Manager and OD Facilitator; the positions will be filled by May and July 2019 respectively. The Learning & OD team objectives are currently being reviewed for 2019-2020 and will be aligned to the overarching Workforce, OD & HR Directorate Plan and will be formally agreed by the Director of HR & OD by early May 2019.

Medical Education – removed

Not Assured/Most Deteriorated

Personal Development Reviews

PDR rates have increased to 75.83% in March 2019 which is a slight decrease in month. Work continues to achieve the target of 85%, and ultimately beyond this target. All CBU's have been asked to revise their trajectories and have stated that they intent to achieve the target of 85% by June 2019.

Alert, Advise, Assure (AAA) Highlight Report	
Committee/Group:	Audit Committee
Meeting Date:	10th May 2019
Lead:	Mr Ged Clarke, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Although all Board members had declared up to date interests the same cannot be said for senior managers especially medical staff.
- There is a challenge relating to getting senior management/decision makers to declare all their interests.
- Although significant training relating to Sickness Absence have been undertaken it will take 6 months to yield tangible results for the Trust which has the second highest absence record of any Trust within England
- Survey of CCTV highlighted a number of areas (including Pharmacies) which required either re-deployment of suitable cameras to cover the area, or purchase of additional resources
- There is lack of site security at Ormskirk between 4pm -12midnight. which is part of the contract – to be reconsidered
- Violence and aggression towards staff continues, some of which may be attributable to dementia in older patients

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)

- Ensure that the security contract includes cover between 4pm and 12 midnight at Ormskirk
- Lone working arrangements to be reconsidered

ASSURE

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

- Co Sec to work with Medical Director to embed a culture of openness and honesty from clinicians with regards to declaration of interests and private work.
- Provision is being made to provide lockers for staff and patient personal items

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:	Finance, Performance & Investment Committee 23 April 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)

- Although work on the Cost Improvement Programme is continuing, progress to date in terms of "banked savings" is limited. The Committee asked that future reports place more emphasis on actual and projected savings.
- Concern was expressed at the level of agency staffing costs, particularly where it has proved necessary to utilise non-framework arrangements. Work on options for improving the situation is underway.

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)

- The actual 2018/19 outturn was £28.961m, £143,000 more than plan; the Annual Accounts are on schedule for completion within the agreed timescale.
- Contract discussions regarding 2019/20 are progressing well
- An improvement programme is in place to address cancer waiting times but at this stage it is not possible to provide assurance that the target will be met consistently throughout the year.
- A target reduction of 0.5 days has been set for the Trust's average length of stay and the Committee will monitor progress over coming months.
- Additional work will be undertaken to better understand A&E attendances and conversion rates.
- A request was made that wherever possible an appropriate 2019/20 trajectory is incorporated into the Integrated Performance Report.

ASSURE

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

- A revised Accountability Framework was agreed and its effectiveness will be reviewed in July.

New Risks identified at the meeting

- The Trust is in the process of recruiting an Associate Director of Estates & Facilities and needs to appoint Interim Head of Estates as there is a potential gap in the professional expertise available within the organisation.

Review of the Risk Register

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Quality & Safety Committee 23rd April 2019
Lead:	Dr David Bricknell, Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- IPR/Mortality Screening – Review of Death statistics indicated the number of review of deaths was less than 100%. A trajectory will be developed to ensure 100% are reviewed.
- Cancer 62-Day RTT target – detailed work is being carried out with each tumour group to establish accurately where the delays in the pathway are.
- Haematology Risk – it was reported at the meeting that a Locum had been identified who would be supported by Clatterbridge for the next 12 months. Whilst this is a short- term solution the longer- term requires a system-wide solution, as with other clinical areas where we are dependant up a sole practitioner.

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)

- Quality Priorities 2019/20 – whilst these have now been established with the Board there is a need to ensure that they are communicated to all staff. We also need to identify targets and progress against them. Work is being led by the Director of Nursing on this.
- The administration of Controlled Drugs has undergone a detailed review. There are still details to resolve. The Committee was assured of progress being made but require an update in 3 months.

ASSURE

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

- Dementia Strategy 2019/21 – the Committee agreed to support the Strategy which was detailed and comprehensive setting out the work to be done in this vital contribution to the care of the older person.
- Quality Impact Assurance (QIA) – the Committee was assured that the process was working well on all CIP and business cases.
- The continuing downward trajectory for the SHMI data was true at both the overall level and each of the constituent elements of the overall figure. This reflects the very focused work being done on reducing avoidable mortality.
- Major Incident Plan – The Committee was assured that this had been tried and tested during the last year. It had been proved adequate although it had been refined as a result of lessons learnt.

