Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 12:45 – 16:00 on Wednesday, 5 June 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				**12:45**
TB103/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**12:45**
TB104/19 (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**		
TB105/19 (D)	**Minutes of the Meeting held on 1 May 2019** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB106/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB107/19 (D) **(D/V)** **(V/P)**	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Patient Story: Dementia Patient Story followed by Improvement in Dementia Care** To **receive** the Patient Story and **note** lessons learnt	**NEDs EDs** **Michelle Kitson**	**30**	**12:55**
STRATEGIC CONTEXT				**13:25**
TB108/19 (D)	**Chief Executive's Report** (signposting results re: Business Cases) To **receive** key issues and update from the CEO	**CEO**	**10**	**13:25**
TB109/19 (D)	**Vision 2020** To **receive** the final version of the document	**DCEO**	**10**	**13:35**

QUALITY & SAFETY				**13:45**
TB110/19 (P/D)	**Quality and Safety Reports:** a) Summary of Complaints & Compliments b) Monthly Mortality Report c) Quality Improvement Plan Update d) Safe Staffing: Monthly e) CQC Preparation Update f) Seven Day Services Self-Assessment Return to NHSE To **receive** the presentation and reports and **approve** the Seven Day Services' Self-Assessment	**MD/DoN**	**40**	**13:45**
TB111/19 (P)	**Maternity & Neonatal Safety Collaborative** To **receive** the presentation	**DoN**	**10**	**14:25**
PERFORMANCE & GOVERNANCE				**14:35**
TB112/19 (D/P)	**1. Integrated Performance Report (IPR)** a. Introduction b. Executive Summary Presentation **2. Integrated Performance Report (IPR)** **3. Executive Summaries** **4. Alert, Advise and Assure (AAA) Reports** a. Finance, Performance & Investment Committee (**Jim Birrell**) b. Hospital Management Board (**Silas Nicholls)** c. Quality & Safety Committee (**David Bricknell)** - *to follow* d. Workforce Committee (**Pauline Gibson**) To **receive** the Integrated Performance Summary Report, the Single Improvement Plan summaries and the highlight reports from the Assurance Committees.	**COO** **Committee Chairs**	**30**	**14:35**
TB113/19 (D)	**Financial Position at Month 1, 2019/20 including Business Cases Update** To **receive** the report	**DoF**	**10**	**15:05**
TB114/19 (D)	**Risk Management:** • **Board Assurance Framework (BAF)** • **Corporate Risk Register (CRR)**	**CoSec/ Execs** **DoN**	**15**	**15:15**

	To **receive** the BAF and monthly corporate risk register reports.			
TB115/19 (D)	**Litigation and Claims Report** To **receive** a position statement on litigation activities and claims for the period 2018-2019 and protocol for seeking legal advice.	**CoSec**	**10**	**15:30**
TB116/18	**Items for approval/ratification**	**Chair**	**5**	**15:40**
CONCLUDING BUSINESS				**15:45**
TB117/19 (V)	**Questions from Members of the Public**	**Public**	**5**	**15:45**
TB118/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**10**	**15:50**
TB119/19 (V)	**Items for Forward Agenda – 5 June 2019** • Southport & Ormskirk Hospital NHS Charity Launch	**Chair**		
TB120/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**		
TB121/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**		
TB122/19 (V)	**Date and time of next meeting:** **10:30, Wednesday 3 July 2019** Ruffwood Suite, Clinical Education Centre, Ormskirk & District General Hospital, L39 2AZ	**Chair**		**16:00** **CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 1 May 2019 Seminar Room, Clinical Education Centre, Southport & Formby District General Hospital, Town Lane Kew, PR8 6PN

(Subject to the approval of the Board on 5 June 2019)

Members Present

Neil Masom, Chair
David Bricknell, Non-Executive Director
Jim Birrell, 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
Gurpreet Singh, Non-Executive Director

In Attendance

Pauline Gibson, Non-Executive Director Designate
Audley Charles, Company Secretary
Steve Christian, Chief Operating Officer
Caroline Griffiths, (NHS Improvement) NHSI
Joanne Morgan, Non-Executive Director Elect (observing)
Jane Royds, Director of Human Resources & Organisational Development
Samantha Scholes, Assistant to the Company Secretary

Apologies:

No apologies were received

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB08619	**Chair's Welcome and Note of Apologies**	
	Mr Masom, as Chair, opened the meeting by welcoming members, attendees and members of the public and apologised for the late commencement of the Board The Chair welcomed Mrs Joanne Morgan, who was observing her first Board meeting in her role of Non-Executive Director elect. The Chair highlighted three substantial topics for the Public Board to discuss in detail, they were: 1. Quality; including mortality, a review of staff establishment, plus safe staffing and the quality strategy 2. Performance and assurance issues 3. The 2019/20 principal risks in conjunction with the Board	

	Assurance Framework and Corporate Risk Register	
TB087/19	**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.	
TB088/19	**Minutes of the Meeting Held On 1 May 2019**	
	The Chair asked the Board to approve the Minutes of the Meeting of 1 May 2019. Amendments included: **TB071/19 Monthly Mortality Report** • Rephrase Mr Nicholls comment regarding the Clinical Care Outreach Team. • Remove *'world-class'* from Mr Birrell's statement in the sixth paragraph. **TB074/19 Financial Position at Month 11** Add *"agency spend would reduce by 10%"* to Mr Nicholls' comment. **PB046/19 Finance Report** Amend the 2018/19 CIP target to £6.9m. **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendments.	
TB089/19	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **TB018/19: AOB** A Litigation Report would be brought to the June 2019 Board. **TB031/19: Integrated Performance Report (IPR)** Action to be re-opened and assigned to Chief Operating Officer (COO), with the IPR to include trajectories in the June 2019 Board report.	**CoSec** **COO**
TB090/19	**Patient and Engagement Issues including:** • **Summary of Complaints & Compliments** • **Non-Executive Directors (NEDs) & Executive Visits/Walkabouts** • **Patient/Staff Story: Winter Pressures – The Patient Experience**	
	• **Summary of Complaints & Compliments** The report would be covered within the Quality & Safety Report (TB092/19) • **NEDs & Executives' Visits/Walkabouts** NEDs had undertaken walkabouts throughout the month. Dr Hankin had recently spent a day 'Back to the Floor' on a ward, Mrs Royds would be undertaking a similar day shortly and Mr Nicholls was due to spend the day as a nursing auxiliary. Ms Patten had spent a day with the Catering Team and noted that portion sizes were large which could be wasteful and potentially intimidating for patients with limited appetites.	

	It was agreed that a feedback loop in terms of the outcome and follow-up actions was required to support the use of the visits and walkabouts and that would be discussed in the Well Led Board Development session later in the day. • **Patient/Staff Story: A Gynaecological Experience** Mrs Michelle Kitson, Matron, Patient Experience, read the experience which a patient had sent to the Trust's Communications Team. She stated that she had been in contact with the patient who had given permission for her experience to be shared with the Board. Mrs Kitson introduced Mrs Helen Hurst, Matron, Planned Care who would answer any questions raised by the Board on the subject. The patient thanked Ormskirk Hospital for the care she had received there following a miscarriage. Staff were caring, helpful and kind and she named a number of staff whom she considered to be 'amazing'. She was admitted onto the ward at 10.30am and taken for surgery around 5pm the same day. On her return to the ward, no nurse had been to see her and her partner. At 6.30pm the patient buzzed to request some painkillers. At 7.30pm and 8pm she buzzed again and asked for painkillers which were not forthcoming. At 8.45pm and 9.30pm she again buzzed and made the same request. At 10pm painkillers were provided and she asked to be allowed to go home. The patient was disappointed that no nursing staff had voluntarily attended to ask how she was, acknowledge her loss or reassure her about discharge arrangements. Notwithstanding the above, the patient thanked the doctor for his care. Mrs Hurst commented that the patient's experience will be discussed with ward staff and considered at the HARM meeting which examined incidents and complaints. Bereavement training was offered to the ward staff. Whilst a balance has to be sought between supporting patients and respecting the need for privacy at such a sensitive and challenging time staff are looking at ways to meet more personal and individual needs. The patient would have been seen immediately post-theatre to check observations. It was acknowledged that on that date, the staffing establishment was not at the planned level due to the configuration of the services at that time. This issue had previously been raised as a concern by Mrs Hurst. The Chair, on behalf of the Board, thanked Mrs Kitson for reading the patient's story and asked her to thank the patient for sharing it with the Board. He apologised for what was an unacceptable level of care in that instance and stated that it was taken for granted that patients expected and experienced professional care, however, it was sometimes the small acts, including personal care which made a significant difference. **RESOLVED:** The Board **received** the presentation and **noted** the lessons learned.	**DCEO**

STRATEGIC CONTEXT		
TB091/19	**Chief Executive's Report**	
	Mr Nicholls presented the report. **Estates and Facilities restructure** The Estates and Facilities departments were undergoing a programme of organisational change, the purpose of which was to bring functions together into a merged Facilities Management structure to meet the provision and delivery of quality, patient-focussed services, responsiveness and compliance. **Nursing establishment review** An extensive nurse staffing review had taken place which would inform an increase in the number of clinical staff on the wards to improve patient care. **Preparations for Care Quality Commission (CQC) Inspection** The Trust received a request from the CQC on 10 April to submit the Provider Information Request (PIR). Within six months of the date of the letter, CQC will carry out a Well Led inspection along with an inspection of core services. Mr Nicholls stated that new Executive Team was working hard to ensure progress was being achieved. **Sharing the operational plan with staff** Briefings were held for senior managers at the end of March and beginning of April. They included information about the Trust's Single Improvement Plan which sets out how we will deliver Vision 2020 during the 2019/20 financial year. "Roadshow" style meetings and individual visits by members of the Executive to teams got underway on 18 April. **£260,000 Trust Sexual Health Clinic opened** The clinic opened on the fifth floor of St Hugh's House in Stanley Road, Bootle, and incorporated services previously available at the nearby May Logan Centre and the Pregnancy, Advisory, Contraceptive Education (PACE) service for under 19-year-olds at Bootle Health Centre. **A&E Pressures** All Trusts in the country were experiencing a high demand for Mental Health patient beds and over the Easter period there were found to be zero beds available in either the public or private sector. That resulted in patients with mental health needs waiting too long in A&E which caused discomfort to both patients and staff. The objective of the Trust, in this regard, was to treat patients safely in all cases and as Southport & Ormskirk did not have ligature-free wards there would have been a greater suicide risk if admissions had occurred onto those. A&E was ligature-free and staff were appropriately trained in supporting patients with Mental Health problems Mr Nicholls had recently met with the Chief Executive and Medical Director of Lancashire Care NHS Foundation Trust, the provider of Mental Health provision in the North West, and would also be meeting with other local Trusts to establish how to address this	

	challenge and the steps needed to be undertaken to provide appropriate care. . **RESOLVED:** The Board **received** the report.	
QUALITY & SAFETY		
TB092/19	**Quality and Safety Reports:** a) Monthly Mortality Report 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 plus Summary of Complaints & Compliments	
	These were sign-posted via a presentation by the Director of Nursing and Medical Director. Details were presented by individual leads. Ms Cosgrove gave an overview of Quality & Safety (Q&S) which included the actions resulting from CQC inspections. The presentation detailed a Plan on a Page which defined the four Quality Priorities: • Care of Deteriorating Patients (Escalation) • Care of Older People • Infection Prevention and Control • Medicines Management The plan also detailed how the Trust planned to move from '*Requires Improvement'* to '*Good*' by 2020 and would also hold the leads for the priorities to account for delivery of the improvement plan. Meetings to review the Quality Improvement Plan had identified that the Fractured Neck of Femur metric had significantly improved and was almost at target level; the Dementia Strategy had been received at Quality & Safety Committee and Falls numbers remained static. **Mortality** was presented by Dr Hankin The level of mortality within the Trust reflected the demographics of the population. An Advancing Quality Alliance (AQuA) collaboration for Acute Kidney Injury (AKI), Pneumonia & Sepsis were planned. A review and revision of Trust documentation would support all four quality priorities and the 24/7 Critical Care Outreach Team would continue to deliver training and support junior doctors. **CQC Update** Following the formal notification of inspection received on 10 April 2019, including the request for the Provider Information Request (PIR), substantial work had taken place to ensure all documentation would be available for submission on 3 May 2019. A CQC engagement event had taken place at Ormskirk & District Hospital in March 2019 and the next scheduled monthly CQC visit would be 10 May 2019, focusing on the Emergency Department and Older Peoples Care.	

Compliments and Complaints

An increase in compliments had been received and a reduction in the number of re-opened complaints had been achieved. In response to Mrs Gorry's query regarding Clinical Business Units (CBUs) and how pro-active they were in gathering compliments, Ms Cosgrove agreed that the statement within the report regarding Planned Care CBU was inaccurate.

Safe Staffing

The monthly review examined the number of planned staff on duty versus the actual number of staff on duty. Compliance could exceed 100% due to a clinical area requiring more than the planned number of staff to support complex patients and was based on two factors:

1. Appropriate professional judgement and monitoring on a regular basis to ensure that the data was correct (i.e. if there were four planned staff but the case mix of the patient was safely manageable with three then it would be adjusted).

2. Correct budgeted establishment was in place to begin with, (i.e. a ward could have planned for four staff and had four staff but the case mix of the patients meant they required five staff).

The Trust reported Safe Staffing in March 2019 of 92.08% with a vacancy rate of 9%.

Nursing Establishment Review

An Establishment Review had been conducted using NHSI workforce methodology which identified the investment required in Registered Nurses and Healthcare Assistants to ensure the delivery of the required standard of care and four Quality Priorities due to the increase in time required for direct patient care.

Guardian of Safe Working (GOSW) was presented by the Guardian of Safe Working

Significant improvement and assurance had been evidenced in relation to exception reports.

Dr Sharryn Gardner, as the new GOSW was welcomed to the Board and thanked for taking on the role.

She stated that the report was for the period 1 November 2018 – 31 January 2019, and was Dr Chapman's final report. She was encouraged by the number of reports raised and stated that the F1 and F2 junior doctors were very bright and had developed and implemented the Friday checklist, the purpose of which was to complete as much routine work before the weekends, so they could be prepared and fully available in the event of urgent or significant pressures during that period.

The refurbishment and upgrade of the doctors' mess had seen a huge improvement to their working lives and included access to VitalPac. In addition, there had been a shift from paying doctors for their overtime to ensuring time off in lieu was facilitated. Instances of double or triple bleep carrying, had not recurred and attendance at the junior doctors' forum was good on the whole.

	In response to questions relating to doctors working over their hours, Dr Gardner and Dr Hankin stated that a weekly meeting was taking place to address the concerns raised by Health Education North West and those issues would be escalated when necessary**Freedom to Speak Up (FTSU)** was presented by the Freedom to Speak Up Guardian An increase in the concerns raised had been seen, which was evidence of an improving trend in staff raising concerns where necessary. Of those who had raised concerns, the majority had found the outcomes positive and would repeat the process if necessary. Reverend Martin Abrams, the FTSU Guardian, confirmed that the volume of concerns raised formally had increased within the month and throughout the year which was a positive indication of staff speaking up. There had been media coverage of a bullying culture within the Trust. There had also been evidence of learned behaviours which might have been considered appropriate many years ago, but were not considered to be so now. The National Guardian Office's (NGO) action plan – progress to date table within the report, identified the positive work which had been achieved and he commented that the sharing of the Culture Review would soon be actioned. *It was agreed that Rev. Abrams would attend the June 2019 Board and his input be included in the detailed action plan being formulated relating to the Culture Review.* Rev. Abrams reported that the National Guardian's Office (NGO) had received 7000 concerns relating to FTSU nationally and it was perceived that the 75 received from Southport & Ormskirk Hospital NHS Trust reflected a similar trend. Of the 75 received, 12 had been carried over from 2018/19 to 2019/20 due to the month in which they were raised. It was however acknowledged that six had been open longer than they should. The FTSU team would focus on further developing listening skills and to overcome the perception that nothing would result from someone voicing their concerns or that doing so would be detrimental when considered by peers/colleagues or line managers. Speaking up professionally should be considered business as usual not a deviation from the norm. Mersey Internal Audit Agency (MIAA) had conducted an annual audit of the FTSU Policy and the work of the FTSU Guardian and had rated the Trust's compliance as *substantial assurance*. Mr Nicholls welcomed the report and stated that 100% of staff who had been asked if they would raise an issue again via the FTSU route if necessary, has stated that they would. He added that serious allegations of bullying had resulted in dismissals and education on banter was needed to address some issues. *Ms Cosgrove and Mrs Gibson would consider what communications could be issued to the Trust to share the positive outcomes without impinging on the anonymity of individuals.*	**CoSec/DoHR** **DoN/ Chair WFC**

	Monthly Mortality Report Dr Hankin presented the report. The rolling 12 Month Hospital Standardised Mortality Rate (HSMR), Summary Hospital-level Mortality Indicators (SHMI), Respiratory Tract Infections and Septicemia indicators had reduced in month. Dr Hankin commented that the in-hospital death rate was low and investment and improvement were needed in relation to flow of patients to enable better performance had contributed to this trend. He was pleased to report that the Trust was second best in the north west for HSMR in September 2018 and the best for administration of antibiotics within four hours of admission for pneumonia. Senior review of patients required improvement evidenced by efficient reporting. The mortality index for Urinary Tract Infections remained higher than anticipated which could be attributable to the age of the population. **Learning from Deaths** The Trust continued to embed the Structured Judgement Review (SJR) method to review in-hospital deaths using a screening tool on a target of 100% of deaths. Mr Nicholls commented that the tool enabled clinicians to interrogate the data and identify how differences in patient care could potentially be made to improve outcomes. Dr Hankin shared the Trust-wide SJR results within his report which evidenced 37 cases of adequate care of the 42 reviewed. Of the five identified as cases of '*poor*' care all had resulted in reviews, lessons learned and Duty of Candour being actioned. No definite avoidable deaths had been found, however, in the case of four patients there may have been some evidence of avoidability. Mr Nicholls added that the Trust was heading in the right direction and would continue to take a robust approach to mortality by paraphrasing the saying that *'The death of one man is a tragedy. The death of millions is a statistic.'* In response to questions from the Board Dr Hankin agreed to undertake the following: • *Confirm if Local HSMR Urinary Tract Infection data included the Spinal Injuries Unit* • *Produce a monthly, single page report on the 'good news' medical stories within the Trust, including the article from 'GP News' regarding cardiac success* **RESOLVED:** The Board **received** the monthly report.	**MD**
PERFORMANCE & GOVERNANCE		
TB093/19	**Assurance & Performance**	
	Alert, Advise and Assure (AAAs) Reports from: Finance, Performance and Investment Committee Mr Birrell, in Mr Clarke's absence as Chair of the Audit Committee, presented the AAAs report.	

	The Committee alerted on: • Declaration of Interests was not being fully complied with by clinicians and it had been noted by MIAA. Mr Birrell, in his role as Chair of the Finance, Performance and Investment Committee, presented the AAAs report. The Committee advised on: • An improvement programme was in place to address cancer waiting times but at this stage it was not possible to provide assurance that the target would be met consistently throughout the year. • A target reduction of 0.5 days was set for the Trust's average length of inpatient stay and the Committee would monitor progress over coming months • A request was made that wherever possible an appropriate 2019/20 trajectory was incorporated into the Integrated Performance Report The Committee assured on: • A revised Accountability Framework was agreed and its effectiveness would be reviewed in July Dr Bricknell, in his role as Chair of the Quality & Safety Committee, presented the AAAs report. The Committee alerted on: • Haematology Risk – it was reported at the meeting that a Locum Consultant had been identified from Clatterbridge Hospital who would provide support for the next 12 months. Whilst that was a short term solution the longer-term required a system-wide solution, as with other clinical areas where the Trust was dependent on a sole practitioner. **Workforce Committee** Mrs Gibson, in her role as Chair of the Workforce Committee, presented the AAAs report. The Committee alerted on: • **Trust-wide Staff Satisfaction Pulse Check Q4** The Trust recorded a low response rate in the Trust-wide Pulse Check results which indicated a deteriorated position from Q2 to Q4 in all four questions. The Committee advised on: • **Personal Development Review (PDR)– Non-Compliance for Three Years or More** Compliance was at 75.83%. Whilst that showed an increase that more outstanding staff had received their PDR, it was progressing at a slow rate. *The Committee requested to receive a report in June 2019.* The membership discussed the lack of consequences if a PDR was not undertaken. The Committee requested each Executive to actively sponsor the completion of PDR's in their CBU's. The Committee assured on:	**DoHR**

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

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

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

Mr Christian highlighted the reports for each set of indicators. He noted that ambitious trajectories would be included in the report from June 2019 and would be benchmarked against plan and the trajectory for continual improvement. Performance would be monitored against constitutional standards and regulatory requirements

Responsive
A&E Performance – 4-hour compliance was 84.2%, an improvement of 5%. In March 2019 the Trust was ranked 67 out of 175 trusts in the country for this performance measure, despite an increase of 1.5% demand in the same month.

Medically Optimised for Discharge (MOFD) patients had been analysed at 60 per day, which was the equivalent of two wards, resulting in a bottleneck within the hospital and poor patient experience. Work with system partners was ongoing to reduce this level.

Norovirus had impacted on 20 occupied beds in March, with patients not being accepted for discharge to nursing homes etc and patients unable to be admitted.

In June 2019 two Emergency Department posts would be filled and would contribute to the optimisation of patient care.

Factors being considered were:
- Winter 2019/20: sufficient capacity and support to manage demand
- Configuration of both Southport and Ormskirk sites
- Bed modelling

Risks
- Community provision was required.
- Daily senior review.
- Weekend provision (variation of weekdays).
- Reliance on agency staff.

Diagnostics
March 2019 saw a fall in the performance of diagnostics due to staff shortages. Urodynamics had been impacted on by short-notice absence which had been resolved.

Cancer 62-day Standard
The Trust had challenges in workforce across a number of tumour groups and Medical Director with the COO were meeting with

	clinical & service leads to determine issues and critical interventions in April/May 2019. - The improvement programme was now setup for 2019/20 and KPIs confirmed with trajectories **Risks** Workforce was impacted on by dependency on non-Trust consultants attending site and SLAs were to be reviewed along with delivery of standards. **Efficiency** Mr Christian noted that in his six-month tenure, a number of changes had taken place including: 1. Patient flow programme which monitored the Length of Stay (LoS) to reduce expenditure and release beds. 2. Theatre efficiency to achieve 85-90% via an improvement plan and a shift from scheduling by administration to the clinicians. 3. Outpatient Productivity; this had seen a decrease in the Did Not Attend rate to 6.4% which was the best in class within the peer group of the local economy. Mr Nicholls raised a concern that repeated cancellation of operations indicated a system under stress and one patient had had their operation cancelled on three occasions which was not acceptable. **Well Led** Sickness absence had decreased in the month of March to 5.15% overall which was the lowest it had been since December 2017. The CBUs' sickness rate was reported at 6.43%. Mandatory Training rate had improved to 86.56%. Personal Development Review rates remained a concern with 75.83% compliance and the Board was asked to support the process within their teams. **Agency Spend** In March 2019 the spend totalled £1m. On Thursday 9 May, an action plan to address that would be reviewed by the Executive Team. In conclusion, Dr Hankin thanked the Orthopaedic Team for their hard work in reducing the Fractured Neck of Femur complications. **RESOLVED:** The Board **received** the highlight reports from the assurance committees, the Executive performance summaries and reports on performance indicators.	
TB094/19	**Financial Position at Month 12**	
	Mr Shanahan presented the report and key highlights. The Trust did not sign up to its 2018/19 control total of £13.681m and set a deficit plan of £28.8m. The Trust delivered a year end deficit of £28.961m, £143k above plan and within the accepted tolerance agreed with NHS. Notwithstanding the outcome of contract negotiations with commissioners, the challenge for Cost Improvement Programme	

	(CIP) remained and a greater level of assurance was needed. Reconsideration would be given to external support. The Chair stated that Jonathan Stevens (NHSI), was very pleased with the outcome and consistency of the reporting. He thanked the Finance Team for the excellent performance during a challenging 2018/19. **RESOLVED:** The Board **received** the report.	
TB095/19	**Risk Management:** **Risk Register**	
	Ms Cosgrove presented the report. All risks were reported at sub-committees and risk would form part of the afternoon's conversation including the Board Assurance Framework. Dr Bricknell commented that with so much work going on it was vital for Assurance Committees to be assured and reported to by their sub-committees. **RESOLVED:** The Board **received** the monthly report.	
TB096/19	**Items for approval/ratification**	
CONCLUDING BUSINESS		
TB097/19	**Questions from Members of the Public**	
	There were no questions from members of the public.	
TB098/19	**Any Other Business**	
	To **receive/discuss** any other business not on the agenda. Dr Bricknell informed members that at a recent consultant recruitment interview, he was pleased to note that the successful candidate had actively researched the opportunities available to them in the area and chose Southport & Ormskirk specifically as they could 'see the green shoots of recovery'. Mr Nicholls reflected that the next big challenge for the Board was that of staff morale and the Trust being a better place in which to work	
TB099/19	**Items for Forward Agenda – 5 June 2019** • Culture Review • Board Assurance Framework and Risk Appetite	
TB100/19	**Message from the Board**	
	Messages, showing progress, which the Board wished to communicate to the wider Trust were: • Mortality rates and progress • Freedom to Speak Up numbers • Financial position • Performance data • Recruitment information	**Communications**
TB101/19	**Meeting Evaluation**	

	The Chair reflected on the evaluations of the Board meeting which had taken place previously and commented that the broad focus was being sharpened as evidenced at the day's meeting.	
TB102/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Date and time of next meetings: **Extra-ordinary Board, Wednesday 22 May 2019, 11.30** Ruffwood Suite, Clinical Education Centre, Ormskirk District General Hospital **Wednesday 5 June 2019** Seminar Room, Clinical Education Centre, Southport & Formby District General Hospital, PR8 6PN	

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	✓	✓										
Joanne Morgan		✓										
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 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

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

Public Board Matters Arising Action Log
as at 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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**

Public Board Matters Arising Action Log
as at 5 June 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
TB031/19	Jan 2019	**Integrated Performance Report (IPR)**	The report to incorporate a target or forecast line	**COO**	May 2019	July 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. **June 2019** The trajectories for KPIs (where applicable) will be in place for July Trust Board.	**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. **June 2019** Amended paper presented to FP&I Committee 28 May. Paper to be brought to Trust Board, July 2019	**GREEN**

Public Board Matters Arising Action Log
as at 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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.	**COO**	Jun 2019	Aug 2019	**May Update** Due in June **June 2019** The COO is reviewing KPIs with system partners to create a whole system health and social care economy dashboard that will monitor overall effectiveness of the system.	**GREEN**
TB090/19	May 2019	**Patient & Engagement Issues**	It was agreed that a feedback loop was required to support the use of findings from the visits and walkabouts and that would be discussed in the Well Led Board Development session later in the day.	**DCEO**	Jun 2019	Jun 2019	**June 2019** A plan is being developed which will be discussed with the Chair**.**	**GREEN**
TB092/19	May 2019	**Quality & Safety Reports**	Ms Cosgrove and Mrs Gibson would consider what communications could be issued to the Trust to share positive outcomes without impinging on the anonymity of individuals.	**DoN/ Chair WFC**	Jun 2019	Jun 2019	**June 2019** The Director of Nursing has spoken with the Freedom to Speak Up Guardian	**GREEN**

Public Board Matters Arising Action Log
as at 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB092/19	May 2019	**Quality & Safety Reports**	Produce a monthly, single page report on the 'good news' medical stories within the Trust, including the article from 'GP News' regarding cardiac success	**MD**	Jun 2019	Jun 2019	**June 2019** MD working with Comms to produce a newsletter for Clinicians.	**GREEN**
TB093/19	May 2019	**Alert, Advise and Assure (AAAs) Report from Workforce Committee**	The Committee requested each Executive to actively sponsor the completion of PDRs in their CBU's.	**DoHR**	Jun 2019	Jun 2019	**June 2019** Report on Private Board Agenda	**GREEN**

Public Board Matters Arising Action Log
as at 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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	Jun 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** 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. **June 2019** On the June Board agenda.	