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

Review of the Risk Register

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

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 18th April 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)

Staff Friends and Family Test Q4

The Trust recorded a response rate of 99 during this period of time which equates approximately to 3.30% overall Trust response rate (based on an average headcount of Q4). This is disappointing as it 4.48% lower than the Q2 response rate.

Trustwide Staff Satisfaction Pulse Check Q4

The Trust recorded a low response rate in the Trustwide Pulse Check results that indicated a deteriorated position from Q2 to Q4 in all four questions.

The HR directorate are developing a strong engagement strategy which is imperative to improve future results in both of the above. A first draft is expected in June.

Gender Pay Gap

The Median pay gap has increased slightly by 0.3% and bonus pay gap has increased significantly by 16.33% this year. The Committee discussed issues with the structure and the data of and within the report. The Equalities and Diversity lead agreed to review the data and escalate these issues to the North West Equality and Diversity meeting.

Health Education North West (HENW) Visit

The Trust continues to remain under enhanced monitoring from HENW following their visit on 28th March. A robust plan is required to set the intention for the future and a united effort is underway to achieve this.

Nursing Establishment Review

The Establishment Review has identified significant shortfalls of staff within the nursing directorate; but there are strong elements of assurance as the ongoing project has been fully supported.

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)

Personal Development Review (PDR)– Non-Compliance for Three Years or More

Compliance is at 75.83%. Whilst this is increasing as more outstanding staff are receiving their PDR, it is progressing at a slow rate. The Committee requested to receive a verbal update on numbers in May followed by a report in June 2019. The membership discussed the lack of consequences if a PDR is not undertaken. The Committee requests the Executive to actively sponsor the completion of PDR's in their CBU's.

TUPE Transfer

The TUPE transfer of the HR directorate from St Helen's and Knowsley moved back to Southport and Ormskirk successfully on 1st April 2019. Only a few minor details relating to employee relations remain a risk from this project. This is not a significant risk to the Trust. The Director of HR and OD held a welcome meeting on 17th April which had a positive, collaborative impact on all those who were present.

Workforce Committee Dashboard
Whilst the dashboard has not been finalised for the Workforce Committee, the membership acknowledged the progress being made on it. It is vital that this is completed as soon as possible as it forms the backbone of the items for review by the Committee.

Freedom To Speak Up (FTSU)
The data is indicating that staff are using the FTSU service and concerns are being reviewed effectively. The process is embedding and working well. There is concern however over issues, such as grievances, being raised via FTSU which would normally follow a managerial route and whether the latter process is working as effectively as it should be. This will be reviewed.

Model Hospital – Project Management Office
The HR and OD directorate are working on model hospital work despite issues with communication but we are still making progress.

ASSURE

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

Apprenticeships
The Trust is maximising the levy and forward planning to deliver and resource the future workforce. The Trust has been acknowledged regionally for their hard work. The Committee formally thanked those involved in this work.

Feedback on placements is very positive with a 97% rating – the highest in the North West.

Recruitment
The Trust is seeing a significant change in its reputation via the amount of applications sent for job posts.

New Risk identified at the meeting	

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**PB094/19**	**Report Title**	**Financial Position at month 12 March 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.

The Trust delivered a year end deficit of £28.961 million which was marginally above plan but within an accepted tolerance agreed with NHSI.

The CIP programme delivered £6.79 million which was £0.75 million lower than the £7.54 million target

Monthly pay expenditure continues to increase. This is mainly related to additional emergency activity resulting in higher levels of premium rate expenditure for nursing and medical staff. Both agency and bank spend have increased significantly in March.

Recommendation:
The Board is asked to **receive** the financial position at month 12 report

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2019/20)*

	Strategic Objective	Principal Risk
☐	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
☐	**SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
✓	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
☐	**SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
☐	**SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*

☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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

List of Appendices

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

NHS
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	ODGH				SDGH				Trust			
	In Month	YTD	Pr YTD	Growth	In Month	YTD	Pr YTD	Growth	In Month	YTD	Pr YTD	Growth
GP Referrals									3,460	40,704	42,209	-3.57%
Consultant Referrals									3,007	36,164	33,639	7.51%
Other Referrals									3,122	36,760	33,229	10.63%
AAE Attendances	2,736	28,567	27,199	5.03%	4,903	57,078	52,546	8.62%	7,595	84,766	78,301	8.26%
NEL Full Admissions	320	3,170	2,615	21.22%	1,044	12,287	11,486	6.97%	3,493	44,574	50,410	-11.58%
NEL Ass. Ward Admissions	161	1,747	1,957	-10.73%	1,175	12,238	5,308	130.56%	1,012	9,620	7,265	32.42%
Daycases	1,216	13,858	14,166	-2.17%	744	8,661	8,260	4.85%	1,961	22,507	22,343	0.73%
Electives	110	1,594	1,769	-9.89%	70	853	1,022	-16.54%	184	2,383	2,778	-14.22%
Maternity												
Births	179	2,146	2,836	-24.33%					179	2,146	2,836	-24.33%
Outpatients First Att.	1,237	17,210	17,346	-0.78%	1,906	20,849	18,416	13.21%	4,754	56,564	52,523	7.69%
Outpatients Follow Up Att.	6,200	77,670	76,928	0.96%	8,258	87,550	82,225	6.48%	19,130	218,424	209,194	4.41%
Scopes		5,323	6,597	-19.31%		500	187	167.38%		5,823	6,784	-14.17%
Radiology Exams A & E Attender	1,354	13,846	13,130	5.45%	2,839	33,271	34,209	-2.74%	4,193	47,117	47,339	-0.47%
Radiology Exams GP Direct Access Patient	1,695	20,541	17,943	14.48%	1,449	17,319	18,605	-6.91%	3,144	37,860	36,548	3.59%
Radiology Exams In Patient	212	2,680	2,181	22.88%	1,669	19,223	15,766	21.93%	1,881	21,903	17,947	22.04%
Radiology Exams Out Patient	2,597	32,038	32,369	-1.02%	2,231	25,356	24,029	5.52%	4,828	57,394	56,398	1.77%
Radiology Exams Other	29	343	659	-47.95%	9	107	247	-56.68%	38	450	906	-50.33%

Pr YTD is Previous Year to Date

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/03/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	122,515	(4,275)	(3,399)
Other assets	1,382	966	(416)	(173)
TOTAL NON CURRENT ASSETS	**128,172**	**123,481**	**(4,691)**	**(3,572)**
CURRENT ASSETS				
Inventories	2,454	2,382	(72)	(66)
Trade and other receivables	9,591	11,678	2,087	(2,284)
Cash and cash equivalents	1,079	1,042	(37)	(660)
Non current assets held for sale	0	0	0	
TOTAL CURRENT ASSETS	**13,124**	**15,102**	**1,978**	**(3,010)**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(22,771)	2,460	3,105
Provisions	(131)	(199)	(68)	2
PFI/Finance lease liabilities	(1,746)	(1,355)	391	391
DH revenue loans	(4,220)	(20,487)	(16,267)	(2,859)
DH Capital loan	(400)	(411)	(11)	(11)
Other liabilities	(471)	(1,025)	(554)	(363)
TOTAL CURRENT LIABILITIES	**(32,199)**	**(46,248)**	**(14,049)**	**265**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(31,146)	(12,071)	**(2,745)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**92,335**	**(16,762)**	**(6,317)**
NON CURRENT LIABILITIES				
Provisions	(278)	(207)	71	7
DH revenue loans	(66,615)	(82,953)	(16,338)	64
PFI/Finance lease liabilities	(13,807)	(13,629)	178	(73)
DH Capital loan	(1,400)	(1,000)	400	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(97,789)**	**(15,689)**	**(2)**
TOTAL ASSETS EMPLOYED	**26,997**	**(5,454)**	**(32,451)**	**(6,319)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	98,214	973	98
Retained earnings	(83,484)	(112,432)	(28,948)	(1,941)
Revaluation reserve	13,240	8,764	(4,476)	(4,476)
TOTAL TAXPAYERS EQUITY	**26,997**	**(5,454)**	**(32,451)**	**(6,319)**

In month material movements are as follows:

Due to year-end time constraints an analysis of the in-month movements hasn't been done in detail, however, highlights are as follows:

The balance sheet has gone negative with a value of just under -£5.5m.