Public Board Matters Arising Action Log
as at 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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**
TB075/19	Apr 2019	**Risk Management**	The Trust would state its Risk Appetite	**CoSec**	May 2019	May 2019	**May 2019** A statement about key steps in this would be made and discussed at the BAF session after the Board **June 2019** Discussed at the BAF session	**BLUE**
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 **June 2019** Included in the June IPR	**BLUE**

Public Board Matters Arising Action Log
as at 5 June 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB092/19	May 2019	**Quality & Safety Reports**	It was agreed that Rev. Abrams would attend the June 2019 Board and his input be included in the detailed action plan being formulated relating to the Culture Review.	**CoSec/ DoHR**	Jun 2019	Jun 2019	**June 2019 Update** Invitation made and item on the June Board agenda	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB108/19**	**Report Title**	**Chief Executive's Report to Board**
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

- £1m investment in nurse staffing
- Trust no longer outlier for patient mortality
- Consultant of the Week and Fractured Neck of Femur
- Dementia strategy
- Preparations for Care Quality Commission (CQC) inspection

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 ✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	☐ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change

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

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

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

N/A

Previously Presented at:

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

CHIEF EXECUTIVE'S REPORT TO BOARD – June 2019

£1m investment in nurse staffing

An additional £1m will be spent on nurse staffing during 2019/20 following an in-depth nurse establishment review.

This is equivalent to recruiting an extra 50 registered nurses and 50 non-registered nurses (health care assistants). There will also be additional investment in ward clerks.

The establishment review was completed to ensure we have enough nursing staff to give safe and appropriate care as well as giving patient the best possible experience in our hospitals.

This investment will be rolled out over the course of the year. It will also have the effect of eventually ensuring nurse ward managers become wholly supervisory in their roles, focussing on patient safety and experience.

Trust no longer outlier for patient mortality

The Trust is committed to improving patient mortality through the Reducing Avoidable Mortality Project which has the overriding aim of reducing avoidable patient deaths to within agreed statistical limits by April 2019.

I am very pleased to report December's national figures released last month for SHMI, the Standardised Hospital Mortality Indicator, showed the Trust is no longer a national outlier and has returned to within the expected range.

SHMI is the ratio between the actual number of patients who die following hospitalisation and number who would be expected to die on the basis of average England figures. It also includes deaths in hospital and deaths 30 days after discharge.

The fall reflects a rapid decline in the other national mortality indicator, HSMR (Hospital Standardised Mortality Ratio), which tracks the ratio of observed to expected deaths.

We expect continued improvements in these indicators which reflect investment by the Trust but, more especially, the huge dedication to continuously improving patient care made by our staff.

Orthopaedic Consultant of the Week brings patient benefits

In March 2019 the Orthopaedic team introduced Consultant of the Week (CoW) as part of our Getting It Right First Time project.

CoW is an on-call rota for surgeons, in line with national best practice. The surgeon who is the CoW is freed up of all other clinical duties and elective commitments in order to provide senior decision-making and leadership on trauma cases.

As a result, the approach is having a positive and noticeable impact on patient care and the quality of the patient experience.

Specific improvements that have been noted to date are that trauma for orthopaedics no longer impacts on elective care for orthopaedics. There has also been a significant positive impact on the timeliness of treatment for patients with a fractured neck of femur. We expect this trend to continue.

Dementia strategy

Part of the Trust's 2020 Vision strategy is to become a district general hospital with specialist skills in the care of older people. This ambition is reflects the needs of the particularly elderly population who live in our area.

To support this, a dementia strategy was published last month which aims to deliver excellent, person-centred care for people living with dementia, and their families and carers through:

- **Patient, family and carer experience of care:** improving the experience of people living with dementia or a diagnosis of delirium, and their families and carers

- **Training and education:** delivering comprehensive education and training for all staff which will equip teams to deliver the best possible care for people living with dementia and with a diagnosis of delirium, with a specialist team to provide further support, advice and guidance

- **Engaging environment:** providing a stimulating environment conducive to patients maintaining physical, cognitive and social function through engaging in activities with patients, families and carers

- **Physical environment:** creating a positive and vibrant environment supporting patients living with dementia to feel empowered, safe and orientated

- **Pathways:** developing system-wide pathways designed to meet the needs of people living with dementia and delirium to ensure that they are cared for in their own home whenever, and as early as possible

- **Communication:** advancing the communication between the Trust and system partners to ensure that appropriate information is shared to minimise duplication and inform decision making in patients living with dementia or with a diagnosis of delirium

Underlining the importance the Trust attaches to the care of older people, this month we will welcome Prof Brian Dolan OBE. He is the founder of the End PJ Paralysis Movement aimed at enabling people to lead fuller lives by reducing unnecessary stays in hospitals.

The campaign was based on the idea that wearing pyjamas or hospital gowns reinforces patients feeling unwell, can prevent a speedy recovery and encourages people to spend more time in hospital than is clinically necessary.

Preparations for Care Quality Commission (CQC) inspection

Inspectors from the Care Quality Commission are visiting and speaking to Trust staff and senior management all the time to keep up to date about the progress we are making.

Most recently, inspectors from the CQC on a relationship visit met colleagues from across the Urgent Care team. The inspectors reported good feedback - in particular, they said they heard leaders were visible and teams felt supported.

The Trust last had a full-scale CQC inspection in November 2017. The next one is expected over the coming couple of months. We are helping staff prepare including providing guidance of what to expect from an inspection of core service and how staff can show the great work and they have made.

In brief …

Magazine editorship. Congratulations to May Ng, who has been appointed the new co-editor-in-chief of Diabetes Care for Children and Young People, the journal for healthcare professionals caring for children and young people with diabetes. The e-journal is distributed free of charge to diabetes practitioners and to allied healthcare professionals.

Globetrotter Challenge. More than 200 staff from the across the Trust in 20 teams are taking part in our second annual Globetrotter Challenge. The event takes place through June and July and is a fun way for staff to improve their well-being, logging every day and sports activities to earn points that move them virtually around the globe. Teams will be reporting their progress on our staff Facebook page, The Meeting Place.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB109/19**	**Report Title**	**Vision 2020**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Therese Patten, Deputy Chief Executive/Director of Strategy		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

In 2018 the Trust developed and launched Vision 2020, a strategy that described our immediate improvement journey over the next two years. Vision 2020 consolidates all the improvement work that the Trust is embarked on and sets this within the context of our five year transformation programme.

2018/19 has been a year of stabilisation for the Trust. Our teams have worked hard to create the building blocks for improvement and sustainability. The achievements are positive, however, there is much more to do. The work is a foundation on which to build, helping create the climate needed to drive continued improvement and success.

During this next phase of Vision 2020, the Trust will consolidate improvements from Board to Ward with the aim of delivering the best quality care within the available resources. We have revised the strategic objectives and priorities for the year ahead, and so have reviewed the Single Improvement Plan and key high level performance indicators to ensure we can demonstrate consistent delivery.

Recommendation

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

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)*

Further progress updates to be brought to Trust Board on a monthly basis.

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
VISION 2020 REFRESH APRIL 19

1 Executive summary

In 2018 the Trust developed and launched Vision 2020, a strategy that described our immediate improvement journey over the next two years. Vision 2020 consolidates all the improvement work that the Trust is embarked on and sets this within the context of our five year transformation programme. The Single Improvement Plan is a means for NHS England (NHSE), NHS Improvement (NHSI) and the Care Quality Commission (CQC) to monitor our progress with the end objective being significantly improved performance across all our quality, operational and financial domains.

2018/19 has been a year of stabilisation for the Trust. The team have worked hard to create the building blocks for improvement and sustainability. Key areas of delivery have included:

- The appointment of a substantive leadership team
- A sustained focus on reducing mortality
- The delivery of CQC Must and Should do actions
- Reducing the deficit whilst investing in key services
- Establishing a clear strategic direction with focussed priorities

The achievement is positive, however, there is much more to do. The work is a foundation on which to build, helping create the climate needed to drive continued improvement and success. During this next phase of Vision 2020, the Trust will consolidate improvements from Board to Ward with the aim of delivering the best quality care within the available resources.

The Trust also continues to work on the development of a sustainable model for acute care with partners from across Southport, Formby and West Lancashire. This work programme aims to develop a solution for services within a three year timeframe, while Vision 2020 and the Single Improvement Plan direct delivery of more immediate objectives.

2 Introduction

The Trust catchment area is home to one of the oldest populations in the UK, with a higher than average number of people aged over 65 and 75. There is a higher than the national average number of care home beds per 1000 population and a higher than average number of nursing home beds per 1000 population. The Trust, therefore, cares for an exceptional population that is unique when compared to other similar acute providers. The statistics demonstrate not only the prevalence of older people, but also of the level of frailty and dependency of people in the community we serve.

The challenges of ageing include decline in physical, mental and social wellbeing, with increasing prevalence of comorbidities correlated with increasing age. The occurrence of malnutrition, falls, fractures, incontinence, heart disease, stroke, arthritis, dementia, dependency on carers, mental health and loneliness are but a few of the challenges faced by older people who we care for every day at the Trust. Therefore we have clearly aligned our Vision 2020 and unpinning in year priorities on developing services equipped and skilled to provide excellent care for older people.

3 Background

Southport and Ormskirk Hospital NHS Trust has had significant challenges in the recent past. A significant financial deficit puts it by percentage of turnover as one of the worst performing hospitals in the country and two consecutive CQC inspections found us lacking in terms of the consistent provision of even the most basic care. Strong, values based leadership has been lacking, and the significant changes and instability in the senior leadership team left a vacuum in terms of strategy and purposeful direction. The Trust was without a substantive Chief Executive for more than three years and in that period there was a successive number of interims filling this and other key executive positions.

The Trust is classed as a Challenged Provider and is in Segment 3 of NHSI's Single Oversight Framework. This is due to the financial performance and quality concerns described above. It means that the Trust does not comply with the conditions set out in its Provider Licence. In May 2018 the Trust agreed with the regulator, NHS Improvement, a set of undertakings which describe a range of outputs and outcomes with timelines for financial and operational improvement. The undertakings are described under the following categories:

- Quality improvement planning
- Financial sustainability and financial governance planning
- Performance management

Progress against these areas is scrutinised monthly through the Southport and Ormskirk Improvement Board, which has a membership drawn from NHSI, NHSE and clinical commissioning groups. Should the Trust not make sufficient progress, further regulatory action may be taken

During 2018/19 the Trust focused on stabilisation and was successful in recruiting a substantive Chief Executive, Chair and balanced Board. Significant work was been done developing Vison 2020, the Single Improvement Plan, and the governance processes to ensure rigor in quality, operational and financial management. This has set out a stable platform for improvement. As we begin 2019/20 we refocus our efforts and will build on this foundation to make progress on our journey towards sustainability.

4 Mission, vision and strategic objectives

Vision 2020 was launched in autumn 2018, is the road map that sets out how we will become a successful and sustainable provider of healthcare for local people. During the first three months of 2019 Trust Board has worked to refine the Vision and ensure that it fits within the context of a coherent mission. To that end our Trust mission statement has been restated as providing safe, high quality services for you and with you.

The four core themes at the heart of Vision 2020 remain, we will:

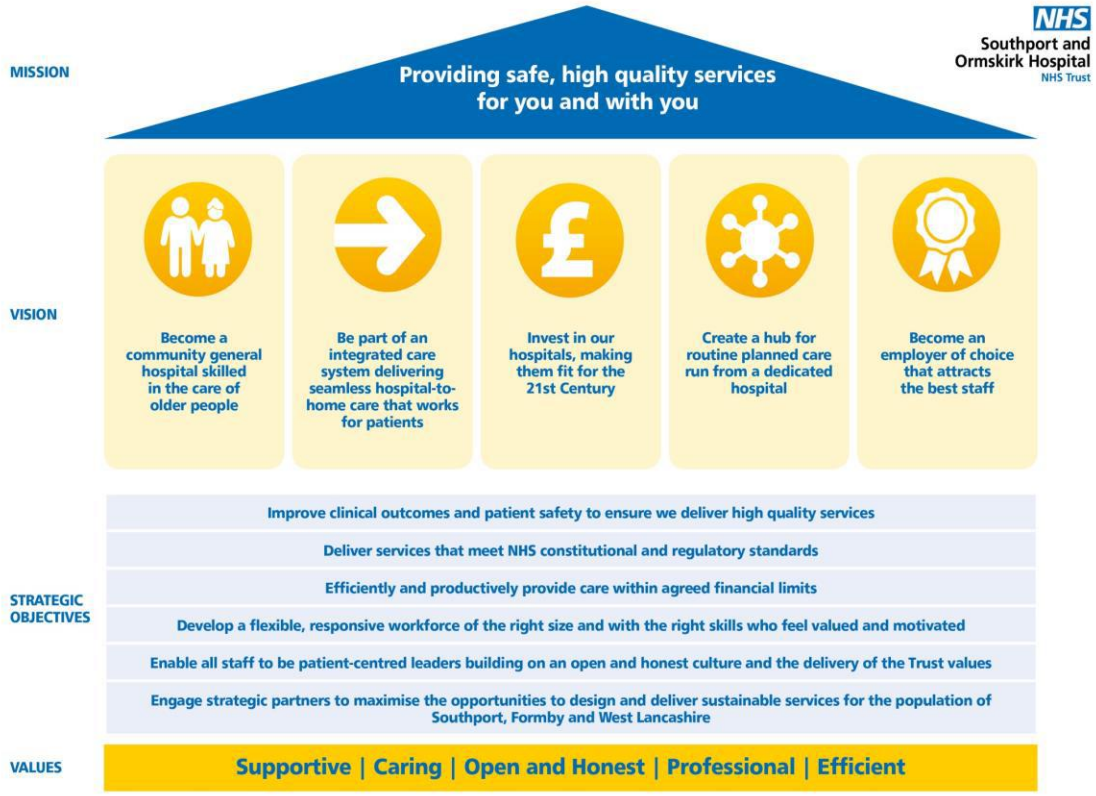
- Become a district general hospital with specialist skills in the care of older people
- Be part of an integrated care system delivering seamless hospital-to-home care that works for patients
- Invest in our hospitals, making them fit for the 21st Century
- Create a hub for routine planned care run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

We have now added a fifth theme: "we will become an employer of choice that attracts the best staff".

Our strategic objectives have been refined to reflect our mission and vision for 2019/20 they are:

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

Our mission, vision and strategic objectives are underpinned by the SCOPE values which were developed from what staff told us was important to them about the Trust. Our values are: Supportive, Caring, Open and honest, Professional; and, Efficient.



5 The Single Improvement Plan

The Trust is one of 16 organisations which have been selected for a more integrated joint approach from NHSE, NHSI, CCG commissioners and CQC aimed at supporting and overseeing improvement with the ultimate aim of enabling the Trust to exit the Challenged Provider (Sector 3) status and the remove the conditions on our Provider Licence.

A System Improvement Board chaired by NHSI has been in place since 2017. This Board has a regulatory oversight and assurance role, and ultimately will make the recommendation to NHSI/E Board on the removal of conditions and exit from the designation of Challenged Provider.

The principle of developing a Single Improvement Plan (SIP) was agreed with the System Improvement Board to ensure there is consistency and continuity in how it takes assurance against the Trust improvement journey. In April 2018 the Trust therefore developed a SIP which was the consolidated plan for all the improvement activities conducted during the year that contributed to the delivery of Vision 2020. The SIP set out the priorities, actions and timescales that the Trust needs to deliver to achieve its Vision. Now we have revised the strategic objectives and priorities for the year ahead, it is timely to review the SIP and present this with revised key high level performance indicators.

6 Operational Planning 2019/20

The Vision describes *what* we want to do and the Single Improvement Plan sets out *how* we are going to achieve it. We have set ourselves the task of making significant progress by 2020 and so have set out a number of stretching objectives that we will achieve within the next two years. Therefore, as part of the operational planning process for 2019/20, Trust Board has had a number of conversations to clearly describe the Trust priorities for the coming year, they were agreed as follows:

Quality

- Recognition and care of the deteriorating patient
- Care of the older person
- Infection prevention and control
- Medicines management

Operations

- Achievement of quality targets for ED, RTT, cancer and diagnostics
- Clinical documentation focus on accuracy, completion and safe storage

Workforce

- Culture – organisational development, staff engagement and Freedom to Speak Up
- Clinical workforce strategy to ensure the right numbers of skilled staff

Finance

- Deliver our control total
- Maximize capacity using transformative efficiency and productivity tools

Strategy

- Engage with partners to develop opportunities for joint working
- Develop an affordable, sustainable acute services model

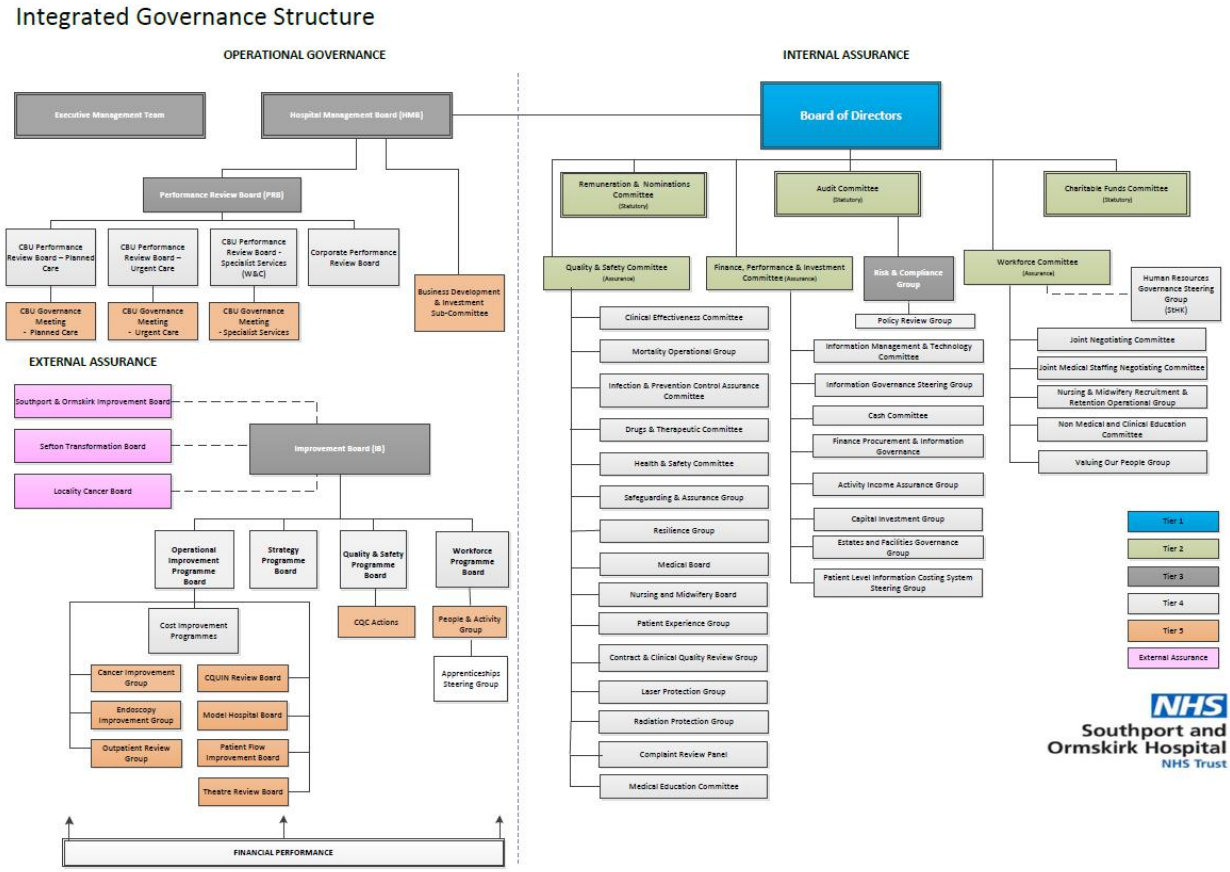
Each priority has a named executive lead that is responsible for delivering against the priority actions during the year. The headlines of the work programme for each area is described below and detailed action plans are attached at Appendix 1:

7 Trust and System Assurance

The Single Improvement Plan provides details of the key actions required to deliver Vision 2020 and the revised 2019/20 priorities. For the purpose of the System Improvement Board the plan identifies key actions, time-scales, control systems and high level metrics. The more detailed information beneath these actions is reviewed and monitored monthly through the Hospital Improvement Board by the Trust using the now established performance and accountability framework.

The Trust continues to improve its internal governance. To date, substantial work has been done on separating and aligning the assurance framework and operational delivery framework, and on the development of fully integrated governance structure shown below:

To further support this work, we have refined our Integrated Performance Report which provides the Board with assurance around key standards. The Integrated Performance Report is submitted to Trust Board Committees with onward reporting by exception to Trust Board. The development of the integrated reporting process continues as we develop our accountability framework, including performance management and reporting at the Clinical Business Unit (CBU) level, and integrate the Trust risk management process and governance framework.



8 Southport and Ormskirk Acute Sustainability Programme Board

The Acute Sustainability Programme aims to deliver transformation of sustainable acute services and care pathways for the populations of Southport and Formby and West Lancashire. The Trust has been running an Acute Sustainability Programme Board

fortnightly since May 2018. In February this year the Programme Board worked together to review governance structures and develop priorities for the year ahead. A new governance structure is now being implemented which comprises an Oversight Group and a Delivery Group, the objectives of which are described below:

The Acute Sustainability and Oversight Group will:

- Have oversight of the Acute Sustainability Programme
- Quality assure programme outcomes
- Address any systems and risk issues

The Acute Sustainability Delivery Group will:
- Grip the delivery and operational elements of the programme
- Provide assurance to the Assurance and Oversight Group

The objectives and deliverables are set out in the separate Acute Sustainability Programme.

9 Exit Challenged Provider

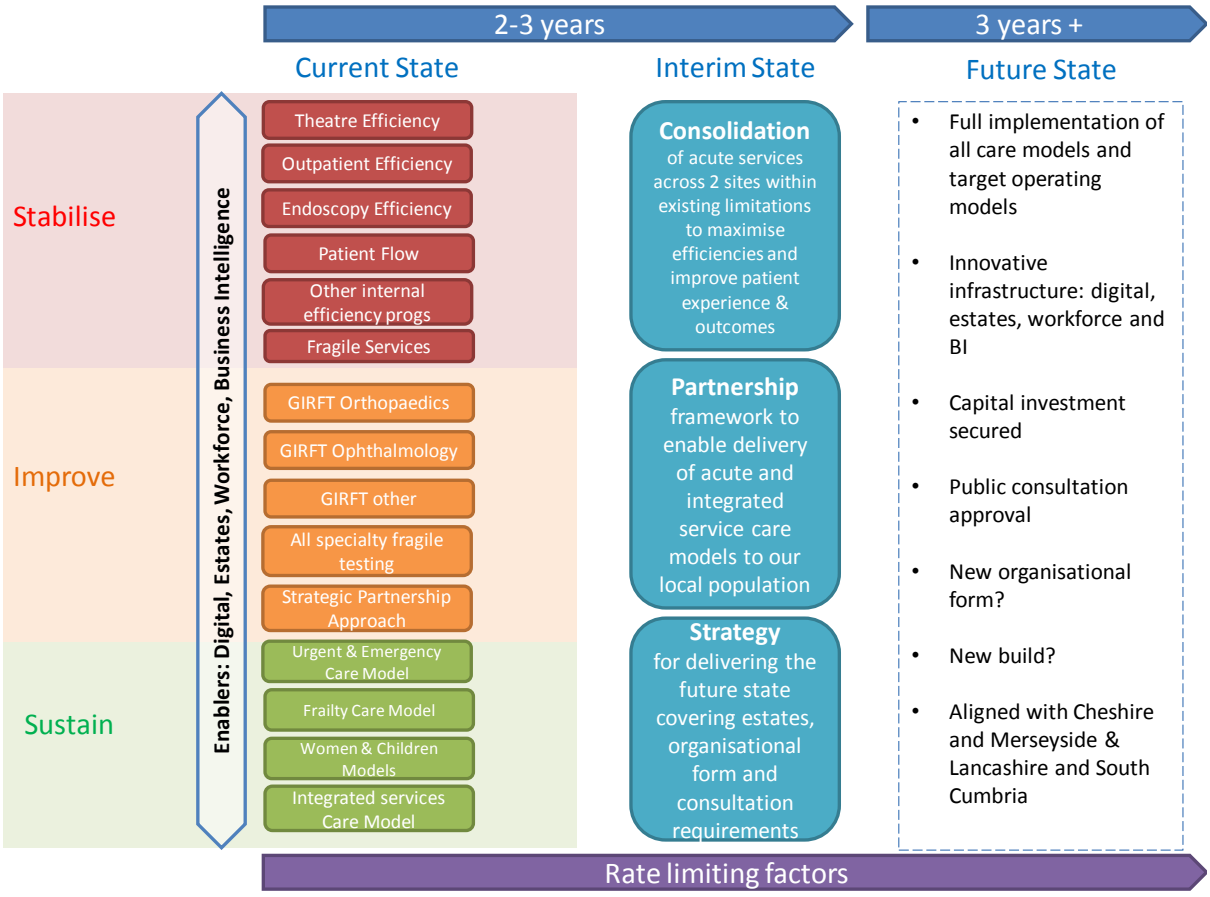
2019/2020 is a key year for removing the Trust's Challenged Provider status. We recognise the importance of this to our community, patients and staff in terms of building confidence and support for the future of our services. We aim to achieve removal of this status by addressing all the Undertakings on our provider licence. The forthcoming CQC Well Led inspection in 2019 will be a key part of this and in particular ensuring we have addressed all inadequate CQC ratings and regulatory actions.