What has accelerated this position is a combination of the in-month deficit together with a revaluation of our land and building assets. This has reduced the value of land & buildings by circa £4.5m.

Cash flows 2019/20

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STATEMENT OF CASH FLOWS	06PLANM01	06PLANM02	06PLANM03	06PLANM04	06PLANM05	06PLANM06	06PLANM07	06PLANM08	06PLANM09	06PLANM10	06PLANM11	06PLANM12	06PLANCY
	Plan 30/04/2019 Month 1 £'000	Plan 31/05/2019 Month 2 £'000	Plan 30/06/2019 Month 3 £'000	Plan 31/07/2019 Month 4 £'000	Plan 31/08/2019 Month 5 £'000	Plan 30/09/2019 Month 6 £'000	Plan 31/10/2019 Month 7 £'000	Plan 30/11/2019 Month 8 £'000	Plan 31/12/2019 Month 9 £'000	Plan 31/01/2020 Month 10 £'000	Plan 29/02/2020 Month 11 £'000	Plan 31/03/2020 Month 12 £'000	Plan 31/03/2020 Year Ending £'000
Cash flows from operating activities													
Operating surplus/(deficit)	(1,484)	(182)	(968)	(545)	(975)	(856)	759	318	(253)	448	(179)	754	**(3,163)**
Non-cash income and expense:													
Depreciation and amortisation	594	597	597	572	573	573	580	581	580	596	595	595	**7,033**
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Income recognised in respect of capital donations (cash and non-cash)	0	0	(25)	0	0	(25)	0	0	(25)	0	0	(25)	**(100)**
Amortisation of PFI credit													**0**
On SoFP pension liability - employer contributions paid less net charge to the SOCI													**0**
(Increase)/decrease in receivables	(913)	(913)	(915)	(1,218)	(1,218)	1,523	(1,827)	(1,827)	1,827	(2,131)	(2,131)	3,348	**(6,395)**
(Increase)/decrease in other current assets													**0**
(Increase)/decrease in other assets													**0**
(Increase)/decrease in inventories													**0**
Increase/(decrease) in trade and other payables	393	(643)	(294)	(193)	(129)	750	(2,780)	(147)	356	(343)	627	65	**(2,338)**
Increase/(decrease) in other liabilities	(50)	(50)	(50)	(20)								170	**0**
Increase/(decrease) in provisions													**0**
Tax (paid) / received													**0**
Other movements in operating cash flows													**0**
Net cash generated from / (used in) operations	**(1,460)**	**(1,191)**	**(1,655)**	**(1,404)**	**(1,749)**	**1,965**	**(3,268)**	**(1,075)**	**2,485**	**(1,430)**	**(1,088)**	**4,907**	**(4,963)**
Cash flows from investing activities													
Interest received	4	4	4	4	4	4	4	4	4	4	4	4	**48**
Purchase of financial assets													**0**
Proceeds from sales of financial assets													**0**
Purchase of intangible assets	(74)	(78)	(55)	(69)	(66)	(68)	(57)	(77)	0	(69)	(66)	(11)	**(690)**
Proceeds from sales of intangible assets													**0**
Purchase of property, plant and equipment and investment property	(1,000)	(118)	(268)	(324)	(378)	(465)	(428)	(344)	(523)	(334)	(244)	(674)	**(5,100)**
Proceeds from sales of property, plant and equipment and investment property													**0**
Receipt of cash donations to purchase capital assets			25			25			25			25	**100**
PFI lifecycle prepayments (cash outflow)													**0**
Prepayment of PFI capital contributions (cash payments)													**0**
Net cash generated from/(used in) investing activities	**(1,070)**	**(192)**	**(294)**	**(389)**	**(440)**	**(504)**	**(481)**	**(417)**	**(494)**	**(399)**	**(306)**	**(656)**	**(5,642)**

STATEMENT OF CASH FLOWS	06PLANM01	06PLANM02	06PLANM03	06PLANM04	06PLANM05	06PLANM06	06PLANM07	06PLANM08	06PLANM09	06PLANM10	06PLANM11	06PLANM12	06PLANCY
	Plan 30/04/2019 Month 1 £'000	Plan 31/05/2019 Month 2 £'000	Plan 30/06/2019 Month 3 £'000	Plan 31/07/2019 Month 4 £'000	Plan 31/08/2019 Month 5 £'000	Plan 30/09/2019 Month 6 £'000	Plan 31/10/2019 Month 7 £'000	Plan 30/11/2019 Month 8 £'000	Plan 31/12/2019 Month 9 £'000	Plan 31/01/2020 Month 10 £'000	Plan 29/02/2020 Month 11 £'000	Plan 31/03/2020 Month 12 £'000	Plan 31/03/2020 Year Ending £'000
Cash flows from financing activities													
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Public dividend capital repaid	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Loans from Department of Health and Social Care - received	3,015	1,714	2,526	2,084	2,512	2,419	4,827	1,827	2,248	2,131	2,131	2,133	**29,567**
Loans from Department of Health and Social Care - repaid	(200)	0	0	0	0	(2,741)	(200)	0	(3,654)	0	0	(5,481)	**(12,276)**
Other loans received	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other loans repaid	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other capital receipts													**0**
Capital element of finance lease rental payments			(24)			(24)	(588)		(24)		(248)	(24)	**(932)**
Capital element of PFI, LIFT and other service concession payments	(15)	(16)	(118)	(16)	(15)	(119)	(15)	(16)	(118)	(16)	(15)	(119)	**(598)**
Interest paid	(190)	(234)	(226)	(194)	(228)	(546)	(195)	(238)	(234)	(205)	(236)	(551)	**(3,277)**
Interest element of finance lease						(240)					(158)		**(398)**
Interest element of PFI, LIFT and other service concession obligations	(80)	(81)	(209)	(81)	(80)	(210)	(80)	(81)	(209)	(81)	(80)	(209)	**(1,481)**
PDC dividend (paid)/refunded													**0**
Cash flows from (used in) other financing activities													**0**
Net cash generated from/(used in) financing activities	**2,530**	**1,383**	**1,949**	**1,793**	**2,189**	**(1,461)**	**3,749**	**1,492**	**(1,991)**	**1,829**	**1,394**	**(4,251)**	**10,605**
Increase/(decrease) in cash and cash equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash and cash equivalents at start of period	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**
Opening balance adjustment													
Restated cash and cash equivalents at start of period	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash transferred to NHS foundation trust upon authorisation as FT													**0**
Cash and cash equivalents at start of period for new FTs													**0**
Cash and cash equivalents transferred by normal absorption													**0**
Unrealised gains/(losses) on foreign exchange													**0**
Cash and cash equivalents at end of period	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

NHS
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CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2018/19 £'000	YTD to M12 £'000		
			Original Plan	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0072	870	735	1,352	(617)
	Beds / Trolleys	G0060	50	50	51	(1)
	Sub total MEDICAL DEVICES		**920**	**785**	**1,403**	**(618)**
IM&T	Electronic Patient Record	F6409	190	190	105	85
	Patient Service Signposting	G0081	0	456	227	229
	Vitalpac	G0007	30	30	14	16
	eDMS	F6447	160	160	11	149
	Wireless network upgrade	G0073	150	302	336	(34)
	Server warehouse infrastructure incl. storage	G0078	75	75	281	(206)
	Telephony system replacement	G0059	120	95	(9)	104
	Cyber security	G0071	50	50	33	17
	Fixed network infrastructure	F6498	100	100	29	71
	Datacentre	G0075	50	50	210	(160)
	Virtual desktop infrastructure	G0076	25	25	59	(34)
	Equipment refresh	G0077	50	50	5	45
	Sub total IM&T		**1,000**	**1,583**	**1,301**	**282**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	400	200	240	(40)
	Southport A&E Redesign	G0068	350	753	848	(95)
	Ward reconfigurations	G0064	140	140	134	6
	Medical gasses	G0067	30	30	43	(13)
	UPS Theatre	G0053	50	140	136	4
	Waste management storage facilities	G0080	100	100	13	87
	Theatre airplant controls		45	45	0	45
	Generator connectors		65	65	0	65
	Fire compartmentation	G0052	165	12	12	0
	Fire Precautions - Fire Doors	G0019	45	7	7	0
	Discharge lounge	G0074	70	134	134	0
	Spinal isolation works	G0070	200	200	0	200
	Additional Car Parking	G0083	0	50	52	(2)
	Sexual Health Accomodation	G0079	0	260	253	7
	Doctor's Mess Facilities	G0082	0	40	74	(34)
	Capital team	F6305	155	110	169	(59)
	Aseptic isolator	G0084	30	75	0	75
	Sub total ESTATE IMPROVEMENT SCHEMES		**1,845**	**2,361**	**2,115**	**246**
FACILITIES	Catering equipment	G0026	100	100	33	67
	Sub total FACILITIES		**100**	**100**	**33**	**67**
	CONTINGENCY	**F6301**	**319**	**290**	**380**	**(90)**
	Capital plan excluding donations and IFRIC 12		**4,184**	**5,119**	**5,232**	**(113)**
OTHER	Donated assets	000000	120	120	170	(50)
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	2,168	1,488	1,173	315
	Sub total Donations and IFRIC 12		**2,288**	**1,608**	**1,343**	**265**
	TOTAL CAPITAL SPEND		**6,472**	**6,727**	**6,575**	**152**