The process for evidencing Trust progress against the ratings and conditions relating to the provider licence is expected to take up to 3 months following the publication of the CQC inspection report. During this period we will work with our regulators to demonstrate sustainable improvement and compliance against the provider licence. Key areas of consideration will include:

- Secretary of State priorities
- CQC inspection report March 2018
- NHSI Enforcement May 2018

10 Conclusion

As we move into 2019/20 it is important that we have clarity and a clear line of sight between our short term priorities and work plans and the strategic ones. The slide below represents our journey as we move towards a more efficient and effective interim state (driven by the Single Improvement Plan) and a final future state (driven by the Acute Sustainability Programme):



Appendix 1: Single Improvement Plan (below)

The following is the assurance template that will be used to provide regular updates on progress:

Vision 2020 Progress Assurance		
No.	**Critical Priority**	**Control System: Quality and Safety Group reporting to Hospital Improvement Board**
1. Quality	▪ Recognition and care of the deteriorating patient ▪ Care of the older person ▪ Infection prevention and control ▪ Medicines management	
Senior Accountable Leaders	**Juliette Cosgrove, Terry Hankin and Audley Charles (CQC)**	

Key Actions	**Outcomes**
Mortality improvement - external mortality review and Reducing Avoidable Mortality Group actions to be delivered across clinical workforce	Continue to deliver the Mortality Improvement Action Plan, including improvements in learning from deaths
Clinical education - development programmes across all roles including implementing new NMC Educational standards	Delivery of the related actions in the Workforce Improvement Plan
Quality improvement - focus on fundamentals including observations of care	Continuation of the delivery of the actions within the Quality and Safety Improvement Plan (previously the Quality Improvement Plan)
Professional standards - NMC process, NMP governance, roles & responsibilities for matrons & ward managers	Delivery of the related actions in the Workforce Improvement Plan
CQC – receive improved feedback following inspection and continue to move towards Good	Delivery against CQC Preparation Plan Delivery of 'must-do' actions
Complaints – improved complaints management and learning from feedback	Full review of processes and development of action plan
Risk management – improved risk management	Full review of processes and development of action plan
Patient experience - enhance feedback, develop volunteers, improve care within frail older peoples care	Improve feedback rates Deliver against the actions in the Care of Older People Programme Plan
Assured/most improved	
Not assured/most deteriorated	

Vision 2020 Progress Assurance		
No.	**Critical Priority**	**Control System: Operational Improvement Board, reporting to Hospital Improvement Board**
2. Operations	▪ Achievement of quality targets for ED, RTT, cancer and diagnostics ▪ Clinical documentation focus on accuracy, completion and safe storage	
Senior Accountable Leaders	**Steve Christian**	

Key Actions	**Outcomes**
Same-day emergency care - enhance the model in medical and surgical specialities, to be delivered 12 hours a day, seven days a week	Deliver actions in Patient Flow Improvement Programme Delivery Plan and achieve agreed trajectory
Length of stay - continued focus on reduction	Deliver actions in Patient Flow Improvement Programme Delivery Plan and achieve agreed trajectory. Average Length of Stay to not exceed 6.07 days (0.5 day reduction of average length of stay at year end – March 19 figures)
Ambulance handovers - zero tolerance of >60 mins delays and treatment in corridors	Deliver actions in Patient Flow Improvement Programme Delivery Plan and achieve agreed trajectory
RTT - no more than 1% of patients to wait longer than six weeks for a diagnostic test	Deliver actions in Endoscopy Improvement Programme Delivery Plan and Cancer Improvement Delivery Plan
Cancer - commence collecting the 28 day faster diagnosis standard to ensure key cancer deliverables are met	Deliver actions in Cancer Improvement Delivery Plan enabling each stage of the pathway to be no longer than 7 days
Assured/most improved	
Not assured/most deteriorated	

Vision 2020 Progress Assurance		
No.	**Critical Priority**	**Control System: Workforce Improvement Programme reporting to Hospital Improvement Board**
3. Workforce	▪ Culture – organisational development, staff engagement and Freedom to Speak Up ▪ Clinical workforce strategy to ensure the right numbers of skilled staff	
Senior Accountable Leaders	**Jane Royds and Terry Hankin**	

Key Actions	**Outcomes**
Improved Resource utilization	Improved recruitment pathways Improved temporary staffing utilization, through better rostering and activity management
Workforce	Delivery of the related actions within the Workforce Improvement Programme - recruitment, retention, new roles, new ways of working
Improved Job planning	Enable a robust annual job planning process, aligned to drive improvements in patient care and support sustainability of services
Clinical workforce strategy delivery	Delivery of the related actions within the Workforce Improvement Programme - succession planning, talent pipeline, future workforce, workforce planning and development of new roles
Engagement strategy delivery	Delivery of the related actions within the Workforce Improvement Programme - meaningful induction, board visibility and development programme, values and behavior compact, leadership development programme and retention plan
Assured/most improved	
Not assured/most deteriorated	

Vision 2020 Progress Assurance		
No.	**Critical Priority**	**Control System: Operational Improvement Programme reporting to Hospital Improvement Board**
4. Finance	▪ Deliver our control total ▪ Maximize capacity using transformative efficiency and productivity tools	
Senior Accountable Leaders	**Steve Shanahan**	

Key Actions	**Outcomes**
Financial controls – continue to control spend and deliver CIP	Spend contained within 2018/19 expenditure budget– Monthly agency spend reduces over the financial year in all staff groups CIP delivery of £6.3m current year effect (CYE) with at least £6m from expenditure reduction Delivery of control total and receipt of central non recurrent funding of £18.3 million
Capital plan – deliver planned investment programme focusing on IT, medical equipment and improvements to ward environments	Trust spend contained within its Capital Resource Limit (CRL) IT infrastructure in place to be able to deliver next stage of the IT strategy Essential medical equipment replaced in line with investment prioritised at Capital investment Group (CIG) Improvements to ward environments to a satisfactory level
Transformation – drive delivery of programmes including GIRFT, Model Hospital, theatre and outpatient efficiency	GIRFT – increase in productivity; consistent quality; better patient experience; reduced cost of joints Model Hospital – Medical - appropriate medical job plans; reduction in WLI's; – HR - improvement in "time to recruit"; improved retention rates; reducing reliance on agency – Estates & Facilities – Tender of car parking and catering; Portering capacity and demand analysis; catering efficiency Theatre Efficiency – productivity improvement; reduce late starts and cancellations; improve patient experience Outpatient Efficiency – reduce DNA rates; reduce waiting times; opportunity to reduce number of clinics
Assured/most improved	
Not assured/most deteriorated	

Vision 2020 Progress Assurance			
No.	**Critical Priority**	**Action**	**Control System: Acute Sustainability Board reporting to Sefton Transformation Board**
5. Strategy	▪ Engage with partners to develop opportunities for joint working ▪ Develop an affordable, sustainable acute services model		
Senior Accountable Leaders	**Therese Patten**		

Key Actions	**Outcomes**
Partnering strategy – develop a partnering strategy to enable a range of clinical and non-clinical development opportunities	New care models for: ▪ Frailty ▪ Urgent and emergency care ▪ Women and Children's services ▪ Elective care, and ▪ Integrated community services Fragility testing Framework for strategic partnerships Site configuration plans
Clinical service model – develop a comprehensive programme definition document which includes the blueprint, project portfolio, timescales and benefits of acute sustainability	System-wide enabling strategies for digital, estates and workforce Options for new models of organisation form Revised financial framework Pre Consultation Business Case
Assured/most improved	
Not assured/most deteriorated	

This includes an Integrated Performance report for the following Key Performance Indicators:

NHSI Improvement Metrics			
FNOF	Trust	90%	Percentage of FNOF operated on within 36 hours of admission.
VTE	Trust	95%	VTE risk assessment: all inpatient Service
Stroke	Trust	80%	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward.
EWS	Trust	8	The % overdue and breached observations for patients with EWS 5-6
Medication errors	Trust	tbc	Medication errors resulting in moderate harm or above
Patient flow	National	95%	A&E 4hr
Learning from deaths	Trust	n/a	% of deaths reviewed by month
NRLS	Trust	tbc	Count of incidents and % low or no harm
Safe staffing	Trust	95%	Safe staffing - nursing
WHO checklist	Trust	100%	WHO compliance
Falls	Trust	0	Falls resulting in moderate harm, severe harm or death
Sepsis	Trust	90%	Timely identification of sepsis in emergency departments and acute inpatient settings (ie. the rate of Sepsis Screening - CQUIN indicator 2a)
Sepsis	Trust	90%	Timely treatment for sepsis in emergency departments and acute inpatient settings (ie. the rate of rapid administration of antibiotics within one hour of diagnosis of sepsis - CQUIN indicator 2b).
Sickness	Trust	4%	staff sickness rate

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB110/19a**	**Report Title**	**Monthly Complaints, Concerns and Compliments Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Mandy Power, Assistant Director Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓ To Note ✓ To Receive	

Executive Summary

The report provides an overview of complaints, concerns and compliments received by the Trust in the month of April 2019.

Key themes included in complaints and concerns have been identified within the report.

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 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 ✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	✓ Statutory Requirement ☐ Annual Business Plan Priority ✓ Best Practice ✓ Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance ☐ Engagement and Communication ☐ Equality Finance	☐ Legal ✓ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

Complaints & Compliments

April 2019

1.0 Introduction

This report provides a breakdown on the number of compliments, complaints, concerns received in the month of April, 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 and attitude, staff availability & competence, also related to privacy & dignity.

The Planned Care CBU received the most compliments with 72 in total and eye clinic receiving 19 compliments in the month.

The Urgent Care CBU received 43 Compliments, with the Short Stay Unit receiving the highest number (11).

The Specialist Service CBU received 2 compliments, 1 for Delivery Suite & 1 Community Children's Nursing Outreach Team.

2.1 Complaints

The complaints data has been split in to low level concerns 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 CBU received the most complaints (14) followed by the Planned Care CBU who received 5, the Specialist Service CBU received 3.

The following themes were identified:

- Possible missed diagnosis
- Delay in treatment and ongoing referral
- Attitude of staff
- Communication
- Discharge
- Waiting times for operations and outpatients

All complaints are currently being reviewed within the business units and response and relevant actions are being put in place.

2.2 Concerns

There have been a total number of 45 concerns raised this month. Concerns related to unacceptable waiting times and requests for further information and advice.

3.0 Conclusion

The numbers of complaints and concerns are decreasing; some of the same themes are coming through. The themes are subject to going improvement work within the Trust

	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 Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB110/19a**	**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 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.

1.0 Mortality Data and Analysis

- Hospital-level Mortality Indicator (SHMI) – (Rolling) to December 2018 - 1.11
- Hospital Standardised Mortality Ratio (HSMR) – (Rolling) to December 2018 – 109.9
- Hospital Standardised Mortality Ratio (HSMR) in month for December 2018 – 98.3
- Disease-Specific Mortality Ratios – December 2018 – detailed herein

In Summary for May 2019:

- 12 month rolling SHMI up to December has been confirmed since the data run for this report at 1.1 or 111.1 which brings the Trusts mortality index within confidence intervals.
- National indicators continue on an improving trajectory with the HSMR (Rolling) at 109.9.
- Monthly HSMR remains at target, although system pressures experienced into 2019 are yet to be factored in. Encouragingly, crude mortality rates for Jan-March 2019 have not shown signs of increase above average levels.
- Sepsis performance remains strong, although AKI has deteriorated. Measures have been implemented and there is a plan and structure to aid recovery.
- The next step for disease specific investigation is non-pneumonic respiratory infection (LRTI / acute bronchitis) and urinary tract infection.
  Mortality screening rates have deteriorated in March, which likely reflects
  1. February changeover of junior doctors.
  2. Escalating system pressure from Spring 2019 onwards.

2.0 External Mortality Report Board Progress Assurance Report* (EMBAR).

3.0 Appendices

Appendix 1: Mortality Dashboard, March 2019
Appendix 2: Distribution Performance Graph, December 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
☐	**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)*

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 Mortality Data and Analysis

Executive Summary

In Summary for May 2019:

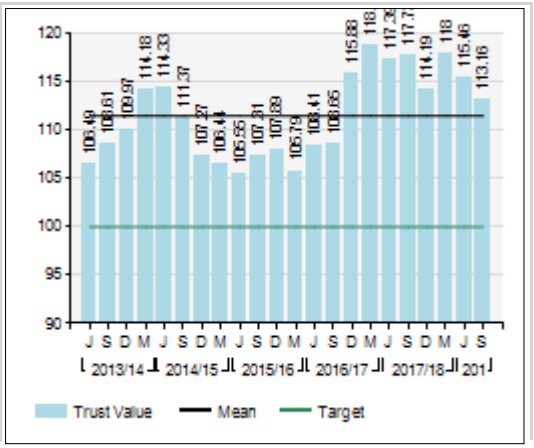
- 12 month rolling SHMI up to December has been confirmed since the data run for this report at 1.1 or 111.1 which brings the Trusts mortality index within confidence intervals.
- National indicators continue on an improving trajectory with the HSMR (Rolling) at 109.9.
- Monthly HSMR remains at target, although system pressures experienced into 2019 are yet to be factored in. Encouragingly, crude mortality rates for Jan-March 2019 have not shown signs of increase above average levels.
- Sepsis performance remains strong, although AKI has deteriorated. Measures have been implemented and there is a plan and structure to aid recovery.
- The next step for disease specific investigation is non-pneumonic respiratory infection (LRTI / acute bronchitis) and urinary tract infection.
- Mortality screening rates have deteriorated in March, which likely reflects 1. February changeover of junior doctors. 2. Escalating system pressure from Spring 2019 onwards.

Key national and local mortality indicators

	2018/19												Target
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Rolling 12 Month HSMR	121.2	120.6	118.3	117.5	116.0	114.8	112.8	111.7	109.9				*100.0*
Monthly HSMR	105.0	125.6	98.9	123.5	96.1	99.1	75.7	87.4	98.3				*100.0*
SHMI			115.5			113.2							*100.0*
Local HSMR Bronchitis	154.5	161.6	154.5	169.7	157.8	152.8	136.6	135.7	136.6				*100.0*
Local HSMR LRTI	155.9	163.0	155.9	171.2	159.1	154.0	137.6	136.5	137.5				*100.0*
Local HSMR Pneumonia	142.5	135.9	133.0	135.8	126.2	128.8	121.7	121.5	116.9				*100.0*
Local HSMR Septicemia	93.8	92.5	90.1	87.1	87.3	87.7	89.9	89.8	89.5				*100.0*
Local HSMR Stroke	135.4	136.6	127.7	123.5	126.1	114.8	107.9	109.6	109.9				*100.0*
Local HSMR UTI	131.6	127.5	126.1	125.0	112.6	116.4	114.9	122.0	116.8				*100.0*
Local HSMR Acute Renal Failure	121.5	109.0	108.0	108.6	104.2	96.8	96.1	106.4	126.7				*100.0*
Mortality Screens - %	106.76%	88.24%	90.77%	92.21%	72.73%	58.90%	53.45%	58.82%	50.62%	63.44%	61.67%	44.44%	*90.00%*
SJRs						33	21	13	7	13	4	8	*0*
2nd Review						0	2	2	0	2	0	0	*0*
In Hospital Deaths	74	85	65	77	66	72	59	69	81	94	60	72	*77*
In Hospital Deaths Crude Rate	30.4	29.0	22.2	26.6	21.1	22.2	17.4	20.6	24.4	27.4	19.2	21.5	*31.0*
LD Deaths	0	1	1	0	1	0	0	0	0	0	0	0	*1*
Steis Incidents	7	5	9	4	8	1	10	2	3	4	6	3	*5*

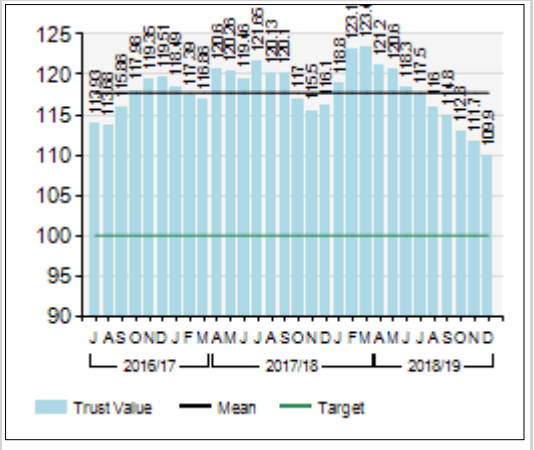
Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

SHMI - Summary Hospital Level Mortality Indicator



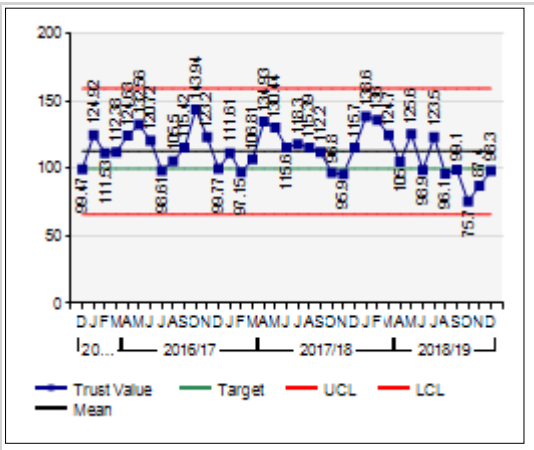
As the SHMI is released quarterly, the narrative for this aspect is similar to the previous month's reports. The general trend is one of improvement. The drivers for this are improvements to patient flow and improved depth of coding of comorbidity (accurate representation of the health of the population treated. The persistently lower than average crude death rate in this context also suggests either an improvement in care or earlier discharge with death occurring in the community, or both. As SHMI includes deaths within 30 days of discharge this aspect should be controlled for in subsequent releases. We are due the next quarterly release.

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



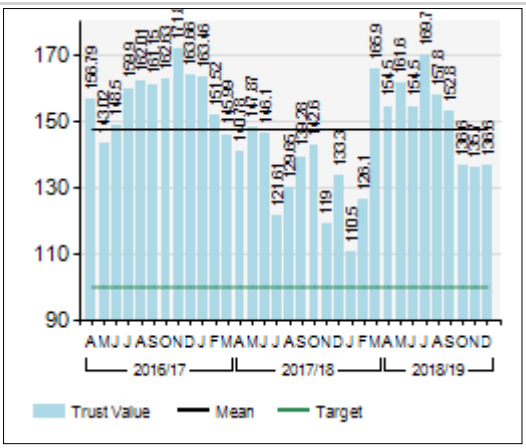
Rolling HSMR continues its improving trajectory. As this is averaged over 12 months, changes are only reflected with persistent month on month improvement. The current HSMR of 109.9 is the lowest recorded in recent history. This figure is expected to improve in line with the monthly HSMR (see below) as the figures average out over time. As previously, this is being driven by the improved recognition of palliative care (which is excluded from HSMR), both clinically and from a coding perspective. Improved flow (as HSMR includes in-hospital death only) and improved recognition of co-morbidity.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



With the measures discussed above implemented, we are seeing our monthly HSMR staying either at the expected position of '100' or performing better than this (a figure below 100 reporting less observed deaths than expected in the HSMR model). Vigilance is required with respect to identification and documentation of co-morbidity and whole-system performance with respect to patient flow to maintain this position. Supporting clinical staff to provide prompt, senior led, response to serious illness is also key in maintaining this position.

Local HSMR Bronchitis

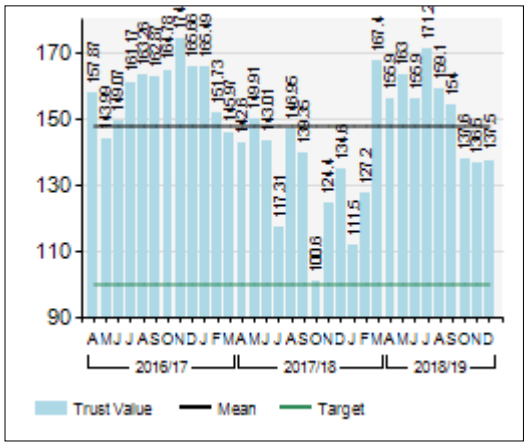


As reported previously, LRTI and Acute Bronchitis are low risk conditions that feature highly in the coding of admissions to the hospital of patients who subsequently die. These diagnoses are taken from the first or second 'finished consultant episode'. The inference drawn from this is that patients are dying from LRTI and acute bronchitis when they should not be. Other possibilities are:

1. That the diagnosis is incorrect – possibly due to the lack of availability, or use, of diagnostic tests (pro BNP for heart failure for example).
2. That the underlying disease process is not recorded as the primary problem (advanced ALD for example).
3. That other significant life-shortening illness is not part of the statistical model (such as advanced frailty).

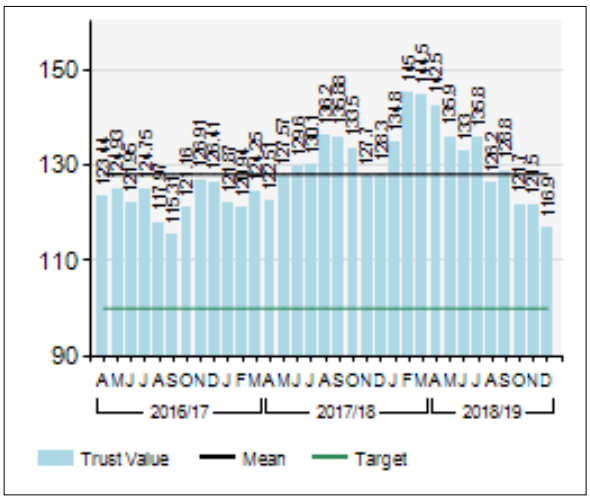
A case record review is needed to answer these questions, but this is delayed due to competing priorities.

Local HSMR Lower Respiratory Tract Infection



See Bronchitis.

Local HSMR Pneumonia



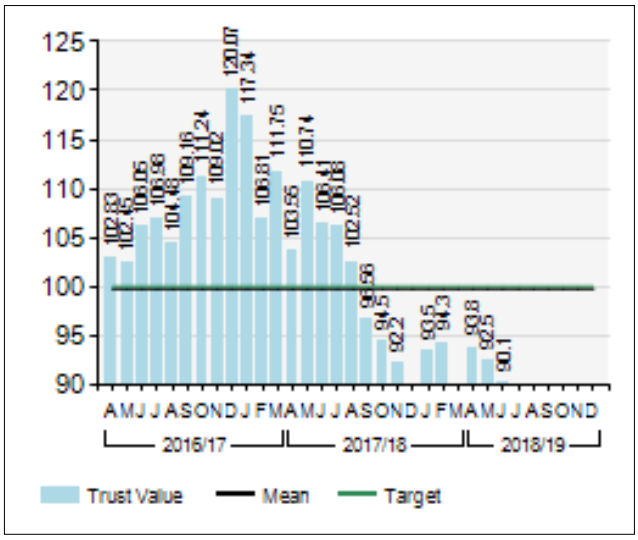
HSMR for pneumonia is sequentially reducing. The current HSMR is the lowest since 2016. Pneumonia is a commonly diagnosed condition in general and frequently at the end of life in a frail, elderly population. The drivers described in the general hospital HSMR are relevant here due to its frequency. Pneumonia is an x-ray diagnosis in hospital, therefore it is subject to a degree of interpretation and conformation bias. Treatment of pneumonia when the diagnosis is inaccurate or underlying conditions, such as CCF, are undiagnosed can be detrimental. The pneumonia pathway (available electronically or in paper form on every orange trolley) advises on diagnostic tests, risk assessment, antibiotic selection and criteria for escalation.
Clinical performance is measured by AQ.

Data up to Feb 2019, red = target not met:

Pneumonia			PN-01	PN-02	PN-03	PN-04	PN-05	CPS
Code Provider		Target	Oxygen Assessment within 4 hours of arrival	Chest x-ray within four hours of arrival	Initial antibiotic received within 4 hours of hospital arrival	CURB-65 recorded (was NHS-50)	Appropriate antibiotic selection (was NHS-34)	COMPOSITE PROCESS SCORE
RVY	Southport	90.8%	100.0%	78.9%	95.0%	62.1%	100.0%	85.2%

Areas for improvement are therefore x-ray performance and recording CURB-65. Work is planned to address x-ray requesting, use of the pneumonia pathway will improve CURB-65 compliance.

Local HSMR Septicemia



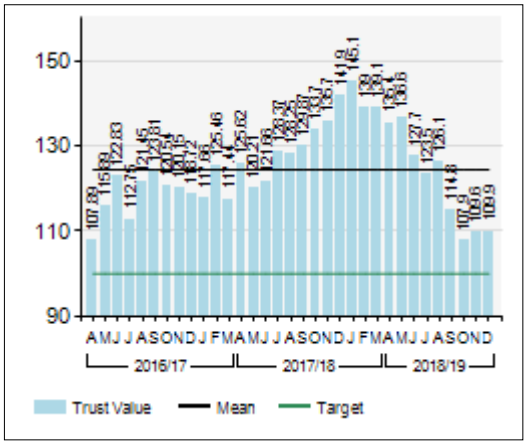
Sepsis mortality rates have been stable and improved for over 12 months. This position appears to be sustained. Vigilance must be maintained as one possible explanation would be that the condition is either under-recognised in sick patients or over diagnosed in well patients. Systems in sepsis are encouraged to treat and de-escalate after senior assessment.

Clinical sepsis performance is monitored by AQ. The data up to February 2019 is presented below, red signifies target not met:

SepsisNEWS			SEPSIS-11	SEPSIS-12	SEPSIS-13	SEPSIS-14	SEPSIS-15	SEPSIS-16	SEPSIS-17	CPS
Code Provider		Target	National early warning score (NEWs) recorded within 1 hour of hospital arrival	Blood cultures taken within 1 hour of sepsis diagnosis	Antibiotics administered within 1 hour of sepsis diagnosis	Serum lactate taken within 1 hour of sepsis diagnosis	IV fluids commenced within 1 hour of sepsis diagnosis	Senior review within 2 hours of sepsis diagnosis	Care pathway commenced following sepsis diagnosis	COMPOSITE PROCESS SCORE
RVY	Southport	75.0%	100.0%	72.5%	84.3%	80.0%	96.2%	39.2%	60.8%	77.5%

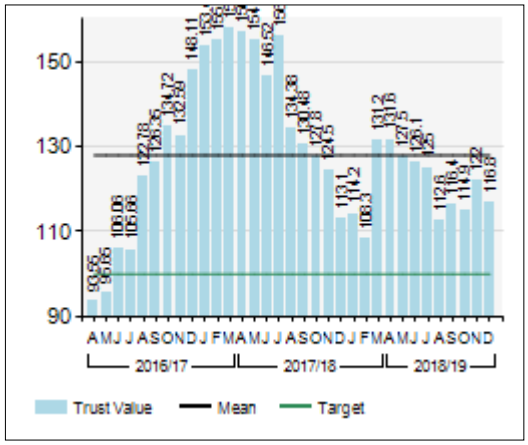
Clearly, the areas of work are increasing senior review within 2 hours, pathway usage and blood cultures within the first hour. Of note however; we are the second best performing trust in the region for blood cultures and pathway completion; and our senior review figure compares with a regional average of 46.5%. This reflects the capacity / demand experienced by all acute providers.

Local HSMR Stroke



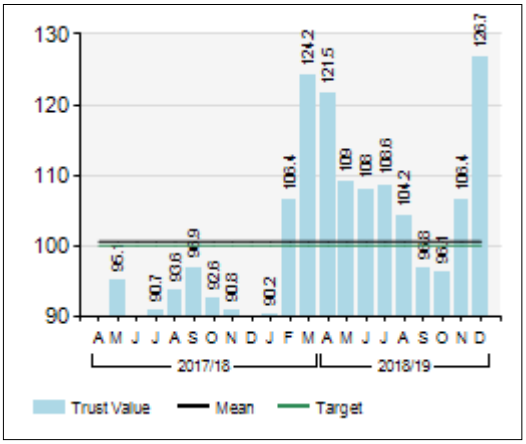
Stroke mortality is lower than reported historically, but the improvement has plateaued. It is known that the HSMR model does not fully account for the high risk variables in acute stroke (such as CT appearance and Atrial Fibrillation as the cause) and the annual report of the stroke specific sentinel national audit project is awaited. However, this situation must be kept under review and action taken should the situation deteriorate.

Local HSMR Urinary Tract Infection



Urinary tract infection will form the next area of clinical focus following the completion of the review of LRTI and Bronchitis. While the HSMR for urinary tract infection is lower than previously, it is showing signs of plateauing outside of the acceptable range. As stated in previous reports, it is likely that this is an over-diagnosed condition. It is also a diagnosis frequently made in frail, elderly populations, and often at the end of life. The focus of improving care around patients with UTI is to remove urinary catheters proactively, maintain and encourage hydration, maintain continence and maintain mobility.