In terms of performance against our CRL the Trust has achieved this statutory target as follows:

	£'000s
Gross capital spend	6,575
Less book value of assets disposed	-75
Less capital donations received	-170
Charge against CRL	**6,330**
CRL	6,330
Under/(over) spend against CRL	0

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PUBLIC TRUST BOARD

1 May 2019

Agenda Item	**TB095/19**	**Report Title**	**Corporate Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Senior Information Analyst & Datix Lead Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

Since the last meeting, one new risk has been escalated onto the risk register.

- **1987 - Haem / Oncology, reduction in medical capacity following resignation of consultant.** This risk was added in March 2019 (rated 20) following the resignation of a Consultant Haematologist. If this position cannot be replaced then the current haematology service cannot be maintained.

One risk has been removed from the risk register.

- **1314 - Management of mental health pathways.** This risk has been reduced from 16 (Extreme) to 12 (High) due to the controls now in place which have reduced the likelihood of an adverse event occurring.

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
- **1862** - Maintaining safe quality nursing care with current level of nursing & HCA vacancies
- **1942** - Eradicating the Trust's deficit by 2023/24
- **1987** - Haem / Oncology, reduction in medical capacity following resignation of consultant

The risk register has been mapped to the new Trust objectives

The Committee is asked to:

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

Recommendation:

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

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2019/20)*

	Strategic Objective	Principal Risk
✓	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and*

services	*patient safety.*
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
✓ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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)*

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

Previously Presented at:

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

APRIL 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 23/04/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
1367	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values	Failure to have a motivated and engaged workforce (culture)	Director of HR	=16	=16	=16	Risk Closed - awaiting confirmation of staff survey results before new risk added		
1329	SO3 - Efficiently and productively provide care within agreed financial limits	Returning to financial balance by 2021	Director of Finance	=16	=16	Risk Closed - replaced with Risk 1942			
1688	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Inadequate Staffing Levels in Anaesthetic Department	Chief Operating Officer	=15	=15	=15	=15	=15	=15
1902	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	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	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards	Quality of Older Peoples Care	Director of Nursing & Quality	=16	=16	=16	=16	=16	=16
1901	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	Cancellation of elective activity in theatres	Chief Operating Officer	=15	9↓	=9 ↘	=9 ↘	=9 ↘	=9 ↘
1314	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards	Management of mental health pathways	Chief Operating Officer	=16	=16	=16	=16	=16	12↓
1862	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards	Maintaining safe quality nursing care with current level of nursing & HCA vacancies	Director of Nursing & Quality	=16	=16	=16	=16	=16	=16
1942	SO3 - Efficiently and productively provide care within agreed financial limits	Eradicating the Trust's deficit by 2023/24	Director of Finance			!16	=16	=16	=16
1987	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Haem / Oncology, reduction in medical capacity following resignation of consultant	Executive Medical Director						!20

TRUST RISK PROFILE AS AT 23/04/2019

	CONSEQUENCE (impact/severity)				
LIKELIHOOD (frequency)	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)				**1987 - Haem / Oncology, reduction in medical capacity following resignation of consultant**	
Likely (4)				**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)					

NHS Southport and Ormskirk Hospital NHS Trust

Board/Sub-Board Committee: Trust Board Risk Register

Strategic Objective		**SO1**- Improve clinical outcomes and patient safety to ensure we deliver high quality services. **SO2** Deliver services that meet NHS constitutional and regulatory standards. **SO3** – Efficiently and productively provide care within agreed financial limits.. **SO6** Engage strategic partners to maximize the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire						**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	17/04/2019	17/05/2019	
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 17/05/2019	**Action Plan Rating**	Completed Moderate Progress Made

	17.04.19 Still awaiting final approval				
Latest Month Progress	Successfully recruited to two substantive Consultant posts and 1 locum consultant post. These are due to commence in post in May and August respectively. Anaesthetic and Critical Care workforce business case completed and has been to BDISC and HMB - awaiting final Board sign off.				