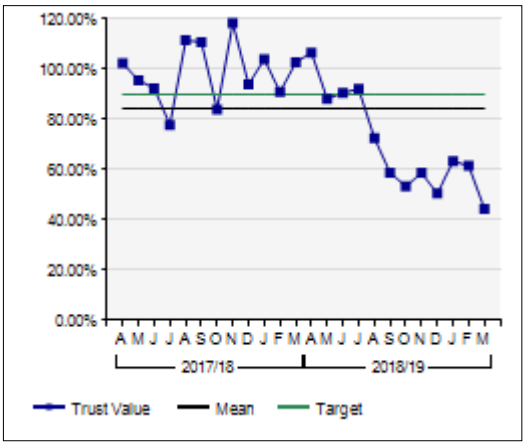
Local HSMR Acute Renal Failure



AKI mortality had shown considerable improvement towards the end of 2018. This has not been sustained, and the December HSMR is significantly elevated. Caution must always be exercised when interpreting a single monthly HSMR, especially disease specific, as the numbers are frequently small. However, AKI is already recognised as a significant issue, leading to the formation of the AKI steering group. Various changes to practice and process have been implemented since the data reported in order to improve performance. The most significant of which is the 24/7 Critical Care Outreach Team (live since April 2019) and the receipt of AKI alerts twice a day by this team. Outreach follow up all AKI stage 3. Less severe AKI is alerted to the parent treating teams. The AKI steering group is leading efforts to improve AQ performance, which is summarised below up to Feb 2019.

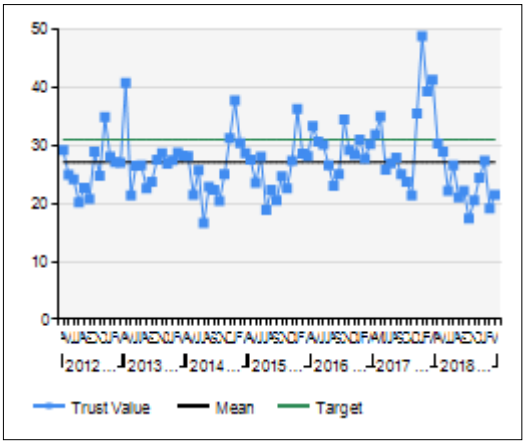
AKI			AKI-01	AKI-02	AKI-03	AKI-04	AKI-05	AKI-06	AKI-07	CPS
Code Provider		Target	Urine dipstick test within 24 hours of 1st AKI Alert	Stop ACE inhibitors and ARBs within 24 hours of 1st AKI Alert	Serum creatinine test repeated within 24 hours of the 1st AKI Alert	Ultrasound Scan of urinary tract within 24 hours of 1st AKI Alert	Specialist Renal or Critical Care Discussion within 12 Hours of 1st AKI 3 Alert	Written self-management information prior to discharge	Pharmacist Medication Review within 24 hours of 1st AKI alert	COMPOSITE PROCESS SCORE
RVY	Southport	57.6%	58.6%	100.0%	63.3%	7.7%	8.3%	68.4%	26.7%	57.1%

Mortality Screens - % Deaths Screened



Mortality screening rates have declined to 44% in this month's report. This is disappointing given the previous months improvement to over 60%. The pressures within the system place strain on the medical staff, leading to certain tasks receiving a lower priority. This is reflected in all levels of organizational governance, and reflects the conditions all are working under. Work is under way to engage with the junior medical teams to make this process as simple and easy as possible, while emphasizing that it is a crucial and necessary foundation for organizational learning.

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



Crude mortality is thus far staying below the historical average. We have also not seen a repeat of the significant spike in crude mortality at the end of 2017. The factors that underpin this have been summarized earlier in this report, but include patient flow, staffing levels, systems, process and staff engagement

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

EMBAR
The 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
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	Update 20th May 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	5%	G	This is the objective of the Patient Flow Improvement Programme Board (delivered by Length of Stay Work Streams).	**The objectives of the Patient Flow Improvement Programme were reset at the beginning of May 2019 with initial targets set for October 2019, ahead of the winter.** **Work Stream 1 - Improving Emergency Department and Assessment Units Services** To ensure that front door services and ambulatory care have the configuration and pathways in place to effectively manage increasing patient numbers within the required target times by October 2019. (To ensure that targets for: ambulance handover, time to triage, the A&E 4 hour standard for majors and minors and aggregated A&E patient delay times are reached). **Work Stream 2 - Standardisation of Best Practice Ward Processes to Reduce Length of Stay** To identify and standardise best practice to reduce the average length of stay, reduce the number of stranded and superstranded patients and increase the number of patients discharged before 12 noon.
		a.	Alternative to admission	Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams					5%	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.	The Trust is now working with Strata Health (patient flow network solutions) to deliver opportunities for improvement. Strata Health deliver critical change in patient flow practices by redesigning pathways, providing data insight and focusing on activity to drive admission avoidance and improve discharge pathways. They are already working in collaboration with the STPs to find cohesive system-wide solutions.
		b.	Criteria led discharge	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.					10%	G	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.	The Trust's "Discharge / Transfer of Care Policy" is to be revised to support the processes and culture required to deliver criteria led discharge. A move from clinical criteria led discharge to criteria led discharge will support non-medical staff to expedite the safe discharge of patients.
		c.	Proactive escalation planning	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.					90%	A		The Trust's National Early Warning Score 2 (NEWS 2) Track and Trigger System Operational Policy is awaiting final ratification through the Trust's governance process. via the Clinical Effectiveness Committee. The policy provides guidance to staff on the track and trigger systems that have been introduced to enable clinical staff to identify patients at risk of deterioration and empower them to ask for appropriate support and intervention. Physiological variables are assigned scores which increase with worsening abnormality. There are trigger scores that mandate referral to medical staff or the critical care outreach team (CCOT).
		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.					50%	A		"Long Stay Tuesdays" are to be fully reinstrated (multi-disciplinary activity involving Therapies and Community Partners to expedite the discharge of stranded and superstranded patients are to given additional focus to ensure consistency and attendance).

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Status Update 29th March 2019	Update 20th May 2019
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 detailed within 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.	AKI is biggest issue from an AQ perspective. The Trust now has a dedlcated AKI Steering Group which meets once a month to drive targeted activity. Since January, daily automated alerts of new cases of AKI are sent by the Medway Team to both the Critical Care Outreach Team and the Pharmacy Team. The new 24/7 Critical Care Outreach Team is now reviewing patients with AKI level 3. These improvements should be reflected in the next biannual report from the Advancing Quality Alliance (AQUA) in October 2019. A revised AKI pathway was finalised April 2019. The Trust's Clinical Education Lead is working with the Associate Director for Patient Safety to incorporate AKI, Sepsis and Pneumonia Care Pathways into the training programmes for junior doctors.
	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.	In line with the AQUA AQ data set; we are performing well in relation to our peers however ongoing areas of challenge include: performance of blood cultures within an hour of diagnosis and senior review within two hours. The most up to date AQ data reports on acitvity up to February 2019; we expect to see improvement going forward reflecting the impact of the increased cover of the 24/7 Critical Care Outreach Team. The Trust will be attending the next AQUA Sepsis Collaborative in June 2019. As detailed above, the Trust's Clinical Education Lead is working with the Associate Director for Patient Safety to incorporate AKI, Sepsis and Pneumonia Care Pathways into the training programmes for junior doctors.
		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 & 2		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.	As detailed above, the Trust's Clinical Education Lead is working with the Associate Director for Patient Safety to incorporate AKI, Sepsis and Pneumonia Care Pathways into the training programmes for junior doctors.
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	Audits of ward cover are being undertaken in order to provide a baseline to inform the required review.	Audits of ward cover are being undertaken in order to provide 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.	The Electronic Board Round is to be piloted on medical ward 11B in June. Board Rounds are to be discussed with surgeons as part the principle of good job planning and the distribution of senior cover.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Status Update 29th March 2019	Update 20th May 2019
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%	A	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. 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.	Documentation is one of the Trust's four main Quality priorities. Meetings are currently underway across departments to ensure that the scope of the programme is robust, appropriate and deliverable. The BRAG status is currently amber as the collective agreement of the scope has been subject to debate and there has been a change in clinical lead; additional PMO resource is being temporarily assigned to manage the required pace of delivery. Compliance with professional standards will be a key component of the delivery of quality improvement, alongside the review and revision of documentation.
	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%	A		
	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%	A		
	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%	A		
	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	20%	G	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.	Audits are undertaken monthly and findings are consistent with feedback relating to the required resource to deliver. Activity to ensure compliance is to be driven by nursing leads in line with the clear pathways of the NEWS2 policy.
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).	The Trust's National Early Warning Score 2 (NEWS 2) Track and Trigger System Operational Policy is awaiting final ratification through the Trust's governance process via the Clinical Effectiveness Committee. The policy provides guidance to staff on the track and trigger systems that have been introduced to enable clinical staff to identify patients at risk of deterioration and empower them to ask for appropriate support and intervention. Physiological variables are assigned scores which increase with worsening abnormality. There are trigger scores that mandate referral to medical staff or the critical care outreach team (CCOT). The VitalPac Team have reported that NEWS2 is live throughout the Trust since March 2019. Areas without VitalPac have all relevant paperwork in place.The exceptions are A&E and Paediatrics for which there is an expected delay to the planned July roll out attributable to a delay to funding.
	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	Update 20th May 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	Completed and closed
	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.	A targeted training programme is being developed as part of the Future Care Planning workstream of the Older Peoples' Care Programme. The findings of the National Audit of Care at End of Life are informing and supporting the case for Advanced Care Planning and the Anticipatory Clinical Management Planning model.
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.	It has been identified that additional training and awareness is required to support the review of deaths which dropped in March to 44%. Work is under way to engage with the junior medical teams to make this process as simple and easy as possible, while emphasising that it is a crucial and necessary foundation for organizational focus. While enough reviewers have been trained further work is being undertaken to review the Mortality Policy.
	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.	The process to diseminate lessons learned through the Mortality and Morbidity Meetings continues to be developed. The Associate Medical Director for Patient Safety is working with the Clinical Lead for Education to incorporate lessons learned disemination through the junior doctors training programme. The AMD for Patient Safety, Clinical Lead for Education and Head of Risk are to meet to discuss the development of governance processes and policy.
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.	The Trust is currently out to advert for a specialist Diabetic Nurse.
	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.	The Trust has one Pain Specialist Nurse who covers both acute and chronic pain. Dr Holden, Clinical Lead for Education is working on a basic guidance for the standardised prescription of analgaesics.

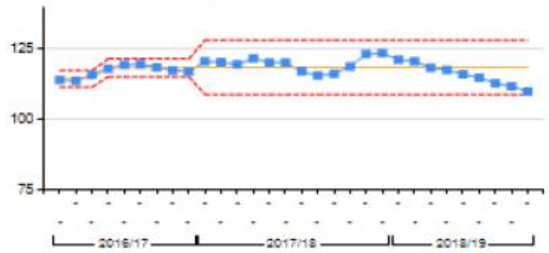
4.0 Appendices Appendix 1: Mortality Dashboard –

Southport & Ormskirk NHS Trust
Mortality Dashboard May 2019

Southport & Ormskirk Hospital NHS
NHS Trust

Dr Foster National Mortality Statistics *Trust Mortality Statistics*

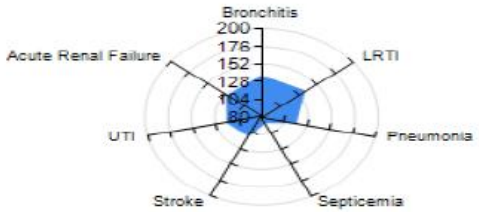
Rolling 12 Month HSMR



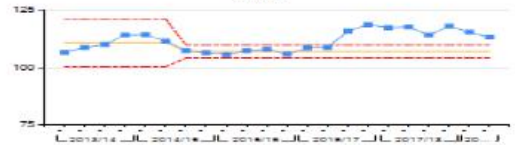
Latest Data Available

UCL and LCL are reset when 6 consecutive periods are above or belowthe mean.

Local HSMR December 2018/19



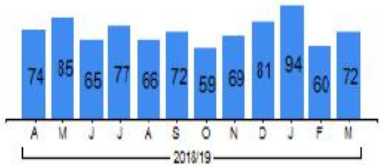
SHMI



UCL and LCL are reset when 6 consecutive periods are above or belowthe mean.

Latest Data Available

In Hospital Deaths



YTD Deaths of Patients with Learning Difficulties: 3

0.34%

YTD Deaths of Patients with GSF Alert: 167

19.1%

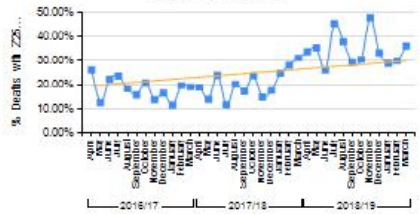
Deaths Post Discharge

Avg Spell LOS whilst admitted: **16**

Avg Days to death post discharge: **13.4**

YTD Deaths of Patients with GSF Alert: 169 — **33.7%**

Palliative Care Coding %



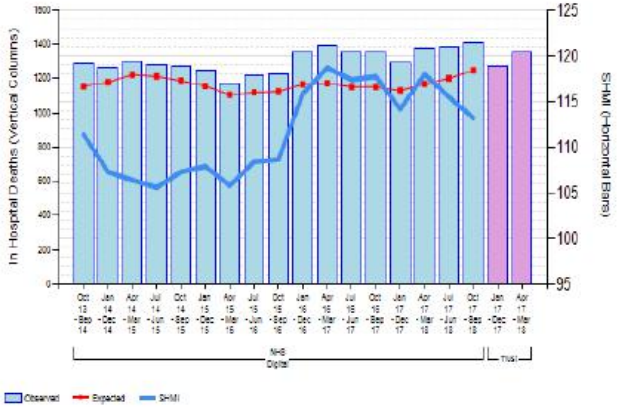
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last

Primary Diagnosis Name	This Month	
Lobar pneumonia, unspecified	9	▼
Sepsis, unspecified	8	▲
Pneumonia, unspecified	5	▲
Pneumonitis due to food and vomit	4	▼
Cerebral infarction, unspecified	3	▲

Mortality Reviews

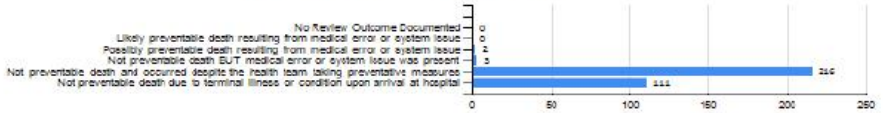
	2018/19											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reviews Completed	79	75	59	71	48							
Reviews %	106.8%	88.2%	90.8%	92.2%	72.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

SHMI Breakdown



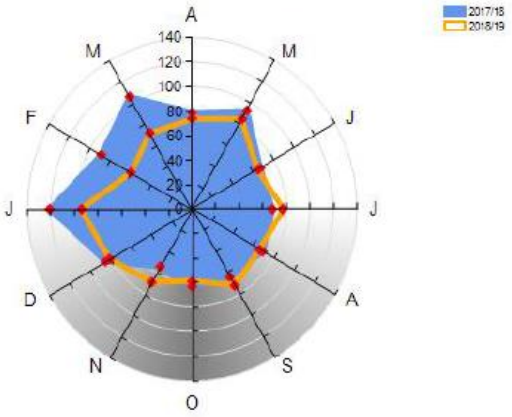
Southport & Ormskirk Hospital NHS

Mortality Review Outcomes - Last 12 Months

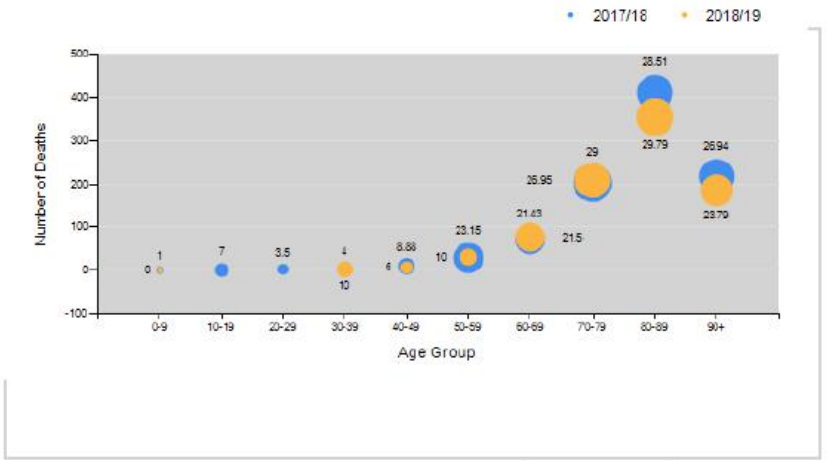


This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).
This should give an indication of the SHMI although the number of expected deaths for the recent periods is unknown.

In Hospital Deaths Seasonality Distribution

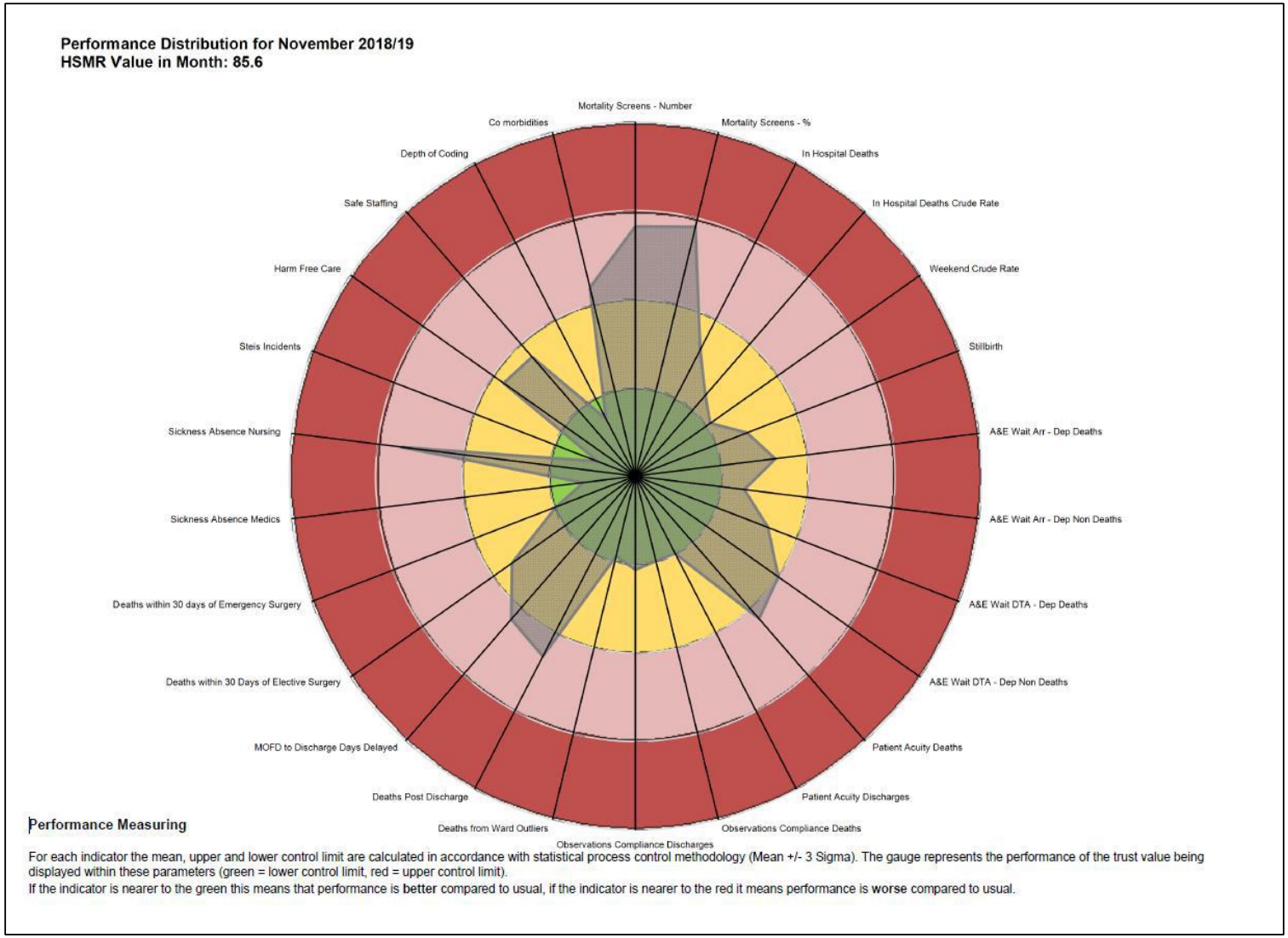


In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



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,



Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB110/19**	**Report Title**	**Quality Improvement Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Paul Jebb, Deputy Director of Nursing Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper provides Trust Board with an update on the progress of the Quality Improvement Plan and progress made in relation to actions and recommendations relating to the Quality Priorities.

Recommendation

Trust Board is asked to **receive t**he report for assurance.

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

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)*	
Board of Directors	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

NHS
Southport and Ormskirk Hospital
NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE MAY 2019

1. PURPOSE OF REPORT

This paper provides the Quality and Safety Committee with an update on the progress of the Quality Improvement Plan and progress made in relation to actions and recommendations relating to the Quality Priorities

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.

The quality strategy has been developed (appendix 1) this highlights the process to which the Quality Priorities were identified and the leads have worked with the PMO to develop KPIs.

3. DEVELOPMENT OF THE TRUST QUALITY IMPROVEMENT STRATEGY

The draft strategy (appendix 1) details our approach to continuously improving the quality of care we deliver.

In the last 12 months our staff have delivered a wide range of improvements and demonstrated just how committed they are to delivering the best standards of care and support for our patients, families and carers, however we can achieve more if we develop a more systematic approach, nurture learning and improvement culture and support our staff in leading improvement and the use of improvement tools and techniques through training and development.

This strategy shows our continuing commitment to delivering care which is safe, effective, caring, responsive and well-led. It translates this commitment into a clear direction and focus which everyone can work towards. It sets out how we will support the delivery of our priorities including roles and responsibilities, governance, improvement tools and individual delivery plans for each priority.

We have also identified how we will measure and review improvement through individual metrics and measures which will enable us to understand progress and inform future priorities.

There are areas of best practice and excellent patient care across the organisation. However, this is not consistent and we recognise that addressing variation is a significant part of our improvement journey.

This new strategy outlines the Trust's desire to increase the quality improvement expertise across our workforce and further develop a culture of continuous improvement.

4. CARE OF OLDER PEOPLE

The care of older people quality improvement programme encompasses a range of projects formulated to improve the direct clinical care delivered to patients in the specific areas of Dementia and Delirium, Nutrition, Hydration and Mouth Care, End of Life Care, Falls, Continence, creating an enabling environment and, Discharge pathways and flow. There are specific project groups formed and in the process of forming to develop and deliver the required improvements with agreed KPIs and governance structures to assure and monitor the progress of the programme. The programme has gained projects continually and will continue to grow as areas for improvement are identified along with the necessary KPIs to evidence improvement.

Current KPIs include:

Hospital Acquired Pressure Ulcer (Grade 3 & 4)	Progress continues to reduce HAPU with no incidents during March 2019 - The team have been part of the NHSI Pressure Ulcer Collaborative, improving care for patients with plaster casts. The team were awarded 'Best project to be adopted across the NHS'.
Falls	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 alongside an educational session to raise the profile of falls awareness and prevention to all nursing staff.
Fracture Neck of Femur	Performance improved significantly in March and almost achieved target. Consultants 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
Stroke – 90% stay on stroke ward	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 an impact on available stroke beds due to no protected bed and the subsequent boarding of additional patients

In May we launched the new education module for all registered staff on 10B incorporating a new care plan aligned to new Malnutrition policy with enhanced dietetic support for staff & patients.

New clinical guidelines relating to Dementia & Delirium have been approved; this included the roll-out of new care plan and assessment pathway which will commence in early June 2019.

Five staff from across the MDT attended the 'Mouth Care Matters' ' train the trainer' programme and will commence a Quality Improvement Project on mouth care provision across the Trust.

5. CARE OF THE DETERIORATING PATIENT

The Care of the deteriorating patient quality improvement programme encompasses a range of projects formulated to enhance the care of those people whose condition deteriorates to improve the outcomes of care. This includes management of specific conditions i.e. sepsis and pneumonia, screening of deaths, mortality, observation management, referrals to critical care outreach team, VTE risks assessments and WHO checklist compliance.

Current KPIs include:

WHO Checklist	Performance remains at 100% compliance for March 2019 - Checklist audits continue
VTE Prophylaxis Assessments	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.
HSMR	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.
SHMI	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.
Percentage of Deaths Screened	Compliance stable 60-70% - 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.
Sepsis – timely identification	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	The Trust is compliant - 23 out of 25 patients received antibiotics within one hour 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

6. INFECTION PREVENTION AND CONTROL

The infection prevention and control quality improvement programme will focus on several areas including development of governance and compliance of IPC standards, Communications, Engagement & Education, Anti-Microbial Prescribing, Isolation, Cleanliness and environment, monitoring and Assurance.

Current KPIs include:

C-Diff	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.
E. Coli	Number of E. coli cases reduced from 32 in 2017/18 to 26 in 2018/19 - In March the Trust reported 3 cases of E. coli bacteraemia; these cases were on 11B(1) and RSIU(2). The first case was related to a patient with alcoholic liver disease and ascites with a hepatobiliary source and the RSIU cases were related to long term catheters. One of the RSIU cases was likely due to the patient not following the advice provided when away from the unit in a social setting and the 2nd case all precautions and care were provided and no lapses were identified. Each of the patients were reviewed by their respective clinical teams in collaboration with the consultant microbiologist and treatment was prescribed and was effective. There are a number of initiatives occurring throughout the Trust with respect to nutrition and hydration - the latter being an important part in reducing UTIs, also the IPC team is including in its monthly monitoring/audits catheter care plans. Each patient who has a catheter also receives a catheter passport.
MRSA	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.

7. MEDICINES MANAGEMENT

The medicines management quality improvement programme will focus on several areas including medicines governance, service delivery plans, performance improvement around in relation to medicines optimisation, ward based processes around safe medicine handling. KPIs are to be developed and will be part of the improvement plan.

The Chief Pharmacist has worked with the PMO lead to develop key milestones these include:

Weekend service	Review weekend service and A&E support and produce a SOC for each of these issues as appropriate with executive support to ensure development of 7 day services Engage with Deputy Director of Pharmacy NHSI re Pharmacy staffing review by October 2019
Pharmacy accommodation / stock control	Agree a plan to have one major site at SDGH for Pharmacy and one replacement robot with a satellite dispensary at ODGH. This will include short term solutions for compliance with the Falsification of Medicines Directive (FMD) and long term full replacement of the current robots
CIP/Stock management	Continue to monitor CIP along with relevant medicines usage with key focus on top 10 medicines Continue to monitor stock turnover with internal KPI based on the Model

	Hospital formula with an aim to remain at 21 days stock turnover with the current configuration of sites.
System working across wider ICS	Continue to work with Cheshire and Mersey HCP (STP) Steering group with the use of Patients Own drugs (PODs) data collection and outcomes.
administration of medicines and medicines management	Implement the ward 7A pilot for administration of medicines and medicines management support by a Pharmacy Technician planed through June – September 2019 and the review of EAU SOP for ward based Technicians by August 2019 (action plan ongoing for all ward based Technician activities)

8. RECOMMENDATIONS

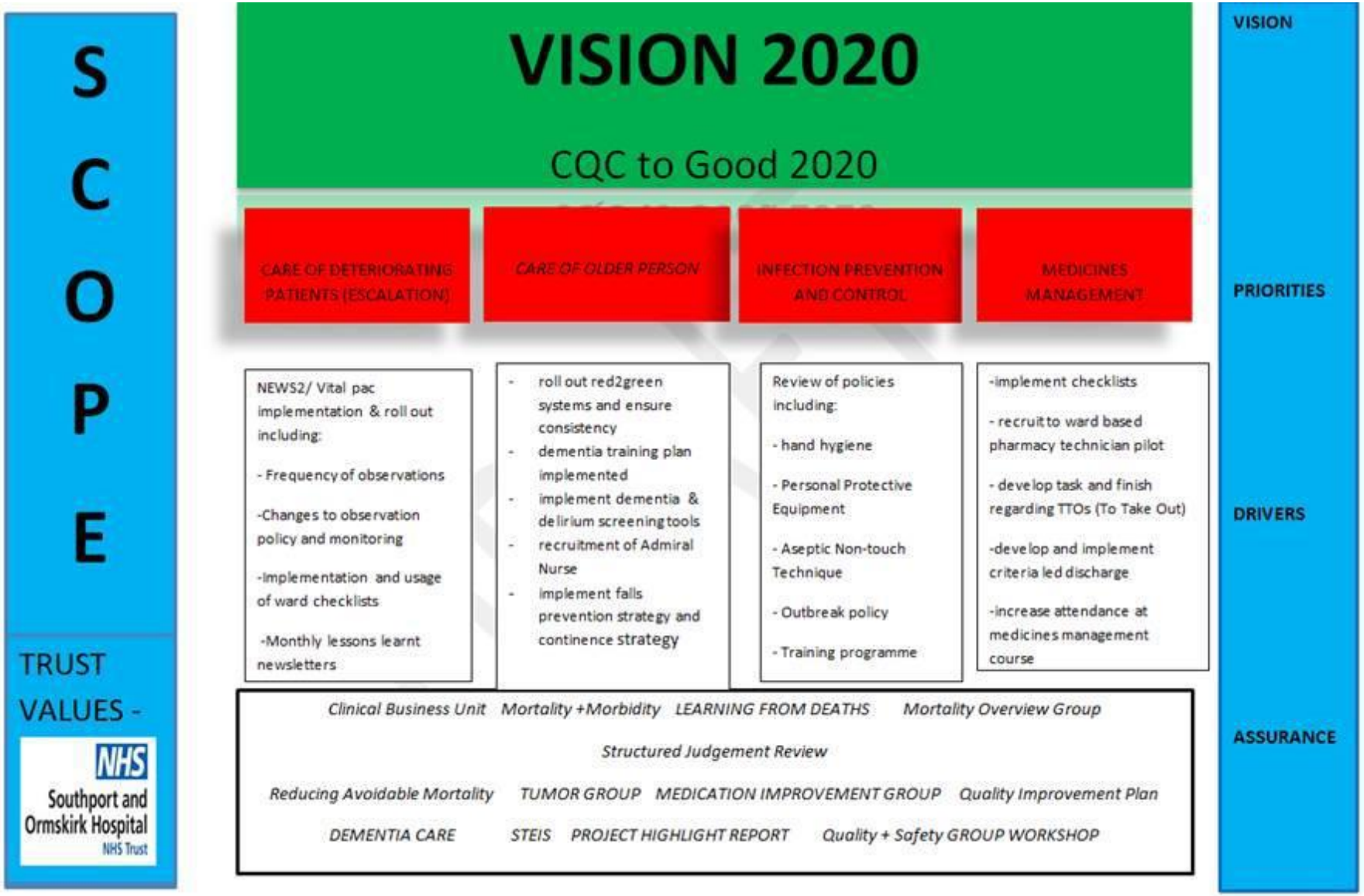
The Quality & Safety Committee is asked to note progress identified in this report in relation to the Quality Improvement.

Southport and Ormskirk Hospital
NHS Trust

Quality Improvement Strategy

Contents

SOUTHPORT AND ORMSKIRK QUALITY IMPROVEMENT PLAN ON A PAGE



1. Exec Summary

This document sets out the Quality Improvement strategy and priorities for Southport and Ormskirk Hospitals NHS Trust and details our approach to continuously improving the quality of care we deliver.

Our commitment is to develop a systematic approach to improvement which involves staff across all services and functions. In the last 12 months our staff have delivered a wide range of improvements and demonstrated just how committed they are to delivering the best standards of care and support for our patients, families and carers.

We recognise however that we can achieve more if we develop a more systematic approach, nurture a learning and improvement culture and support our staff in leading improvement and the use of improvement tools and techniques through training and development.

Our Quality Improvement Priorities are:

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

This strategy shows our continuing commitment to delivering care which is safe, effective, caring, responsive and well-led. It translates this commitment into a clear direction and focus which everyone can work towards. It sets out how we will support the delivery of our priorities including roles and responsibilities, governance, improvement tools and individual delivery plans for each priority.

We have also identified how we will measure and review improvement through individual metrics and measures which will enable us to understand progress and inform future priorities.

There are areas of best practice and excellent patient care across the organisation. However, this is not consistent and we recognise that addressing variation is a significant part of our improvement journey. This new strategy outlines the Trust's desire to increase the quality improvement expertise across our workforce and further develop a culture of continuous improvement.

2. Introduction

The challenges facing Southport and Ormskirk Hospital NHS Trust have been well documented over recent years;

- Care Quality Commission (CQC) inspections found it lacking in terms of the consistent provision of even the most basic care.
- a significant financial deficit puts it by percentage of turnover as one of the worst performing hospitals in the country
- regulatory enforcement and undertakings leading to designation of Challenged Provider (Segment 3 in the Single Oversight Framework) by regulators
- frequent changes in executive leadership and a lack of a substantive CEO for more than three years which left a vacuum in terms of strategy and purposeful direction.

In 2017 the Trust was rated as requires improvement, in the 2018 inspection the trust ratings were not changed.

Following the inspection a number of 'Must and Should do' actions were highlighted for the Trust to undertake, this totalled 114 actions. These actions were themed into 10 broad areas which made up the Trust Quality Improvement Plan

Requirement Notices

Within the CQC reports the inspectors highlighted several legal requirements that we were not meeting. These covered:

- Regulation 5 HSCA (RA) Regulations 2014 Fit and Proper Persons: Directors
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance

- Regulation 20 HSCA (RA) Regulations 2014 Duty of Candour
- Regulation 9 HSCA (RA) Regulations 2014 Person Centred Care
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect
- Regulation11 HSCA (RA) Regulations 2014 Need for Consent
- Regulation12 HSCA (RA) Regulations 2014 Safe Care and Treatment
- Regulation15 HSCA (RA) Regulations 2014 Premises and Equipment
- Regulation18 HSCA (RA) Regulations 2014 Staffing

In May 2018 the Trust agreed with our Regulator, NHS Improvement, a set of Undertakings which describe a range of outputs and outcomes with timelines for financial and operational improvement. The undertakings include;

- Quality Improvement Planning
- Financial Sustainability and Financial Governance Planning
- Performance Management

Progress against these areas is scrutinised monthly through the Southport and Ormskirk Improvement Board, which has a membership drawn from NHS England, NHS Improvement and Clinical Commissioning Groups. Should the Trust not make sufficient progress, further regulatory action may be taken.

During 2018/19 the Trust focused on stabilisation and was successful in recruiting a substantive Chief Executive, Director of Nursing, Medical Director and Chair to establish a unitary Board. Significant work was been done in developing this quality improvement plan and the governance processes to ensure rigor in quality, operational and financial management. This has set a stable platform for improvement. As we begin 2019/20 we refocus our efforts and will build on this foundation to progress on the improvement journey towards improvement and sustainability.

Over the last 12 months we have worked with the support of our staff our staff to stabilise the organisation and we have made significant improvements in;

- Management of sepsis
- Ambulance waiting times to access our emergency dept.
- Reduction is the use of the corridor within our emergency dept to care for patients
- Reviewed and developed a programme relating to additional and replacement of equipment.
- The management of complaints

- Delivery of comprehensive geriatric assessments (CGA) within ED
- Development of a frailty team and recruited frailty practitioners.

We also committed an extra:

- £2.8m to clinical staff and now employ 7.2% more doctors and 3.2% more nurses than 12 months ago.
- As part of this we will recruit an Admiral Nurse to lead the dementia and delirium services.

We also saw the biggest sustained investment for many years in our older buildings in 2018/19:

- Extension and refitting of A&E at Southport (£1.25m)
- A new base for Sefton Sexual Health at Bootle (£250,000)
- A Surgical Assessment Unit (£280,000)
- A discharge and transfer lounge
- Quiet rooms for A&E patients at both hospitals

The commitment, enthusiasm and hard work undertaken by our staff has been key to delivering these improvements often in very difficult circumstances and unprecedented demand on our services. This provides a solid base from which to build further improvements, accelerate progress and develop our approach to continuous improvement and innovation.

Our aim through Vision 2020 and this Quality Improvement Strategy and priorities is to;

- remove all inadequate ratings for our services
- establish solid foundations and trajectory for Good by the regulatory inspection in 2020
- exit Challenged Provider and Segment 3 of the single oversight framework (SOF)

In achieving these aims we will build confidence amongst our patients, staff and stakeholders and establish ourselves as an organisation which continually improves and learns from experience.

This Quality Improvement Strategy and priorities will address a number of concerns relating to the quality of care received by patients. The Board is committed to ensuring quality improvement and the delivery of consistently high quality care is a core aspect of everything we do. In doing so it will apply focus and rigor to ensure delivery of the strategy and individual quality improvement plans.

The Board will also start to work to create the conditions that allow staff to do their job well by removing blocks to success of managing risk to delivery though Vision 2020.

3. Developing our QI Priorities

Following the Trust CQC inspections in 2016, 2017, and 2018 several common themes emerged relating to the quality of care that people received whilst being cared for within Southport & Ormskirk Hospitals NHS Trust.

Each of these inspections led to the development of the 'must' and 'should do' actions. The Trust has also analysed other aspects of feedback including incident reports and complaints, using these to identify common themes. In December 2018 the Trust undertook a comprehensive internal service review, which involved a wide range of services, staff and stakeholders.

The Trust also commissioned and external review of governance led by Mersey Internal Audit Agency (MIAA) and the Advancing Quality Alliance (AQuA). A number of recommendations were highlighted for action over the next 18 months, commencing with identification of strategic quality priorities and a delivery plan.

These activities provided valuable sources of information which we used to generate the key areas of improvement focusing on areas which would have the greatest impact on patient safety and quality of care and which had the potential to become a common purpose across all aspects of our services – across clinics, wards, theatres, and non clinical areas such as estates and facilities and corporate services.

When developing the priorities, it was fundamental that these areas should be wide ranging to encompass broad themes which will enhance the fundamental care that people receive within Southport and Ormskirk Hospitals NHS Trust. These priorities have been agreed as:

- Care of Older People
- Medicines Management

- Infection Prevention and Control
- Care of the Deteriorating Patient

Engagement and ownership of the priorities across all staff groups in the organisation is essential to ensure ownership at all levels as well as enhancing senior leadership across these areas. A key part of this engagement was a programme of activities in Quality Week which was held in early 2019. This enabled people to showcase their work across the organisation culminating in a quality summit. The enthusiasm, pride and commitment from staff during Quality Week and at the Summit was outstanding and enabled the Trust to coproduce the priorities further and engage wider clinical teams in their development. The clinical teams were supportive of the priorities and engaged in shaping the areas to ensure that operational teams could recognise, understand and take these priorities forward locally.

The Trust Board identified quality improvement as a strategic objective in Vision 2020 and this is further demonstrated in the 2019/20 operational plan, as such there is commitment, support and senior ownership of these quality priorities directly from the Trust Board.

In relation to commissioner involvement the quality priorities have been discussed and will form a standard part of the quality contract meetings, to enable progress to be reported. Broader system engagement and support from regulators and stakeholders has been confirmed by the Southport and Ormskirk Improvement Board.

As part of our strategic development of these priorities it is recognised that further work is needed in engaging members of the public, patients, relatives and carers of all ages.

4. Our QI Approach

In common with most organisations we are developing our internal approach to Quality Improvement led by an Executive Director (Chief Operating Officer) who has substantial experience in service improvement.

The development of our approach will be aligned to the delivery of our quality and operational priorities which have been developed in Vision 2020. In developing our approach we will focus on the use of evidence-based tools and techniques, learning from best practice and research, particularly in organisations which have achieved improvement to Good and Outstanding.

The development of our QI approach will be in three stages and based on the following principles;

- Fit for this Trust and its quality improvement priorities
- Simple and easy to use across all staff groups
- Applicable to any improvement initiative irrespective of size
- Scalable and can be adopted across all aspects or the Trust and its services
- Co-designed with our staff and tested/evaluated in the workplace

The three stages of development are summarised below;

Stage 1	Selection of tools and techniques based on Institute of Healthcare Improvement (IHI) improvement cycles Externally facilitated training and coaching Small scale testing in key initiatives in 2019/20 plan Showcase tools and impact Evaluation by lead executive and staff including review of outcomes
Stage 2	Develop selected improvement tools as the overall improvement approach – 'Southport and Ormskirk Way' Up-scale adoption of Trust approach across broader range of improvement initiatives Implement Trust wide training and development programme (practitioners, experts and facilitators) Establish Improvement Academy and showcase quality improvement initiatives
Stage 3	Sustainable adoption of tools across all aspects of Trust business Established learning sets supporting and mentoring staff with wide range of rapid small scale incremental approaches Continue to showcase quality improvement initiatives internally and externally

The Trust will use additional external support from NHSI in stage 1 which includes practical training in key improvement concepts, tools and techniques applied to 'real time' projects e.g. theatre efficiency. One to one and team coaching will also be provided as part of this support.

In addition to developing our approach to quality improvement we are engaging in several external relationships and collaboratives. These include a partnership with Leeds Teaching Hospitals NHS Foundation Trust which supports the development of the Care of Older People improvement plan and Board leadership for quality improvement.

The Trust has re-established its membership with the Advancing Quality Alliance (AQuA) which enables services to engage in broader improvement initiatives which are pathway specific and benchmark progress against clinical outcomes across the North West.

The Trust is also engaged with a number of national collaborative which enables it to share and implement best practice across a wide number of Trusts. The collaborative cover;

- Frailty
- Pressure Ulcers
- Home First
- Ambulatory Emergency Care
- Mouthcare Matters Programme with Health Education England

5. Roles and Responsibilities

The delivery of this plan is reliant on clear roles and responsibilities, from the Trust Board to all staff involved in the delivery of care.

We will approach our quality Improvement priorities through;

- Focused Board oversight and scrutiny
- Executive accountability for delivery
- Supported Programme and Project Management
- Streamlined, single reporting for delivery and assurance

We have identified the following specific roles and responsibilities taking into consideration the development of the Trust's performance and accountability framework. All staff have a role in delivering quality care and quality improvement, keys roles are listed below with their specific responsibility.

Role	Responsibility & Accountability
Trust Board	Strategic oversight and leadership
Executive Team	Strategic planning QI Programme governance Project resources and reporting
Clinical Business Unit Triumvirate Management Team	Ensuring full engagement with the quality improvement plan and delivery within their specific clinical areas. Realising and celebrating improvements within their area
QI Project Lead	Developing and delivering the plan Stakeholder inputs Ensuring the programme governance framework is followed Appropriate reporting an escalation to the SRO. Ongoing review and refining of plans.
Clinical Leads and Matrons	Engaging with clinical colleagues Enabling leadership at all levels, as well as delivery within their specific areas. The clinical leads and Matron also have a responsibility to inform future priorities.
Deputy Director of Performance	Development of appropriate reporting dashboards and collation of information Information flows for Performance Review Boards and the Quality and Safety committee.
Head of Programme Management Office	Development of programme governance Providing project and programme management resource as required for delivery of the quality improvement plans. Identifying inter-dependencies across the workstreams.
Head of OD	Delivery of the programme to support culture development and leadership development

	required to deliver these plans.
All Staff	All staff have a responsibility to deliver quality improvement and identify further improvements needed.

6. Governance

The Trust integrated Governance Structure supports delivery of the quality improvement plans and ensures there is rigorous board oversight and assurance both in terms of implementation and the impact on improvement. (See Appendix A)

The following diagram highlights the governance arrangements for this strategy highlighting:

Operational Delivery

The Trust has established a Quality and Safety Improvement Board chaired by the Executive Director of Nursing and attended by the Medical Director and Chief Operating Officer. This group meets monthly to provide operational oversight of the improvement priorities and associated plans.

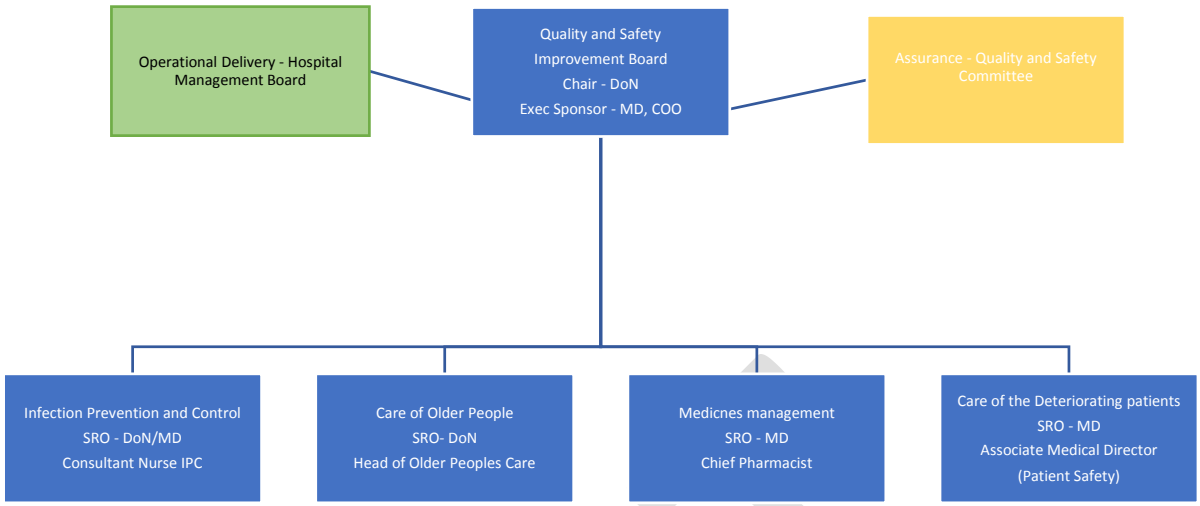
The engagement and contribution of the Clinical Business Units will be reviewed within their individual Performance Review Boards as part of the Trust accountability and performance framework.

Assurance

The Quality and Safety Improvement Board reports to the Quality and Safety Committee which is a subcommittee of the Board. This committee will receive monthly progress reports on delivery of the plans as well as the improvement measures.

The Committee is chaired by a Non-Executive Director whose role is to hold the relevant executive director to account for delivery of the plans. The key enablers for the quality improvement plans will be reviewed by the relevant sub committee of the board e.g. culture, training and education, leadership development will be reported to the workforce committee.

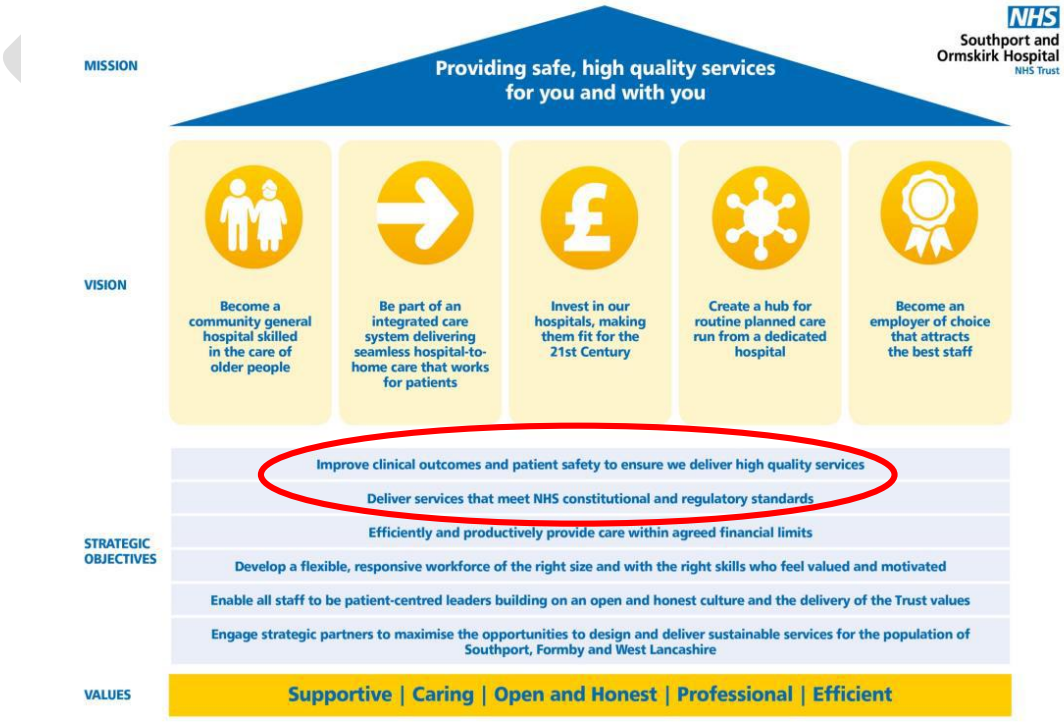
External Assurance for regulators and commissioners will be provided to the Southport and Ormskirk Improvement Board.



7. <u>Developing Capacity and Capability</u>

Vision 2020 sets out our mission, vision and strategic objectives. These are underpinned by the SCOPE values: Supportive, Caring, Open and honest, Professional; and, Efficient.

This Quality Improvement Strategy and the priority improvement plans are critical to the delivery of the first two strategic objectives set out in the diagram below;



These quality improvement objectives should not be seen in isolation and we recognise in the other strategic objectives the critical relationships with developing our workforce and our leadership at all levels in the organisation.

We also recognise the legacy in terms of culture and how important it is to develop meaningful engagement with our staff if we are to establish a common purpose for delivering safe, caring, effective, responsive and well led services.

The key enablers for this strategy and the individual quality improvement plans are;

- Delivery of an OD programme which supports an open honest culture and raising concerns
- Developing leadership skills and talent management across all staff groups and within the Clinical Business Units
- Using a range of efficiency improvement models including Get It Right First Time (GIRFT) and Model Hospital
- Developing a consistent methodology/improvement science which is applicable and can be used effectively across all aspects of the Trust's operations

The progress of these enablers will be reviewed at the Hospital Management Board and at the relevant sub Committee of the Trust Board.

8. Quality Priority Delivery Plans

Each quality priority has an identified lead executive sponsor and senior manager responsible for the development and implementation of the relevant implementation plan. As described in section 6 these plans are monitored via the Quality and Safety Programme Board (chaired by the Executive Director of Nursing, Midwifery, Therapy and Quality and attended by the Chief Operating Officer and Medical Director). For assurance this group reports to the Quality and Safety Committee as a sub committee of the Trust Board, Chaired by an identified non-executive Director.

For each quality priority we have summarised the key actions to be delivered over 2019/20 as well as the improvement measures which will be used to evaluate progress

Care of Older People

Workstreams	Improvement Measure
Reducing falls (i) Ensure that bed rails are only used when necessary. (ii) Ensure that risk assessments for moving and handling are undertaken, documented and reviewed. (iii) Ensure that individual care plans are in place for people who are at risk of falling	Reduction in falls resulting in moderate harm, severe harm or death
Improving care for people with delirium and dementia (i) Undertake a review of the care of people with delirium and/or dementia and make recommendations for improvement and deliver the improvement plan	Improvement against 6 key areas: • Patient, Family and Carer experience of care • Training & Education • Environment – Engagement • Environment – Physical • Pathways • Communication
Improving Nutrition, Hydration and Mouth Care	
(i) Ensure that there are sufficient numbers of staff to assist with patients dietary needs.	Ratio of catering assistants to patients
(ii) Ensure that all patients receive a Malnutrition Universal Screening Tool (MUST) score where appropriate.	All 16+ inpatients beyond a 72 hour stay screened
Continence	
(i) Undertake a review of continence management currently in the Trust	Improvement in patient experience Improvement in patients maintaining their continence management strategy through an acute admission Reduction in falls related with continence Implement new guideline, documentation
(ii) Develop a continence group	
(iii) Develop a continence and catheter education and training provision	

(iv) Develop champions on each ward to facilitate the rolling out of improvement and changes in clinical practice	and education as required
(v) Review the continence pathways including assessment, management and onward referral processes	
End of Life Care	
(i) Develop an accreditation/assurance framework for the wards to be measured against in terms of delivering excellent End of Life care	Improvement in patient experience Improvement in audits of End of Life Care
(ii) Improve the education and training of staff in End of Life care therefore improving quality of care provided	
Discharge Pathways and Flow	
(i) Develop a HomeFirst Pathway	Reduction in LOS and delay between patients being 'MOFD' and leaving the Hospital Reduce number of patients discharged to an alternative from their usual place of residence when diagnosed with a Delirium Reduce average LOS for patients diagnosed with a Delirium
(ii) Develop a Delirium Discharge Pathway	
Creating an Enabling Environment	
(i) Review the equipment including competencies for Nursing/HCA staff	Improve the environment and normal practices to minimise deconditioning in the acute setting
(ii) Develop Education & Training including patient & family education around the enabling Hospital environment	
(iii) Develop the practice of Get up, get dressed, get moving across the acute wards	
(iv) Embed Making every contact count into therapy interventions	
(v) Develop an exercise bank for patients to independently manage and avoid deterioration in movement and strength where possible	
(vi) Develop an Activity planner on the wards	
(vii) Embed Fit to sit principles for patients in S&O NHS Trust.	