Strategic Objective		**SO1**- Improve clinical outcomes and patient safety to ensure we deliver high quality services. **SO2** Deliver services that meet NHS constitutional and regulatory standards. **SO3** – Efficiently and productively provide care within agreed financial limits. **SO5** – Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values... **SO6** Engage strategic partners to maximize the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire			**Link to BAF**	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**		
06/03/2019	1987	Executive Medical Director	Dr David Snow	Haem / Oncology, reduction in medical capacity following resignation of consultant		
Description	If a replacement Consultant haematologist cannot be found then the current haematology service cannot be maintained. This will result in loss of income and significant impact on patient experience.					
Controls	- Service will begin a risk assessment in terms of the impact of the resignation on the service continuity and organisational reputation of any loss of local provision. Consideration of Southport to attempt to recruit locum consultant Consideration of Aintree to recruit a locum on behalf of Southport Or - collaboration including Clatterbridge to bring forward the longer term plans for haematology - oncology for the region. sc			**Gaps in Controls**	- There is no written / formal SLA between the respective organisations, other than then remuneration of the cost of the clinicians. - Aintree are currently carrying 2wte vacancies for haematologists for the past 18 months and consequently are unable to support the historical arrangements to provide alternative at the end of the Consultants contact (in 6 weeks' time) tertiary caseload of patients from Preston area as there is a limited provision within the present area	

Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Almost Certain (5)	Major (4)	20	20	Extreme risk	4	Moderate risk	11/04/2019	11/05/2019

Assurance	Discussion at Trust Board, Q&S, Cancer network, CCG	**Gaps in Assurance**			
Action Plan	CEO and EMD to discuss with counterparts at Clatterbridge and Aintree in order to provide a network solution to continue to provide haematology service across Cheshire & Merseyside. WLI clinics to be approved at PAG	**Action Plan Due Date**	01/05/2019 27/03/2019	**Action Plan Rating**	Little or No Progress Made Completed
Latest Month Progress	Funding has been approved for WLI clinics. Discussions are underway with counterparts at Clatterbridge and Aintree to provide a network solution to continue to provide a haematology service across Cheshire and Merseyside				

Strategic Objective							Link to BAF	
	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services **SO2** Deliver services that meet NHS constitutional and regulatory standards **SO3** Efficiently and productively provide care within agreed financial limits. **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire							

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		Gaps in 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		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	15/04/2019	15/05/2019

Assurance		Gaps in 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		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		Action Plan Due Date		Action Plan Rating	
	Incorporate any Red Must Do Actions into CBU Risk Register 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 (QID)Group To deliver against the 96 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.		31/05/2019 31/07/2019 28/06/2019 31/07/2019 31/05/2019		Moderate Progress Made Moderate Progress Made Moderate Progress Made Actions Almost Completed Moderate Progress Made

Latest Month Progress	
	Significant progress has been made against the 96 Must and Should do CQC recommendations outlined I the CQC action plan. Weekly progress meetings are in place to review and challenge evidence, key themes identified for Quality Improvement to be monitored via new ward coordinator, manager and matron checklists. The Quality Improvement Development Group met in April and will be incorporated into the weekly Exec meeting going forward to increase the pace of progress against the action plan. Interim members of staff are in post to facilitate training with lead CQC

	Executive/Manager to increase understanding of expectations prior, during and after inspections. A communications plan has been put in place, with staff identified to lead on the development and roll out of staff communications for CQC preparation, including a shared intranet area and staff handbook.