Monitoring and Assurance
Performance Review Board Quality and Safety Improvement Board Quality and Safety Committee

Care of the Deteriorating Patient

Workstreams	Improvement Measure
Patient Flow Improvement Programme	Urgent and Emergency Care dashboard including constitutional standards and operational metrics Mortality indicators including HMSR, SHMI, Crude Deaths, diagnostic group indicators % overdue and breached observations for patients with EWS 5-6 (Standard 8) Referrals to CCOT Timely identification and treatment of sepsis in ED and acute inpatient setting (CQUIN 2a/b % #NOF operated on within 36 Hrs of admission VTE Risk Assessment all inpatients Proportion of stroke patients who have 90% of their hospital stay on dedicated stroke ward WHO Checklist Compliance Pneumonia – Adults with community-acquired pneumonia who are admitted to hospital start antibiotic therapy within 4
I. Ambulance Handover and management at the front door of ED	
II. Update and implement new triage process for patient streaming	
III. Develop Ambulatory Care Streaming	
IV. Ward Based Patient Management	
• Develop standardised ward rounds with senior review	
• Enable greater staff engagement in Red to Green process	
• System prioritisation of discharge management through the A&E delivery group	
Pathways	
I. Develop and implement UTI Pathway	
II. Advancing Quality engagement to improve performance across the pathways for sepsis, AKI and pneumonia	
III. Implement and embed new pathway relating to care of people with fracture of neck of femur	
IV. Implement and embed new pathway relating to care of people with abdominal pain	
Specialist Services	
I. Develop workforce plan for specialist diabetes service	
II. Refresh and disseminate pain guidelines to improve recognition and treatment	
III. Develop a business case for an acute pain service	
Senior Ownership	
I. Use Medway to identify named consultant for all patients	
II. Develop a virtual ward board	
III. Identify risks to patients on admission and appropriate escalation plans developed, including end of life care, critical care or ward based management	
Escalation	

I.	Continue to implement NEWS2 and monitor compliance with policy	hours of presentation
II.	Develop and plan implementation of VitalPac within A&E	
III.	Embed critical care outreach team with continuous remote monitoring	Palliative care coding and ACPs
Documentation & Observations		
I.	Review standards of documentation and complete clinical document audits	
II.	Review AHP documentation	
III.	Ensure Prescribing is legible, clearly signed and in line with national existing guidelines for care.	
IV.	Ongoing audit of physiological observation	
V.	compliance and fluid balance completion	
I.	Develop a virtual ward board	
II.	Enable access to the Lancashire Patient Record Exchange Service	
Learning from Deaths		
I.	Improve the consistency and learning from mortality review processes	% Deaths screened per month
II.	Uptake of the new screening tool, use of SJR as a second review	% Deaths reviewed per month
III.	Dept. M&M meetings to be developed	Lessons Learned
IV.	Quarterly analysis of themes and disseminate accordingly through CBU and mortality leads to identify and share lessons learnt	Duty of Candour
Monitoring and Assurance		
Mortality operational group Monthly report to the Quality and safety committee Monthly report to quality and safety operational group Learning from Deaths publications on Trust website		

Infection Prevention and Control

Workstreams	Improvement Measure
Develop Governance and Compliance of IPC	
(i) Coordinate monthly IPCAG and IPC operational meetings	
(ii) Report quarterly to Trust Quality and Safety meeting	
(iii) Provide monthly IPC performance report	
(iv) Update processes within the IPC Manual and ensure ease of access for staff	
(v) Update the RCA processes for IPC incidents	Lessons learnt shared
(vi) RCAs are processed as per Trust policy in line with harm rating.	
Communications, Engagement & Education	
(i) Ensure systems in place for internal and external communications for IPC issues	Lessons learnt shared
(ii) Ensure engagement across all staff groups	IPC awareness increased
(iii) Develop core competencies for teams	Mandatory training compliance
(iv) Provide training for all staff and link staff and develop mandatory training programmes	
(v) Develop a new training programme for clinical staff	
Anti-Microbial Prescribing	
(i) Ensure compliance with Trust formulary	Adherence Anti-Microbial Prescribing guidelines
(ii) Continue with antibiotic review kit (ARK) documentation and audits	
Isolation	
(i) Ensure that isolation rooms have correct signage and the door is kept closed when necessary.	All rooms have appropriate signage Audit process in place
(ii) Ensure that staff in clinical environments wear suitable personal protection to minimise the spread of infection.	IPC Mandatory Training, HEAT/IPC Inspection - Report to Matrons and HoN - feedback to IPC meeting and PRBs
(iii) Develop ANTT training programme	Reduce infection rates

(iv) Ensure staff are bare below the elbows and comply with hand hygiene policies	Point prevalence audits
(v) Implement a local testing system for influenza	
(vi) Increase isolation rooms within the North West Spinal Injuries Centre	
(vii) Ensure patients are protected from infections by completing the relevant local pathways and cleaning areas where patients receive care in line with their infection control policies and procedures in the emergency department.	Evidence of audits and pathways completion
(viii) Ensure that all that any patient diagnosed with a transmittable infection is nursed appropriately.	Care plan compliance
(ix) Ensure that infection control risks are consistently and effectively managed at all times.	Care plan compliance
Cleanliness	
(i) Ensure that all wards and corridors are clean and well maintained. (ii) Ensure that all equipment in wards is clean and free from dust. (iii) Ensure consideration is given to the times of day to clean ward areas. (iv) Monitoring the cleanliness of privacy curtains in wards and theatres (v) Ensure all hazardous substances are securely stored in ward areas and dirty utility rooms.	Cleaning4Credits, HEAT, IPC Inspections
Environment	
(i) Consider storage options for equipment in corridor areas.	HEAT, IPC Inspections, hand hygiene audits
(ii) Continue with HEAT (Hygiene Environment Action Team) inspection programme which engages with IPC, Facilities, Estates and Nursing – include other senior managers/directors	
(iii) Develop and embed Matrons/IPC team walk rounds and embed relevant checklists	
(iv) Review and revise cleaning policies	

Monitoring and Assurance	
Performance Review Board Hospital Management Board Quality and Safety Committee Hospital Improvement Board Quality and Safety Committee Southport and Ormskirk Improvement Board	

Medicines Management

Workstreams	Improvement Measure
Medicines Governance	
(i) Review Medicines Safety Committee and Medicines Optimisation Group to ensure multidisciplinary and Clinical Business Unit involvement	
(ii) Annual communication programme to raise awareness	
(iii) Review and keep up to date all Policies, guidelines and Procedures	
Service Delivery Plans	
(i) Develop a Business Case for 7 day clinical pharmacy and pharmacy service for acutely ill patients	
(ii) Develop role of ward based pharmacy technician	
(iii) Extend current service to A&E and pre-admission clinics	
Performance Improvement	
(i) Agree KPIs for medicines optimisation and pharmacy	
(ii) Use NHSI Model Hospital benchmarking and CQC CD framework to identify opportunities for improvement	
(iii) Quality and Safety balanced scorecard for medicines optimisation and pharmacy	Model Hospital Indicators Pharmacy audits
(iv) Use NHSI Model Hospital benchmarking and CQC CD framework to identify opportunities for improvement	
(v) Medicines Optimisation reporting quarterly to Quality and Safety Committee	
Medicines Optimisation Strategy and Plan	
(i) 7 day service	
(ii) Workforce (recruitment, retention, roles and training)	100% medicines within their expiry date
(iii) Technology – EPMA implementation plan including new processes	
(iv) Mandatory training re medicines optimisation	Ambient room temperature and fridge temperature compliance
Ward based processes – safe medicine handling	
(i) Medicines processes included in ward checklist and dashboard; • Medicines within expiring date • Medicines storage • Oxygen prescribing and administration	Medication errors resulting in moderate harm or above

• Medication checks • Medicines on resus trolleys • Use of PGDs • Controlled Drug checks • Missed doses • Temperature monitoring • Medicines security	Incident reporting Audit or ward based checklists
(ii) Delivery of pharmacy audit programme	
(iii) Staff information on safe handling	
(iv) Induction training on safe medicines and medicines optimisation	
Monitoring and Assurance	
Medicines Safety Committee Drugs and Therapeutics Committee Medicines Optimisation Group Quality and Safety Programme Quality and Safety Committee	

9. Measuring Improvement

Measuring improvements made by delivery of the quality strategy utilises the Trusts' performance and accountability framework. By adopting an integrated performance management and reporting process, we align our improvements and progress to both the integrated assurance framework, and the operational delivery structure. We measure performance from both a metric and process perspective. By doing both we can demonstrate actual improvements in performance and also progress on actions taken towards making those improvements

The following provides the Key Performance Indicators (KPIs) currently reported on to measure delivery against the strategy:

Key Performance Indicator	Target
Infection, Prevention and Control	
All rooms have appropriate signage	100%
Mandatory Training Compliance	85%
Heat Inspection Scores	
Infection control pathways completed	100%
Credits4cleaning compliance	
Infection Control Risks completed on Datix	100%
Care of the deteriorating patient	
% overdue and breached observations for patients with EWS 5-6 (Standard 8)	0
Timely identification of sepsis in ED and acute inpatient setting – within one hour of arrival (CQUIN 2a/b)	90%
Timely treatment of sepsis in ED and acute inpatient setting – within one hour of diagnosis(CQUIN 2a/b)	90%
% #NOF operated on within 36 Hrs of admission	90%
% deaths screened per month	100%
% deaths reviewed per month	10-20%
Pneumonia – Adults with community-acquired pneumonia who are admitted to hospital start antibiotic therapy within 4 hours of presentation	100%
Care of the older person	
Falls resulting in moderate harm, severe harm or death	0
Dementia assessment and referral - those with diagnosis of dementia or delirium or to whom case finding is applied	80%
Dementia assessment and referral - where the outcome was positive or inconclusive, are referred on to specialist services	80%
Dementia assessment and referral - who, if identified as potentially having dementia or delirium, are appropriately assessed	80%
Improving Medicines Management	
Medication Errors resulting in moderate harm or above	0%
Medication 'in date'	100%
Resuscitation trolley medication 'in date'	100%

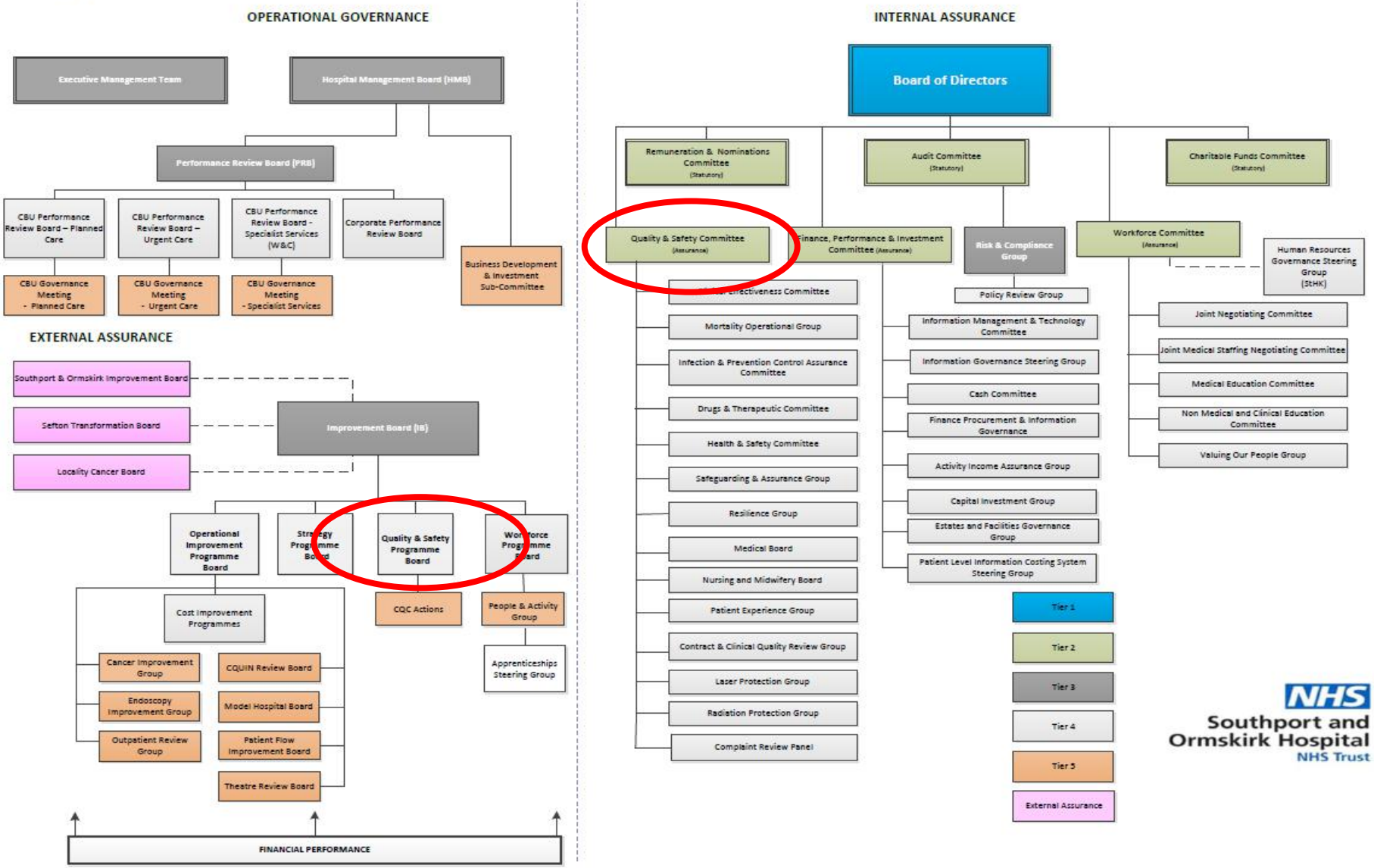
Additional Key Performance Indicators Supporting Delivery	
Safeguarding - mandatory training completion	90%
Trust Mandatory training compliance	85%
Staff sickness rate	4%
Duty of Candour – evidence of discussion	100%
Duty of Candour – evidence of letter	100%
Medical equipment maintained	100%
Reduction of outliers	%
Discharge before noon from Inpatient Ward	%
Reduction in stranded and super stranded patients	25%
Emergency Care 4 Hour Standard	95%

10. Appendices

A. Integrated Governance Structure

Appendix A

Integrated Governance Structure



NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB110/19c**	**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 Board with the current position of nurse 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 April 2019.

Alert

- Trust vacancy rate for nurses and midwives has increased from 9% to 11.8%. This is reflective of increased establishment through business case approval.
- Scrutiny in datasets is required to assure Trust reporting of workforce Key Performance Indicators (KPI's).

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.

Assure

- For the month of April 2019 the Trust reports safe staffing against the national average (90%) at 94.45%.
- There has been an increase in approx.19 wte registered nurse vacancies within the Trust – this is aligned to budget changes to establishments through business case agreements. These vacancies are active within the recruitment process.

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

Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance	☐ Legal
✓ Engagement and Communication	✓ Quality & Safety
✓ Equality	✓ Risk
✓ Finance	✓ Workforce
Equality Impact Assessment	☐ 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)*	
Previously Presented at:	
☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	✓ Workforce Committee

1. Introduction

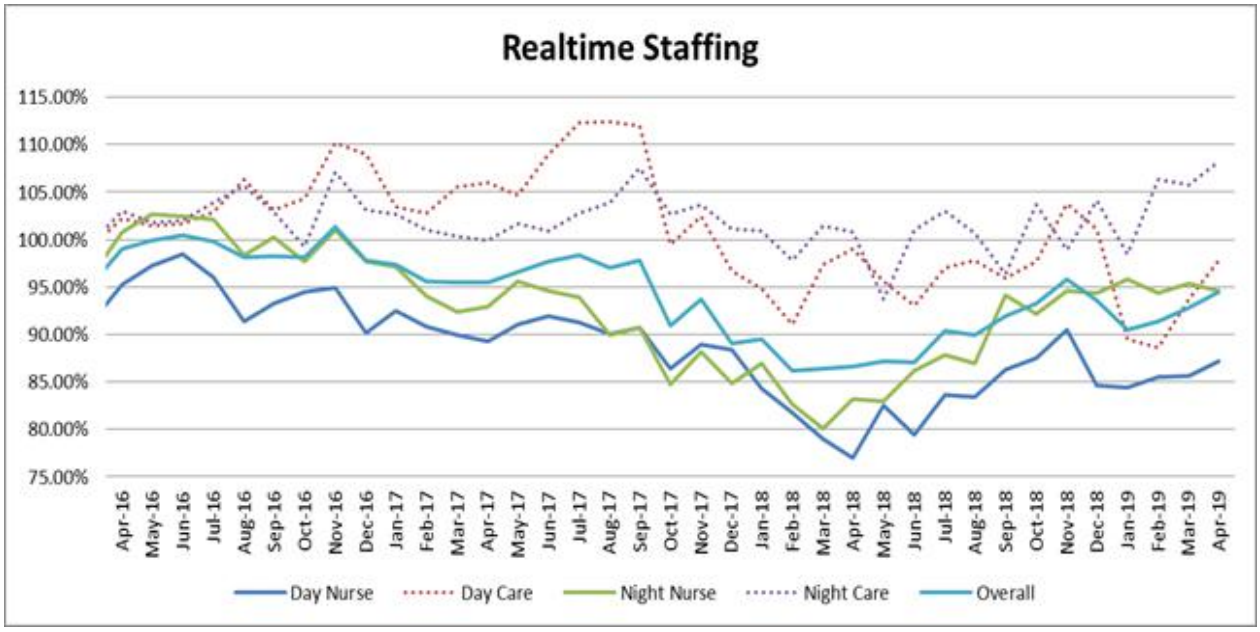
This report provides an overview of the staffing levels in April 2019 and highlights the mitigation put in place to address any gaps in fill rate and addresses the rationale for gaps that have been identified.

Based on recent publication in Health Service Journal (HSJ April 2019) the Workforce Committee was advised, although fill rates are no longer published via NHS choices (since Sept 2018), they remain an invaluable metric. CHPPD values, as a stand alone metric, are triangulated with fill rate data to help determine staffing issues due to real time deployment availability or fundamental establishment shortfalls. To this end the Workforce Committee agreed with the request to continue to present both workforce metrics.

Overall fill rate for April 2019 was 94.45% compared to March 2019 was 92.8% and February 2019 that was 91.34%, (appendix 1).

- 87.19% Registered Nurses on days
- 94.62% Registered Nurses on nights
- 97.82% Care staff on days
- 108.17% Care staff on nights

There remains a continued increase in the Trusts overall fill rate since last month.



The overall CHPpD for the Trust is 8.6 hours (appendix 1) and slightly above the national average, there are 4 wards that have a low CHpPD, for example 14B, general medicine/respiratory shows 5.1 CHpPD. This means that in a 24hour period a patient would receive 5.1 hours of direct care, which could be registered nurse or HCA, against the national average of 7-8 hours CHpPD.

2. April Safe Staffing

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

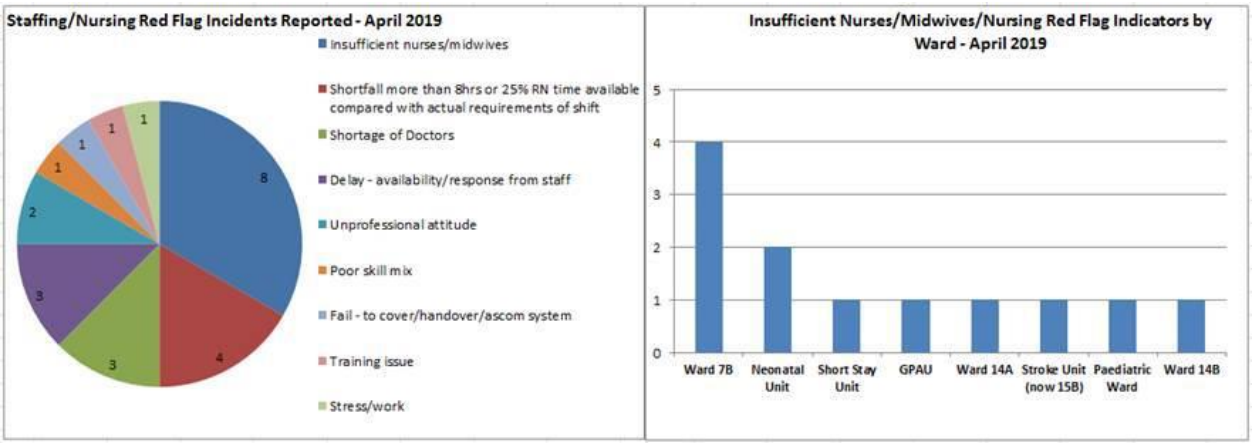
	Funded WTE	Contracted WTE	Vacancy
Registered	883.03	779.48	103.55
Non-registered	384.98	365.09	19.89

Total	1268.01	1144.57	123.44

Funded establishment has increased in month due to funding agreements through business cases. This is shown in vacancy reporting in month with active recruitment to posts in place. Ongoing scrutiny to Trust datasets is required to provide clarity of reporting.

Roster performance support and challenge meetings are now embedded within the clinical business units supported by the Key Performance Indicators (KPI'S) within the dashboards. Clinical Business Units report continued improvements through action logs and further scrutiny of outcomes and data reporting is evident in monthly support and challenge meetings with the DoN.

3. Staffing Related Reported Incidents April 2019



In April 2019 24 staffing incidents/nursing red flags were reported, 12 less than the previous month. 12 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, 9 less than the previous month, of which 4 were reported as 'red flags' (3 within urgent care, 1 within planned care) and are reflected in the CHPPD report (appendix 1). No patients suffered harm as a result of these incidents/ 'red flag events'. The 'red flag' events were proactively managed through the Safe Staffing Huddle and the internal escalation process. We continue to proactively review the safe staffing huddles, its recording/reporting methods in order to align with the trusts escalation requirements.

The Assistant Director of Nursing & Midwifery W'force is reviewing the current dashboard that incorporates clinical metrics with workforce data that will be presented in line with national guidance in future reports.

4. Trust compliance with relevant & recent NICE, NQB & NHS I guidance

A gap analysis of recommendations from the following national guidance was completed and shared with Trust Board earlier in the year.

- Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, July 2014)
- Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals (NQB, January 2018)
- Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – safe sustainable and productive staffing (NICE, 2016)

In March 2019 a gap analysis of the NHS Improvement 2018 'Developing workforce safeguards- supporting providers to deliver high quality care through safe and effective staffing' was completed.

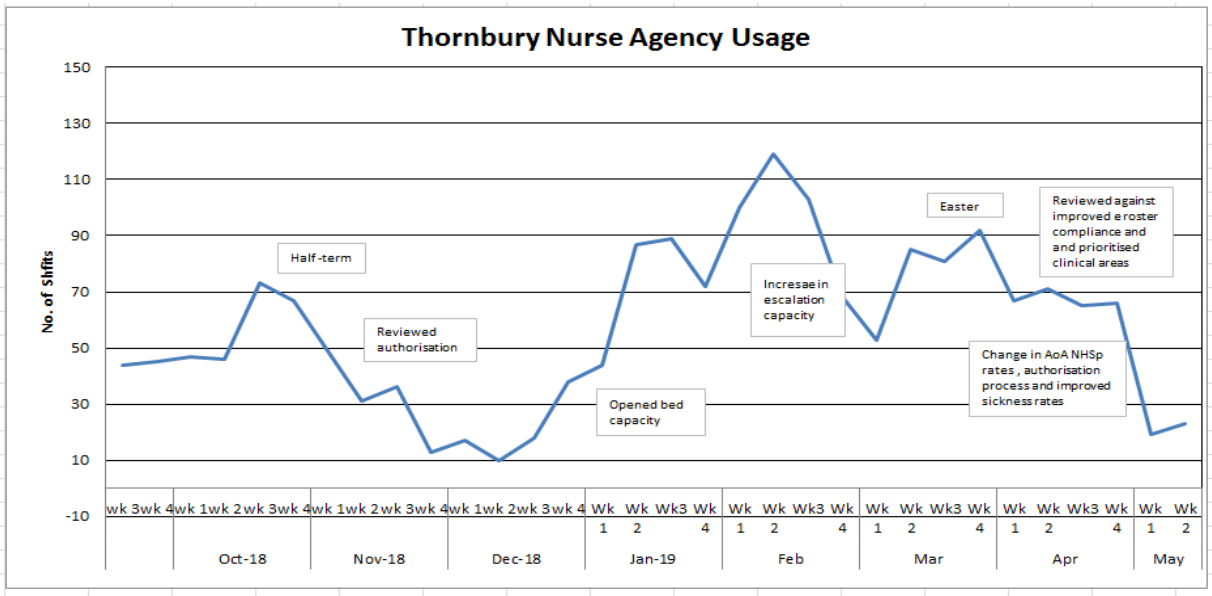
The Safe Staffing Improvement Plan now incorporates all of the above recommendations to enable the Trust to monitor our progress. Updates will be provided to the Workforce Committee and Trust Board on a monthly basis for those actions that are not 'on-track', see appendix 2.

5. Non Framework Nurse Agency Usage

Over the past few months there has been a continued use of non framework nurse agency shifts to maintain patient safety. Although there has been a recent improvement in the reduction of sickness and in the e-roster compliance further work has been required to safely reduce the use of non framework nurse agency (Thornbury). The Trust is:

- Proactively sourcing nurse agencies that are within the framework to supplement NHSp and replace Thornbury as 'Tier 2' supplier
- Continuing to work with 'cascade' agencies to fill 'long-day' bookings
- Utilising a block booking for Frail & Elderly ward & EAU through NHSp
- Working closely with NHSp to increase the number of 'Allocate on Arrival' shifts
- Utilising 'enhanced rate of pay' for Bank staff via 'Allocation on Arrival' and selected wards
- Not booking HCA agency as advised by NHS Improvement
- Reduced the number of authorised 'golden key' users
- Re-enforcing the authorisation process which is through DDoN only

It is planned that the 'tier 2' agencies will be able to provide staff by early June 2019 thus further reducing and stopping the need and use of Thornbury.



6. Recommendations

The Trust Board is asked to receive the content presented in this paper and support the on-going plans to achieve and sustain compliance against Safe Staffing Plan.

Fiona Barnes
Deputy Director of Nursing

Carol Fowler
Assistant Director of Nursing – Workforce

Appendix 1: Care Hours per Patient Day (CHPPD) – April 2019

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Ward 7A-SDGH	300 - GENERAL MEDICINE	1,583.17	1,134.42	2,162.75	1,659.50	1,055.00	994.50	742.50	705.50	788	71.65%	76.73%	94.27%	95.02%	2.7	3.0	5.7		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	748.25	768.25	411.00	403.50	706.50	623.00	363.50	351.00	255	102.67%	98.18%	88.18%	96.56%	5.5	3.0	8.4		
E A U	300 - GENERAL MEDICINE	1,636.75	1,379.23	1,480.75	1,222.25	1,054.00	1,017.50	706.50	693.50	568	84.27%	82.54%	96.54%	98.16%	4.2	3.4	7.6		
FESS Ward	300 - GENERAL MEDICINE	1,585.00	1,090.25	1,362.00	1,679.00	1,060.00	975.50	714.50	796.00	806	68.79%	123.27%	92.03%	111.41%	2.6	3.1	5.6		
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,366.25	1,176.65	1,174.75	1,389.50	1,073.00	714.50	697.83	1,020.33	789	86.12%	118.28%	66.59%	146.21%	2.4	3.1	5.5		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,483.00	1,452.83	1,319.35	1,364.60	1,071.50	1,059.00	718.50	718.00	901	97.97%	103.43%	98.83%	99.93%	2.8	2.3	5.1	Y	Due to staff relocation relocation requirements- Risk assessed through Trust safe staffing processes
Short Stay Unit	300 - GENERAL MEDICINE	1,462.08	1,092.33	1,826.50	1,754.50	1,069.50	1,000.50	1,051.50	955.00	812	74.71%	96.06%	93.55%	90.82%	2.6	3.3	5.9	Y	Due to short term sickness - risk assessed and mitigated within trsust safe staffing processes
Ward 15a General Med	300 - GENERAL MEDICINE	1,407.25	1,155.00	879.75	1,866.00	1,073.25	1,061.75	713.50	1,399.83	737	82.07%	212.11%	98.93%	196.19%	3.0	4.4	7.4		
Stroke Ward	300 - GENERAL MEDICINE	1,749.33	1,486.33	1,256.92	1,249.92	1,356.50	1,069.50	735.17	686.17	573	84.97%	99.44%	78.84%	93.33%	4.5	3.4	7.8		
Rehab & Discharge Lounge	314 - REHABILITATION	1,458.33	1,180.17	1,352.50	1,689.50	715.50	703.00	723.50	1,048.00	760	80.93%	124.92%	98.25%	144.85%	2.5	3.6	6.1	Y	Escalated timely and assessed within trust process, patient safety maintained and workload prioritised
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,277.65	1,450.15	1,660.00	2,044.97	798.25	1,071.00	908.50	1,405.50	880	113.50%	123.19%	134.17%	154.71%	2.9	3.9	6.8	Y	Escalated patient acuity - assessed through trust process
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,380.50	1,231.75	1,335.00	1,360.00	711.00	712.00	357.50	708.75	463	89.22%	101.87%	100.14%	198.25%	4.2	4.5	8.7		
Ward H	110 - TRAUMA & ORTHOPAEDICS	718.50	564.50	715.25	413.75	718.00	562.00	355.00	175.00	100	78.57%	57.85%	78.27%	49.30%	11.3	5.9	17.2		
Surgical Ward	100 - GENERAL SURGERY	1,301.75	1,119.50	1,187.75	1,195.25	711.50	700.50	708.50	612.00	515	86.00%	100.63%	98.45%	86.38%	3.5	3.5	7.0		
Spinal Injuries Unit	400 - NEUROLOGY	3,711.67	3,440.83	3,574.75	3,250.08	2,816.92	2,665.92	1,452.50	1,363.00	1136	92.70%	90.92%	94.64%	93.84%	5.4	4.1	9.4		
Ward G	101 - UROLOGY	2,049.58	878.42	1,071.50	622.83	1,089.50	719.00	721.00	407.00	258	42.86%	58.13%	65.99%	56.45%	6.2	4.0	10.2		
TOTAL		**24,919.07**	**20,600.61**	**22,770.52**	**23,165.15**	**17,079.92**	**15,649.17**	**11,670.00**	**13,044.58**	**10341**	**82.67%**	**101.73%**	**91.62%**	**111.78%**	**3.51**	**3.50**	**7.01**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
A&E Nursing		4,118.00	4,167.98	1,892.75	1,476.50	3,247.75	3,477.50	713.50	797.00	0	101.21%	78.01%	107.07%	111.70%					
Ambulatory Care Unit		540.00	323.50	630.42	384.42	165.00	310.50	165.00	0.00	87	59.91%	60.98%	188.18%	0.00%					
TOTAL		**4,658.00**	**4,491.48**	**2,523.17**	**1,860.92**	**3,412.75**	**3,788.00**	**878.50**	**797.00**	**93**	**96.43%**	**56.18%**	**73.75%**	**90.72%**	N/A	N/A	N/A		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
ITU/CCU	192 - CRITICAL CARE MEDICINE	4,740.25	4,312.92	1,176.00	1,048.50	3,935.25	3,497.00	1,071.00	687.50	407	90.99%	89.16%	88.86%	64.19%	19.2	4.3	23.5		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Delivery Suite	501 - OBSTETRICS	1,590.75	1,531.08	355.00	337.50	1,437.50	1,442.50	357.50	356.50	60	96.25%	95.07%	100.35%	99.72%	49.6	11.6	61.1		
Maternity Ward	501 - OBSTETRICS	1,137.33	1,123.00	708.00	661.00	720.00	721.50	356.50	727.00	337	98.74%	93.36%	100.21%	203.93%	5.5	4.1	9.6		
MAU	501 - OBSTETRICS	1,139.00	1,136.00	359.50	347.50	707.25	695.75	0.00	0.00	63	99.74%	96.66%	98.37%	#DIV/0!	29.1	5.5	34.6		
TOTAL		**3,867.08**	**3,790.08**	**1,422.50**	**1,346.00**	**2,864.75**	**2,859.75**	**714.00**	**1,083.50**	**460**	**98.01%**	**94.62%**	**99.83%**	**151.75%**	**14.46**	**5.28**	**19.74**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,068.50	1,098.50	108.00	96.00	1,140.50	1,176.50	24.00	0.00	209	102.81%	88.89%	103.16%	0.00%	10.9	0.5	11.3		
Paediatric Unit	420 - PAEDIATRICS	3,765.98	3,215.98	1,545.00	1,385.75	2,152.50	1,970.25	720.00	696.00	306	85.40%	89.69%	91.53%	96.67%	16.9	6.8	23.8		
TOTAL		**4,834.48**	**4,314.48**	**1,653.00**	**1,481.75**	**3,293.00**	**3,146.75**	**744.00**	**696.00**	**515.00**	**89.24%**	**89.64%**	**95.56%**	**93.55%**	**14.49**	**4.23**	**18.72**		
PLANNED		15,179.90	12,998.07	10,720.25	9,935.38	10,780.42	9,927.42	5,574.00	5,358.75	3759	85.63%	92.68%	92.09%	96.14%	5.5	3.7	10.2		
URGENT		19,137.42	16,406.94	15,749.43	16,139.18	13,647.50	13,006.75	8,045.50	9,170.33	7076	85.73%	102.47%	95.31%	113.98%	6.9	3.9	6.1		
W&C		8,701.57	8,104.56	3,075.50	2,827.75	6,157.75	6,006.50	1,458.00	1,779.50	975	93.14%	91.94%	97.54%	122.05%	5.9	4.5	19.2		
TRUST TOTALS		**43,018.88**	**37,509.58**	**29,545.18**	**28,902.31**	**30,585.67**	**28,940.67**	**15,077.50**	**16,308.58**	**11,810**	**87.19%**	**97.82%**	**94.62%**	**108.17%**	**5.0**	**3.6**	**8.6**		

Green- 80% and above
Red- Under 80%

Appendix 2

Safe Staffing Improvement Plan Update (May 2019)

Recommendations from Safe Staffing for Adult Wards, NICE July 2014

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
Development of the Enhanced Levels of Care guidelines	Ratified SOP through Nursing, Midwifery (NM Group)	Head of Safeguarding	March 2019	Draft guidance trialed in April, updated in May 2019 due for ratification at May N&M Group	A
Development of the Clinical Metrics	Clinical metric dashboard	DDoN/quality matron	February 2019	Draft clinical metrics formatted however limited capacity within the BI team to finalise.	A
Professional Learning Communities for Ward Managers & B 6– to include training opportunities in regard to budget setting & workforce planning	PLC to be set up in the new year	DDoN	April 2019	Due to commence early Summer	A

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

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement nurse agency rules, supplementary guidance and timescales	On-going work to reduce non framework nurse agency and consider other alternative companies	ADN WF	On-going	Due to current vacancies, sickness & opening of Escalation areas this work has been delayed however, improved sickness rates in May and revised authorisation process has reduced the use of non-framework agency 'in month'	R

Recommendations from 'Developing workforce safeguards- supporting providers to deliver high quality care through safe and effective staffing' (NHS Improvement 2018)

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
Trust must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Safe Staffing Improvement plan incorporates NQB 2016 recommendations	DDoN	2019	Although actions in progress Trust is not fully compliant with NQB 2016	G
Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement	Governance process for Safe Staffing to be finalised On-going improvements in line with NQB recommendations	ADN WF	May 2019	N&M W'force Governance to be ratified by NM Group & W'Force Committee.	A
As part of this yearly assessment NHS I will also seek assurance through the Single Oversight Framework, in which a provider's performance is monitored against five themes. • Quality of Care • Finance & use of resources • Operational performance • Strategic changes • Leadership & Improvement capability	Dashboard with quality metrics Budgetary expenditure, Bank & Agency usage, E roster compliance HR metrics Service development/changes that require QIA Implementation of NER	DDoN/ AD W'Force	2019	Dashboard – development in progress Bi-weekly meetings with HoN/M & matrons to review E roster efficiencies On going monthly review of HR metrics, focused on vacancies and sickness levels NER – business case to Trust Board in May 2019	A
The Trust must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality	Draft dashboard that incorporates both qualitative and quantitative data is being developed with support from BI unit.	DDoN/ ADN WF	June 2019	Limited progress due to capacity constraints	A

Action	Measure of Success	Lead	Timescale	Progress Update	BRAG
metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.					
Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Draft Staff Escalation process to be ratified	DDoN	April 2019	Draft Staff Escalation process in progress for ratification at N&M Group in June 2019	A

Red	Little or No Progress Made/Delay
Amber	Moderate Progress Made/On track
Green	Actions Almost Completed
Blue	Completed
White	Not due to commence

NHS
Southport and Ormskirk Hospital
NHS Trust

CQC PREPARATION UPDATE

1. PURPOSE OF REPORT

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

2. BACKGROUND

Following the 2017 CQC inspection and the 2018 inspection of the Urgent and Emergency Services all the highlighted must and should dos have been brought together into one overarching document containing total of 114 actions including 63 must and 51 should do recommendations, where progress will be reviewed within this report.

The Trust has developed a CQC Preparation plan to ensure we are able to be flexible to facilitate the inspection team as well as plan for the Well Led and Use of Resources reviews.

The Trust received notification from the CQC on Wednesday 10th April of the Provider Information Request (PIR). The PIR was successfully submitted on 3rd May, to date we have received 15 initial data enquires; which relate to information on sites and services, workforce and training, all requests were addressed and responded to within the agreed timescales. 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.

3. TRUST PROGRESS AGAINST MUST AND SHOULD DOs

A review in relation to the accountability framework has been completed 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 Panel for Surgery took place in early May 2019, the result of which have recommended mandatory training compliance and compliance with duty of candour policy move to action completed (green) 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 and June 2019 for all core services and Trust wide actions.

Following the submission of the CQC PIR there has been an increased focus on the progression of the Must and Should Do actions through the BRAG ratings. Excellent progress has been made and at this stage, all areas previously identified as red have progressed to on track (amber) or completed (green), subject to review of supporting evidence by the assurance panels. The 10 red actions which have progressed include:

- Seven Day Services
- Storage of hazardous substances
- Resus trolley checklists
- Storage
- Controlled Drugs check
- Patients self-medicating in A&E
- Trust wide governance systems
- Duty of Candour
- Mortality review process
- Bed management service at Ormskirk

Trust overall BRAG rating

OVERALL SUMMARY – May 2019

Rating	Must Do	Should Do	Total
Delivered and Sustained	9	1	10
Action Completed	44	40	84
On track to deliver	11	9	20
No progress / Not progressing to Plan	0	0	0
TOTAL	**64**	**50**	**114**

April 2019

Rating	Must Do	Should Do	Total
Delivered and Sustained	9	1	10
Action Completed	36	38	74
On track to deliver	13	7	20
No progress / Not progressing to Plan	6	4	10
TOTAL	**64**	**50**	**114**

4. PROGRESS AGAINST OTHER CQC ACTION PLANS

The Trust were part of the CQC review of health services for Children Looked After and Safeguarding in Sefton which took place in July 2018. Several recommendations were made as part of the inspection and there is a current action plan in place to address these recommendations. One of these recommendations was to develop a system to quickly identify young people under 18 years attending adult A&E. As a result the Trust has developed and implemented a separate CAS card for under 18 year olds attending adult A&E. This is piece of work will improve the safeguarding process and ensure that the

vulnerabilities of our 16-17 year olds attending an adult A&E are fully considered and risks were assessed.

5. CQC PREPARATION

A communications strategy has 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 developing a staff booklet and dedicated intranet page to share relevant information during the preparation phase. Quality Improvement Checklist Plans have been developed and launched to support key areas in ensuring they had key processes, policies and areas of preparation ready for when the CQC inspect the services. There is a Trust master plan incorporating CBU preparation and key lines of enquiry identified from the PIR, there are also plans in place for Human Resources and Estates & Facilities. Progress will be monitored by exception through the Quality Improvement Delivery Group (QID)

The weekly QID has been re-established, initial focus includes:

- Completing and embedding any outstanding CQC Must any Should do Actions
- Addressing and closing down any Key Lines of Enquiry (KLOES) identified during the recent PIR
- Preparing for Use of Resources, CQC Unannounced Core Services and Well Led Reviews
- Monitoring progress and completion of Quality Improvement Checklist Plans

Further focused Core Service Reviews (CSRs) are being planned with external support for specific core and support services which will enable us to identify good practice as well as further areas for improvement. Training will also be provided for identified staff to participate in 'KLOE' Reviews across all wards and clinical areas.

6. FEEDBACK FROM RELATIONSHIP VISIT

The relationship visit was attended by Debs Lingley – CQC Relationship Owner and focused on Urgent and Medical Care (including Older People). The Urgent Care CBU triumvirate started the visit with a brief presentation to introduce the CBU and discuss the improvements and challenges.

Feedback included:

- It was evident everyone cared about the patients.
- Staff highlighted the 'busyness' of recent weeks, and that patients were cared for on corridors, but they knew this was short term and the Matron had a zero tolerance. Escalation areas still being used – staff highlighted that patients are risk assessed and seen as appropriate
- A staff member highlighted an example of poor corridor care – this was reported to the HoN following feedback session
- A&E staff – feel supported, 'Jane is fantastic', the Band 7 very supportive but needs support as jobs build up, maybe needs admin support, data inputting, admin around recruitment and sickness management all given as examples.
- Great therapist input to focus groups
- Short staffing issues highlighted, but staff recognised Band 5 were being recruited and PDRs/Mandatory training performed.
- Senior leaders were visible across the organisation
- Staff highlighted how they felt valued and supported to make changes
- Staff highlighted lots of improvements over the last year
- Social media engagement seen as good to raise profile and share ideas

- Discharge lounge – single sex accommodation discussed, staff highlighted that if people in beds then it goes to a single sex area

- Good MDT working in medicines, needs more and consistent social care input
- Food was limited selection for patients overnight who are cared for in A&E

General feedback session – held in restaurant

- Waste disposal – waste not being segregated in general and linen also mixed with it in storage areas (staff took the Relationship Owner to see a cupboard) bags burst in cupboards so staff expected to clean up clinical waste
- Trolleys for collecting waste difficult to move
- Bed moves especially ward to ward to make room for patient from A&E
- Yoga was seen as positive

Conclusion

- Organisation seen as friendly and supportive and people enjoyed working here
- Overall a good visit

A CQC representative attended the May 2019 Mortality Operational Group, verbal feedback was that it was an informative meeting.

7. RECOMMENDATIONS

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB110/19e**	**Report Title**	**Seven Day Hospital Services**
Executive Lead	Therese Patten, Director of Strategy		
Lead Officer	Rachel Flood-Jones**,** Project Delivery & Quality Improvement Manager Janette Mills, Head of Clinical Audit		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The Seven Day Hospital Services (7DS) Programme was developed by NHS England to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Providers are required to complete a Seven Day Services self-assessment return every six months. To date submissions have been made through the on-line, audit tool however from June 2019 this will be done through a Board Assurance Framework. (A trial having run in February 2019).

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. Narrative is provided against the remaining 6 clinical standards.

The return is presented in two parts; the first provides the full narratives for each of the clinical standards in numerical order. The second part provides screenshots of the recommended Excel template for submission.

Recommendation:
The Board is asked to **approve** the return.

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

7DS Self-Assessment Return May/ June 2019
Southport and Ormskirk Hospital Trust

CS1 **PATIENT EXPERIENCE. (Shared decision making and informed choices for families and carers 7/7).**

The Older People's Care Project is driving a standardised approach to Advance Care Planning. One of the 9 main areas of focus of Work Stream 1 of the Patient Flow Improvement Programme is; "Family expectations and participation is managed on and throughout admission to support removing choice as a delay to discharge". This will ensure shared decision making and informed choices for patients, families and carers.

The Trust's Patient Charter developed through the Patient Experience Group incorporates pledges to 'Develop and implement systems and processes to involve Carers and Families in decision making' and 'Ensure that access to information is easy and relevant for patients, carers, families and professionals.'

CS2

14 HOUR REVIEW: All Emergency Admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest, within 14 hours of admission to hospital

An audit of 10 sets of notes in April 2019 achieved a 70% compliance against this standard. This is a slight drop on the previous return for April 2018 which reported a 74% complaince against this standard against a national average of 72%.

Historically compliance for Paediatrics was low due to consultant cover time. (Consultant rotas start at 9am impacting on the ability to deliver the required 14 hour review to those who arrive late afternoon and evening the previous day). Compliance has improved with the use of SAS Drs to review admissions.

CS3

MDT REVIEW. (14 hour assessment by MDT for emergency in-patients. An integrated management plan with EDD and medicines reconciliation within 24 hours).

Emergency admissions to the Observation ward have a consultant ward round with Occupational Therapy and Physiotherapy input 7 days a week each morning. The last Medicines Reconciliation Audit undertaken in January 2019 reported that 48% of patients had a drugs history completed with 24 hours of arrival.

CS4

SHIFT HANDOVERS. (Handovers by a senior decision maker at designated time and place. Handover processes including communication & documentation requirements formalised in a policy).

A formalised Electronic Board Round process has been developed to standardise handovers and documentation, the pilot is timetabled for June 2019. The Patient Flow Improvement Programme is also introducing the daily use of the NHSI Board Round Checklist.

CS5

ACCESS TO DIAGNOSTIC SERVICES: Hospital inpatients must have scheduled access to diagnostic services such as X-ray, Ultrasound, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Echocardiography, Endoscopy, Bronchoscopy and pathology seven days a week. Consultant-directed diagnostic tests and completed reporting must also be available seven days a week: Within 1 hour for critical patients Within 12 hours for urgent patients Within 24 hours for non-urgent patients

In April 2018 the Trust reported 92% compliance with this standard. In May 2019 the standard continues to be met as per the detail provided here.
Upper GI endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust.

7DS Self-Assessment Return May/ June 2019
Southport and Ormskirk Hospital Trust

CS6 **Consultant Directed Interventions: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: Critical care, Interventional radiology, Interventional endoscopy, Emergency general surgery.**

The Trust continues to be compliant in May 2019 as per the detail provided. The Trust's Critical Care Outreach Team was extended to 24/7 cover on 1st April 2019.
Out of hours Interventional Endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust.
The Trust has stroke thrombolysis 24/7 cover with support of Cumbria and Lancashire Telestroke network, we are involved in the redesign of the stroke pathway in North Merseyside with Aintree and Royal Liverpool University Hospital.

CS7

MENTAL HEALTH. (Mental health needs identified for acute admissions to be assessed by psychiatric liaison within 1 hour for emergency care and 14 hours for urgent care 7/7).

A Mental Health Service is now resident and available within the Trust (Mersey Care) , auditing to be undertaken for spring 2019 to quantify compliance levels to target.

CS8

Ongoing Review in High Dependency Areas All patients on the Acute Medical Unit, Acute Surgical Assessment Unit, Intensive Therapy Unit and other high dependency areas are seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Patients with high dependency needs are cared for on the Critical Care Unit based in Southport and Formby District General Hospital. Ward rounds are conducted by the Critical Care Consultant of the day, twice daily and documented on the Critical Care proforma. This process occurs seven days a week.

All new patients while on EAU get 2 daily reviews one in the morning which is direct patient contact and second in the afternoon which is a 'board round'. Any unwell patients identified at board round will then get a full review as well.

We currently do not have 7 day Consultant cover for inpatients and are working on a business case to secure funding for staffing to implement this. This will require significant capital investment and we are only very initial stages of discussion.

Until very recently, even on weekdays, the consultant job plans allowed only 2 ward rounds per week and only board rounds on remaining days. Work is underway to increase this to at least 3 times per week through job planning but we are still very far away from the target of daily ward round 7 days per week.

The Trust's Critical Care Outreach Team was extended to 24/7 cover on 1st April 2019; the team are giving a daily review of all high risk patients, patients with a NEWS 2 score of 5 or above, patients with AKI level 3 and patients for whom deterioration concerns have been flagged.

A new Electronic Board Round method is being trialed from May/June 2019 which will ensure the online documentation of the senior daily review of patients.

In Spring 2018 it had been noted that the requirement for daily review was falling short for patients on general wards over the weekend, where resource was instead focused on the 14 hour reviews of new admissions.

7DS Self-Assessment Return May/ June 2019
Southport and Ormskirk Hospital Trust

CS9

TRANSFER TO COMMUNITY, PRIMARY & SOCIAL CARE. (Support services to be available 7/7 to ensure next steps for patient care are consultant led whether in hospital, community or mental health setting).

The Trust currently has the following support services available: 7 day pharmacy cover, weekend therapy service, 24/7 in-reach from Mersey Care into the Emergency Department for mental health. There are daily discharge huddles and "Long Stay Tuesday" (Multi-agency discharge events) with with Local Authority and community teams which cover 7/7 days and support weekend discharges; the Trust is working with local authority for Sefton to develop improvements for weekend transfers to transitional beds.
At the end of 2018, the Trust employed eight Discharge Facilitators to liaise with community, primary and social care. As reported in February 2019, while this supported the transfer of patients back home, the full handover to community services fell short due to inadequate community service provision. (For example the Home First initiative which was scoped as a joint venture was put on hold for 6 months due to a lack of community resource to match Trust Resource to deliver). In May 2019, there were still no Home First Discharges being facilitated by ICRAS in North Sefton. West Lancashire are able to facilitate up to 10 patients a week and have adopted a flexible approach to time slots for discharges. Therapy services are running over 7 days a week in the hospital with a focus on discharge planning and patient flow at weekends both hospital sites.
Ongoing engagement with community health care partners is needed to fulfil this clinical standard; the Trust is now working with Strata Health on the recommendation of NHSI to drive system-wide improvements to support discharge and patient flow through the hospital.

CS10

QUALITY IMPROVEMENT. (All those involved in delivery of acute care to be involved in the review of patient outcomes to drive care quality improvement).

The Trust is undertaking The Trust launched a 2 Year Capability Training Programme with the Advancing Quality Alliance (AQuA) in Feburary 2019. The programme will provide all staff with QI improvement tools to drive a universal QI mindset. There will also be advanced levels of specialism for champions, practitioners and experts. This work will link into the 'Learning Culture' project work to ensure that there is Trustwide learning from complaints, incidents, harm and mortality. NHSI is working with the Trust to run a two day intensive QI Practitioner Training Module in June 2019 with key stakeholders responsible for delivering quality improvement projects.

NHS Southport and Ormskirk Hospital Trust

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	An audit of 10 sets of notes in April 2019 achieved a 70% compliance against this standard. This is a slight drop on the previous return for April 2018 which reported a 74% complaince against this standard against a national average of 72%. Historically compliance for Paediatrics was low due to consultant cover time. (Consultant rotas start at 9am impacting on the ability to deliver the required 14 hour review to those who arrive late afternoon and evening the previous day). Compliance has improved with the use of SAS Drs to review admissions.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	In April 2018 the Trust reported 92% compliance with this standard. In May 2019 the standard continues to be met as per the detail provided here. Upper GI endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust.	Echocardiography	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	The Trust continues to be compliant in May 2019 as per the detail provided. The Trust's Critical Care Outreach Team was extended to 24/7 cover on 1st April 2019. Out of hours Interventional Endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust. The Trust has stroke thrombolysis 24/7 cover with support of Cumbria and Lancashire Telestroke network, we are involved in the redesign of the stroke pathway in North Merseyside with Aintree and Royal Liverpool University Hospital.	Emergency Renal Replacement Therapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Urgent Radiotherapy	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Cardiac Pacing	Not applicable to patients in this trust	Not applicable to patients in this trust	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients with high dependency needs are cared for on the Critical Care Unit based in Southport and Formby District General Hospital. Ward rounds are conducted by the Critical Care Consultant of the day, twice daily and documented on the Critical Care proforma. This process occurs seven days a week. All new patients while on EAU get 2 daily reviews one in the morning which is direct patient contact and second in the afternoon which is a 'board round'. Any unwell patients identified at board round will then get a full review as well. We currently do not have 7 day Consultant cover for inpatients and are working on a business case to secure funding for staffing to implement this. This will require significant capital investment and we are only very initial stages of discussion. Until very recently, even on weekdays, the consultant job plans allowed only 2 ward rounds per week and only board rounds on remaining days. Work is underway to increase this to at least 3 times per week through job planning but we are still very far away from the target of daily ward round 7 days per week. The Trust's Critical Care Outreach Team was extended to 24/7 cover on 1st April 2019; the team are giving a daily review of all high risk patients, patients with a NEWS 2 score of 5 or above,	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
CS1. PATIENT EXPERIENCE. (Shared decision making and informed choices for families and carers 7/7). The Older People's Care Project is driving a standardised approach to Advance Care Planning. One of the 9 main areas of focus of Work Stream 1 of the Patient Flow Improvement Programme is; "Family expectations and participation is managed on and throughout admission to support removing choice as a delay to discharge". This will ensure shared decision making and informed choices for patients, families and carers. The Trust's Patient Charter developed through the Patient Experience Group incorporates pledges to 'Develop and implement systems and processes to involve Carers and Families in decision making' and 'Ensure that access to information is easy and relevant for patients, carers, families and professionals.' CS3. MDT REVIEW. (14 hour assessment by MDT for emergency in-patients. An integrated management plan with EDD and medicines reconciliation within 24 hours). Emergency admissions to the Observation ward have a consultant ward round with Occupational Therapy and Physiotherapy input 7 days a week each morning. The last Medicines Reconciliation Audit undertaken in January 2019 reported that 48% of patients had a drugs history completed with 24 hours of arrival. CS4. SHIFT HANDOVERS. (Handovers by a senior decision maker at designated time and place. Handover processes including communication & documentation requirements formalised in a policy). A formalised Electronic Board Round process has been developed to standardise handovers and documentation, the pilot is timetabled for June 2019. The Patient Flow Improvement Programme is also introducing the daily use of the NHSI Board Round Checklist.

7DS and Urgent Network Clinical Services

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

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB112/19**	**Report Title**	**Integrated Performance Report**
Executive Lead	Steve Christian, Chief Operating Officer		
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 at the Board. Some of these indicators require corrective action to be taken. Executive assurance and action plans have been provided in order to provide assurance that corrective measures are in place. The reporting forms part of the Trust's Performance and Accountability Framework, where governance is in place to drive and monitor both operational performance improvement and delivery of the Vision 2020 Single Improvement Plan.

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

Alert:

- Stroke remains significantly below target due to bed pressures
- Same Sex Accommodation breaches remain a concern, although numbers are down significantly from the previous month. There is ongoing management.
- Friends and Family test is achieving target but the response rate remains low

Advise:

- Trajectories and benchmarks (where these apply) are in the process of being included within the IPR at both Trust and CBU level. Constitutional standard trajectories are the first to be added.
- Rolling staff turnover will show a target of 10% in future reports.

Assure:

- HSMR continues to show month on month improvement
- The Trust is compliant for Sepsis identification and treatment
- Mandatory training compliance has been achieved for the third month in succession.
- Staff turnover remains steady and on target. We are in the upper quartile for Model Hospital
- Sickness rates continue to reduce month on month

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)*

Assure: 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

Integrated Performance Report Overview

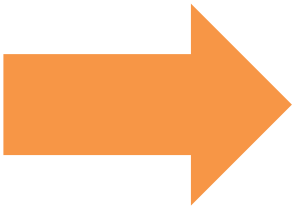
April 2019

Steve Christian
Chief Operating Officer

IPR Performance Summary – April 2019

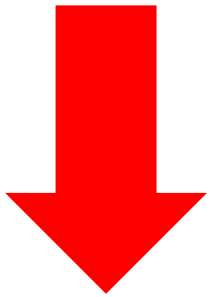
22 indicators have improved

Safe	2
Effective	4
Caring	1
Responsive	5
Well-Led	6
Efficiency	4



9 indicators have remained the same

Safe	2
Effective	2
Caring	0
Responsive	2
Well-Led	3
Efficiency	0



24 indicators have deteriorated

Safe	5
Effective	0
Caring	2
Responsive	6
Well-Led	8
Efficiency	3

Most significant Deteriorating Indicators

C-Diff

There have been 7 cases of C-Diff in the last 3 months. This is an increase of 4 on the 3 months before.

Length of Stay

Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 7.47 days in April. This is slightly increased on previous months.

Friends and Family Test

The Friends and Family Test results have decreased for the second consecutive month Friends & Family Test (FFT) response rate continues to be low, however the likely to recommend in April 2019 was 93%

A&E 4 hour

Since January 2019 there has been a decline in the A&E 4 hour performance driven by an increase in attendances and acuity of patients. However the Trust was ranked 53 of 129 Trusts

Referral to Treatment

Although green at present there is a decline in RTT performance from 96% in October 2018 to just above 94%. However the Trust was ranked 4 of 129 Trusts (improved national ranking position against previous month).

Diagnostics

The Trusts reported Diagnostics waiting time percentage >= 6 weeks - All Tests performance was 2.82% in April.