Strategic Objective		**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services					**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	11/04/2019	11/05/2019
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 practice and therefore improve patient/relative/carer experience and outcomes. To improve education, understanding and therefore change practices of those working with patients to manage continence appropriately, identifying when a patient may need support, maintaining the ability of patients to go to the toilet, using catheters and pads which are individually identified as a need for a patient and demonstrating better awareness of patients displaying the need to go to the toilet particularly in areas requiring enhanced care. Business case to be developed to enhance the provision of the geriatrician service at S&O. Patients with such high frailty factors must have appropriate care and advanced care management plans with sensitive, individual conversations in order to support the individuals and families with delivering the patient's wishes and best quality end of life care possible. Review of wards to take place to establish how to maximise potential of the areas we have to provide better environments for patients particularly with enhanced needs. Particularly looking at signs, colour of objects, orientation devices, tables/chairs to encourage interaction, stimulating activities, getting up dressed and moving. Continue to roll out Red2Green and education across all wards	**Action Plan Due Date**	07/05/2019 07/05/2019 07/05/2019 07/05/2019 07/05/2019 29/05/2019	**Action Plan Rating**	Actions Almost Completed Moderate Progress Made Moderate Progress Made Actions Almost Completed Little or No Progress Made Completed
Latest Month Progress	The Risk Lead met with the lead Dietician to discuss improvement work relating to nutrition/hydration and mouth care in April, although there are concerns over clinical capacity to release staff. A plan has been agreed for protected time to work on improvements. Concerns raised that NEWS2 has not resolved MUST issues, but the Dietetic Team are going to assess this throughout April before changing any plans. A Continence lead has been established and a meeting has been held in April 2019 with the Project Management Office to commence project planning, identify stakeholders and set up scoping meeting to improve the education, understanding and change practice in the management of continence issues. A business case to improve care of elderly workforce has been approved at BDISC and is pending approval at HMB and Trust Board, although recruitment planning is underway. A project lead has been identified for the End of Life elements of quality improvement and an initial meeting with the Palliative Care Team has taken place to scope out the work. Estates work is required to make the hospital environment more conducive to patients' needs, awaiting feedback from charitable funds process to progress this. Work to improve the discharge process has continued; Red2Green is now fully rolled out and the HomeFirst pathway has been officially launched in April 2019.				

Strategic Objective		SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality 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 M-Fri Daily staffing huddles with Matrons & Senior nurse Review Health roster Policy & compliance due to be ratified in April 2019 NHSP contract Continued review of nursing establishments due for ratification at Trust Board May 2019 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, part of the Nurse Establishment review Establishment review not undertaken on a 6 monthly basis with recommendations to the TB NHSp contract for review in 6 months T&F group for Retention with a focus on Recruitment, supported by NHSI Workforce Plan to be developed following Establishment review See risks 1132, 278 and high risk 1368.
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	17/04/2019	17/05/2019
Assurance	Workforce data (sickness & AL) Dedicated H roster Lead for N&M CQC inspection Monthly staffing report mandatory training Complaints Incident reporting Quality and safety reports Bi annual staffing reports						**Gaps in Assurance**	Establishment Review Process not consistent Workforce Plan (including Retention & Recruitment) Updated E roster policy Matrons dashboard/Clinical metrics needs to be developed further Mandatory training not being at Trust required standard Managing Performance Framework process	
Action Plan	Senior nursing staff deployed to identified areas to review current nursing practice and care delivery. Deployment of senior staff to wards identified. Quality improvement approach of the themes to address actions form CQC inspection, complaints and incidents						**Action Plan Due Date**	29/06/2018 31/01/2019 29/03/2019	**Action Plan Rating**	Completed Completed Moderate Progress Made
Latest Month Progress	The Nursing Establishment Review that covers all ward areas across the two sites of the Trust is in its final stages. The analysis of the data from the SNCT, Professional Judgement, skill mix and CHpPD has been completed. It has been acknowledged that the proposed 'skill mix' is below RCN guidance and a separate QIA will be undertaken by an external Chief Nurse for those wards. The financial profile of the proposed establishment had been prepared and reviewed. A summary of the case has been to Executive Team, F P &I Comm. & Workforce Committee which have all agreed the methodology and to move forward to full business case. The Business Case for the investment has been agreed by the Trust Business Development & Investment Case group and has been to HMB. The final decision for the investment and the establishment review will be through Trust Board in May 2019.									

Strategic Objective		SO3 Efficiently and productively provide care within agreed financial limits						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	17/04/2019	20/05/2019
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**	30/06/2019 31/01/2019 30/04/2019	**Action Plan Rating** Actions Almost Completed Completed Moderate Progress Made
Latest Month Progress	Discussions are on-going with the CCG's to agree the payment mechanism for 2019/20. The Trust is still awaiting published guidance from NHSE to formulate the 5 year recovery plan.								