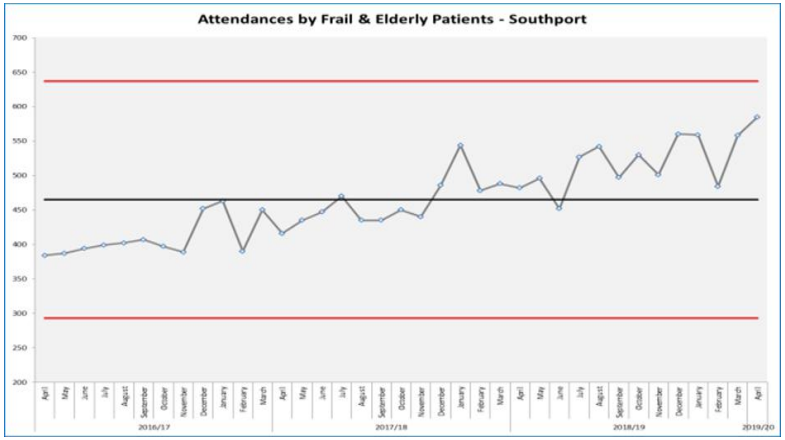
Personal Development Reviews (PDR)

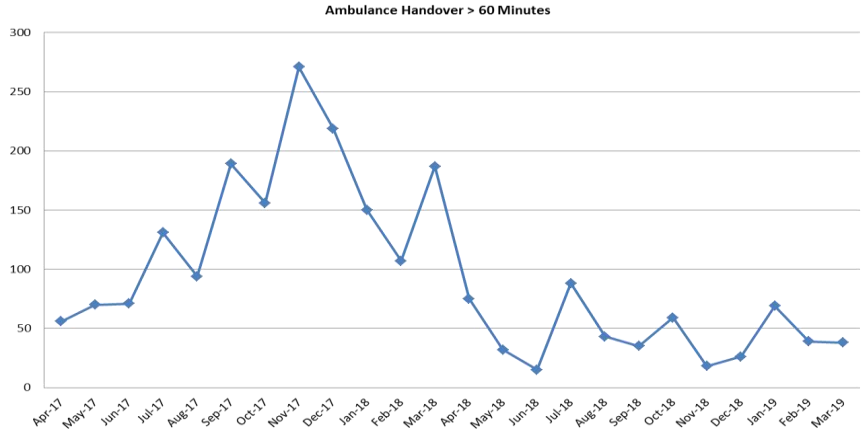
PDR compliance is now at 72.71% for April 2019 which is nearly a 3% decrease from March 2019. This is the lowest compliance rate since January 2019 and has bucked the monthly improvement trend.

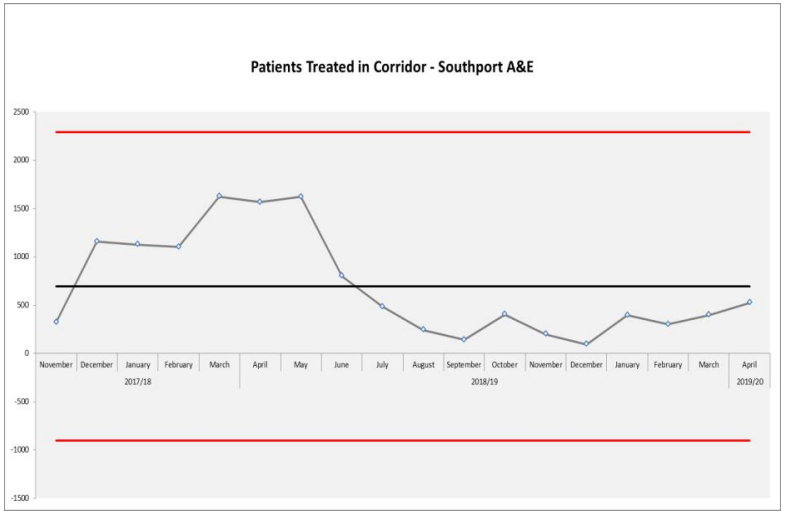
Most Significant Improving Indicators

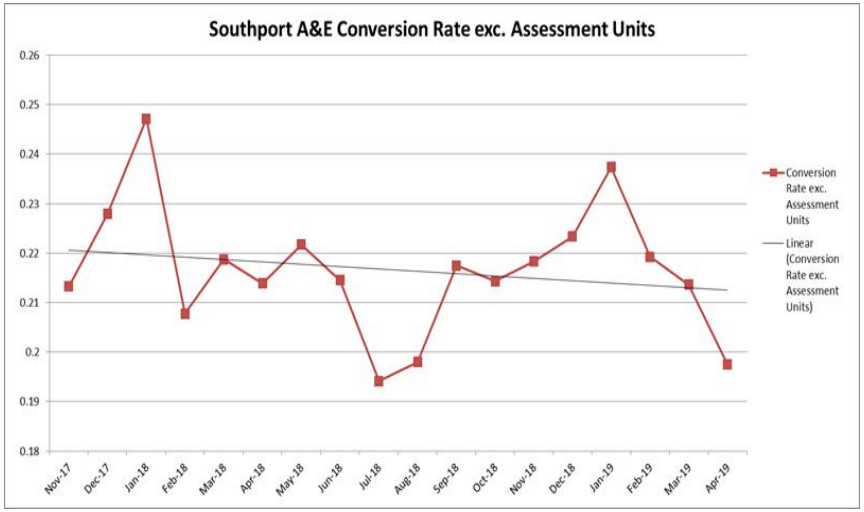
 HSMR	HSMR has seen 9 months of consecutive improvement and is now at 109.9
 Sickness	Sickness has improved for the 3rd consecutive month and is now at 4.85% the lowest figure since August 2017
 Stroke 90% Ward Stay	Following a decrease in Feb 2019, the Stroke 90% ward stay figures have been recovering well
 Bed Occupancy ODGH	The bed occupancy in Ormskirk has been on an increasing trend since August 2018 and is now at 43.14%. However bed occupancy remains above national standards and performed at 93.2% which adversely affects DSSA (Delivering Same Sex Accommodation) breaches
 Safe Staffing	The safe staffing figure has improved for the third consecutive month and is now 95.45%
 Cancer	The Trust reported Cancer treatment within 62 days of urgent GP referral performance in March was 81.2%. The Trust was ranked 71 of 131 Trusts (improved national ranking position against previous month)
 Did Not Attend	Whilst performance was down from the previous month the Trust performance of 6.9% was within local targets and continues to perform better than peers.

4 hour performance – KPI Deep Dive at a Glance (April overview)

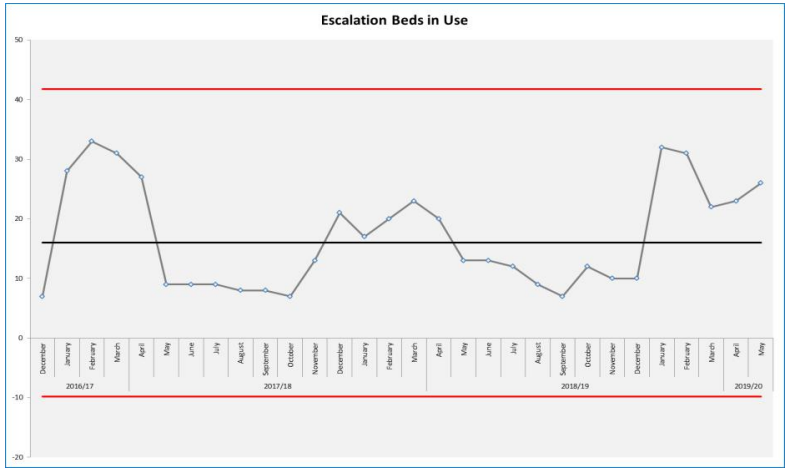


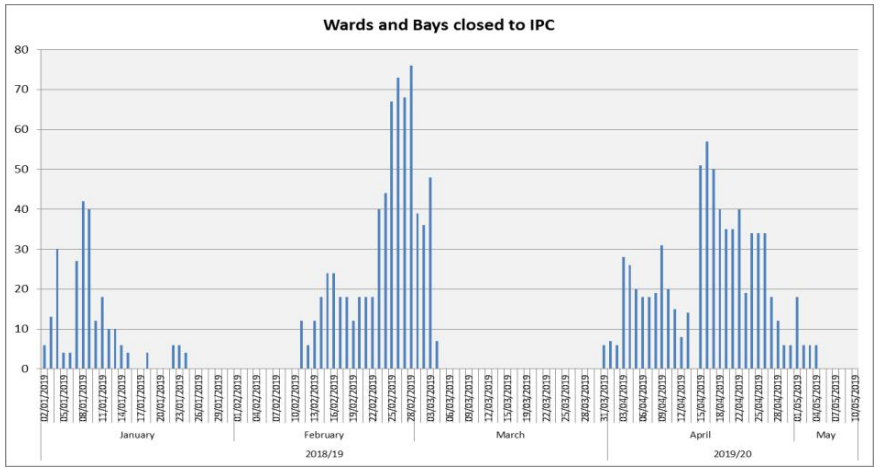


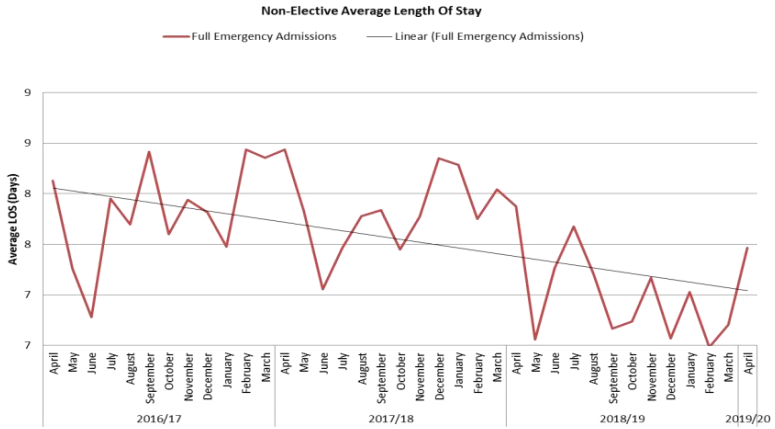


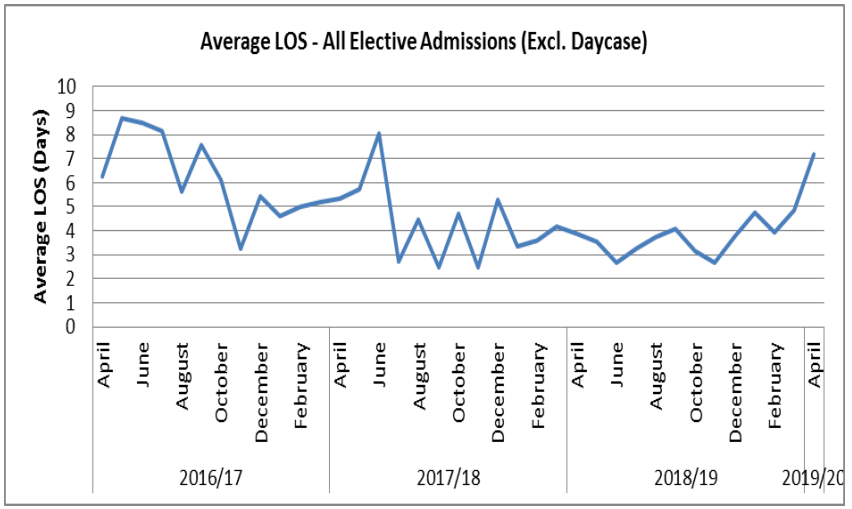


Length of Stay – KPI Deep Dive at a Glance (April overview)

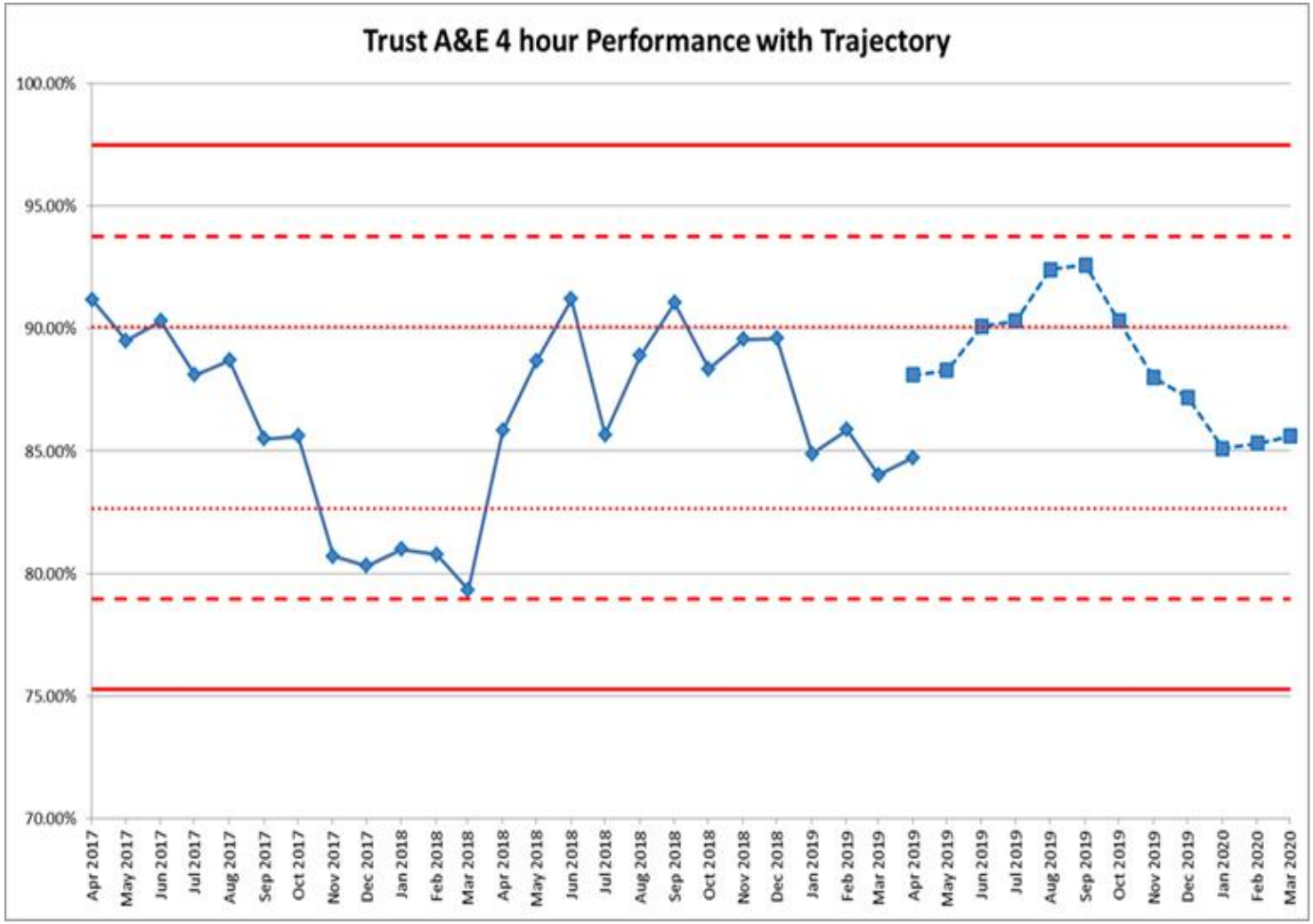








Next Step… Trajectories



NHS
Southport and Ormskirk Hospital
NHS Trust

Integrated Performance Report

Trust Board June 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - April 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	3	3	3			
Never Events	0	0	0	0			
VTE Prophylaxis Assessments	95%	98.3%		81			
Harm Free (Safety Thermometer)	94.99%	96.3%	96.3%	14			
Falls - Moderate/Severe/Death	1	1	1	1			
Patient Safety Incidents - Low, Near Miss or No Harm		781	781	781			
Safe Staffing	90%	94.5%	94.5%	N/A			
Fractured Neck of Femur	90%	80%	80%	20			

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	109.9	109.9	N/A			
WHO Checklist	99.9%	100%	100%	581			
Stroke - 90% Stay on Stroke Ward	80%	65.7%	65.7%	12			
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	32	32	32			
Written Complaints	44	23	23	23			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	92.9%		37			

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%	84.7%	88.6%	1566			
Accident & Emergency - 12+ Hour trolley waits	1	10	10	10			
Ambulance Handovers <=15 Mins	99%	47.6%	47.6%	862			
Diagnostic waits	1.01%	2.8%	2.8%	93			
14 day GP referral to Outpatients	93%	97.5%	95.1%	22			
31 day treatment	96%	100%	98.4%	0			
31 day treatment (Surgery)	94%	100%	97.4%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	81.3%	77.4%	6			
62 day GP referral to treatment	85%	81.2%	78.2%	6.5			
Referral to treatment: on-going	92%	94.2%	94.2%	654			
Bed Occupancy - SDGH	93%	93.2%	93.2%	N/A			
Bed Occupancy - ODGH		43.1%	43.1%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	100%	100%	0			
Duty of Candour - Evidence of Letter	100%	100%	100%	0			
I&E surplus or deficit/total revenue	-1%	-17.2%	-19%	N/A			
Liquidity	-23	-65	-65	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%	7.9%	7.9%	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%	0.9%	6.8%	N/A			
Staff Turnover (Rolling)		10.9%		N/A			
Vacancy Rate - Medical		9.8%	9.8%	N/A			
Vacancy Rate - Nursing		9.7%	9.7%	N/A			
Sickness Rate	3.9%	4.8%	4.8%	N/A			
Personal Development Review	85%	72.7%	72.7%	N/A			
Mandatory Training	85%	86.8%	86.8%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.6	8.6	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		51	51	51			
Length Of Stay		7.5	7.5	N/A			
New:Follow Up	2.64	2.5	2.5	N/A			
DNA (Did Not Attend) rate	8%	6.9%	6.9%	1565			
Cancelled Ops	0.61%	0.4%	0.4%	7			
Theatre Utilisation - SDGH	90%	50%	50%	N/A			
Theatre Utilisation - ODGH	90%	62.8%	62.8%	N/A			

Reporting Frequency is monthly except for SHMI which is quarterly.

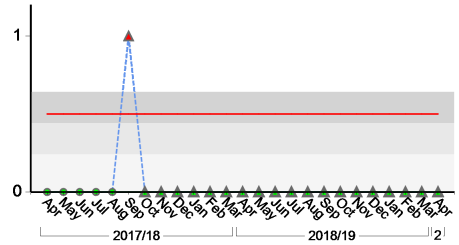
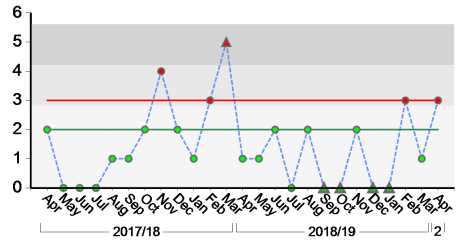
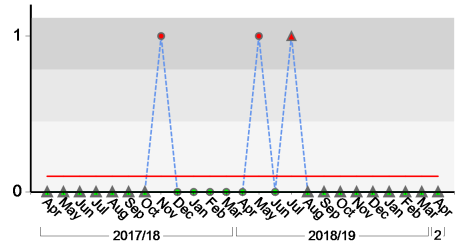
NHS
Southport and Ormskirk Hospital
NHS Trust

KPI Graphs and Update

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

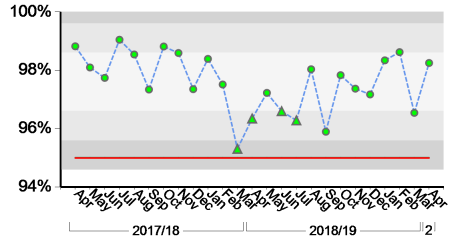
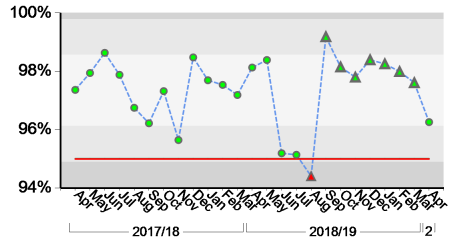
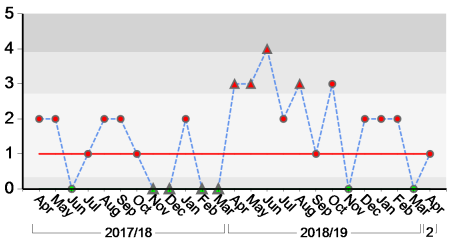
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	The Trust continues to report zero MRSA bacteraemia - The last MRSA bacteraemia was in September 2017 and since that time no Trust cases have been reported.	
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.	3 cases of C. diff. in April - 15A case will not be appealed because there were missed opportunities to obtain a stool sample and isolate the patient - local staff have been appraised of this and in addition this is being emphasised in clinical induction and mandatory training. HDU case no lapses in care and will be appealed. SIU case there were no apparent lapses in care however due to the lack of isolation provision in SIU the patient was unable to be isolated. This was mitigated against by barrier nursing in place and disinfection cleans. In addition the plans are in place and work should commence in June to provide 2 additional isolation pods with further isolation builds planned for later in the year when plans are finalised.	
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.	No Never Events to Report during April -	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

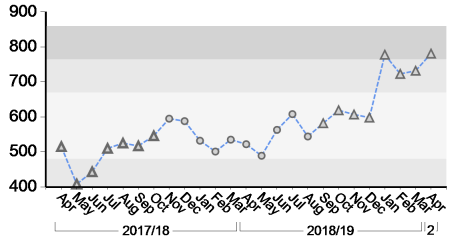
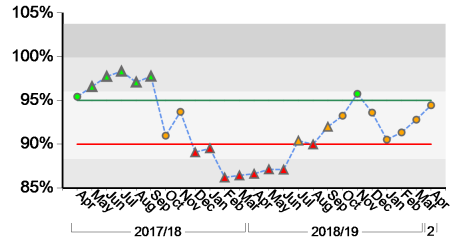
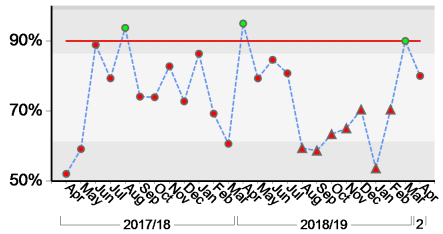
Safe

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 8.25% for April continues to be above required compliance level - There has been a substantial improvement in performance compared to previous months with the potential to further 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.	Increasing trend for previous 5 months on reportable harms - Trust Performance for April fell in relation to previous month but continues to exceed the national benchmark of 95%. On the day of census (n=374 patients) there were 14 new harms attributed to the hospital which included 2 grade 2 hospital acquired pressure ulcers (Critical Care x 1 and NWRSIC x 1) , 2 falls (Obs ward x 1 and 14b x 1) resulting in low harm to the patient,6 x VTE (7b x 2 PE, 14a x 1 PE, 14b x 1 PE, 10b x 1 PE and 11b x 1 DVT). The remaining harm events related to 4 patients receiving treatment for Catheter Associated UTI since being admitted to hospital (15a x 1, Obs ward x 1 and NWRSIC x 2).(Critical Care) and 1 x grade 2 (NWRSIC). The continued increase in reportable harms was escalated to the Senior Nurses, Clinicians and Governance teams within Planned and Urgent Care CBUs. Falls , HAPU and CAUTI are all reported on DATIX and therefore subject to an RCA; however there is no longer a robust process in place for undertaking RCA's on the VTE's in a timely way which would be recommended and the Quality Team will support the CBUs in the development of reintroducing this process if considered appropriate	
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	The Trust was non-compliant in April -	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

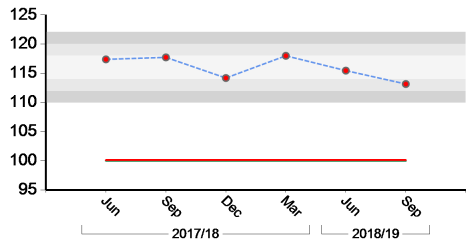
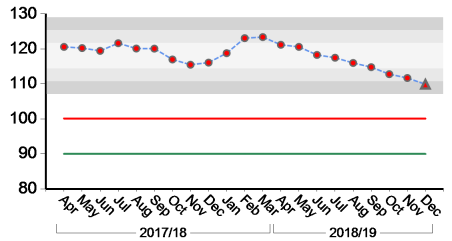
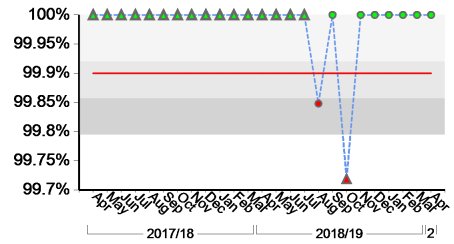
Safe

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.	there were 801 lower level incidents reported in April an increase from March 732 - In April there were 801 lower level incidents reported - 59 Near miss incidents, 622 No harm and 120 Low harm incidents. 57 of these were DoL's applications , 49 safeguarding . The other categories with the highest reported incidents relate to Bed management issues such as delay in transfer to the ward -71 reported , same sex breaches 35 reported and patients nursed in the corridor in A&E -27 reported , the other category relates to patient falls where 69 incidents were reported a decrease of 30 this month , themes -28 delay in treatment , 31 delay in obtaining pt. records. the increase shows a positive reporting culture throughout the Trust.	
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 levels remains consistently withiin tolerance - 95.45% was achieved in April -	
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance has improving since the introduction of consultant of the weekalthough April saw a reduction from 90% to 80% (20 out of 25 patients received their care within 36 hours) - Full cycle of Consultant of the week now finished, for review by the 10 consultants. This is having a positive effect on patient care, by patients being reviewed quickly and plans for treatment being made. Looking into possibility of ring fencing orthopaedic beds for #NOF patients.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

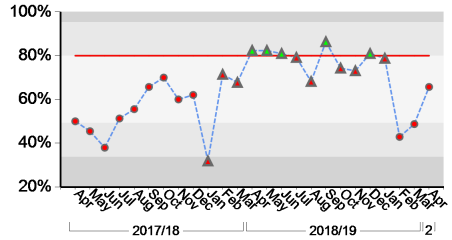
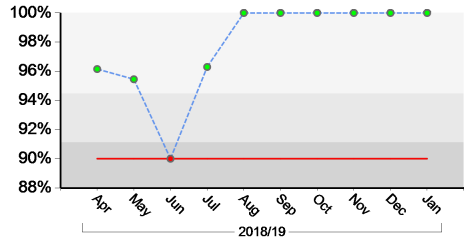
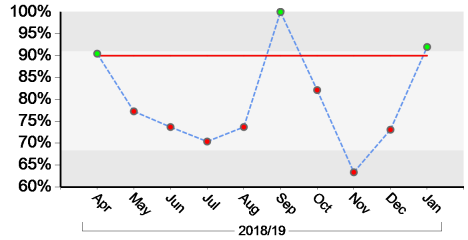
Effective

Indicator Name	Description	Narrative	Month Trend
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly (rolling 12 months) and is 6 months behind due to when Dr Foster publish the data. Good performance is 100 or less.	Gradual improvement as predicted. - As the SHMI is released quarterly, the narrative for this aspect is similar to the previous month's reports. The general trend is one of improvement. The drivers for this are improvements to patient flow and improved depth of coding of comorbidity (accurate representation of the health of the population treated. The persistently lower than average crude death rate in this context also suggests either an improvement in care or earlier discharge with death occurring in the community, or both. As SHMI includes deaths within 30 days of discharge this aspect should be controlled for in subsequent releases. We are due the next quarterly release. footnote: next quarter has been released - 111.1 (within statistical tolerance).	
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.	Improving as predicted - Rolling HSMR continues its improving trajectory. As this is averaged over 12 months, changes are only reflected with persistent month on month improvement. The current HSMR of 109.9 is the lowest recorded in recent history. This figure is expected to improve in line with the monthly HSMR (see below) as the figures average out over time. As previously, this is being driven by the improved recognition of palliative care (which is excluded from HSMR), both clinically and from a coding perspective. Improved flow (as HSMR includes in-hospital death only) and improved recognition of co-morbidity.	
WHO Checklist	WHO Checklist.	Compliance is showing at 100% - Theatre department have implemented additional internal checks to support this audit.	

Board Report - April 2019

Southport and Ormskirk Hospital NHS Trust

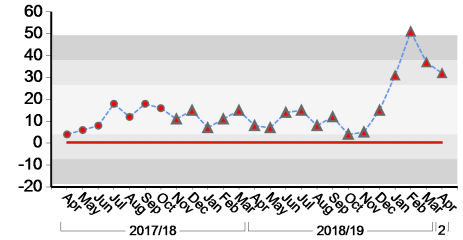
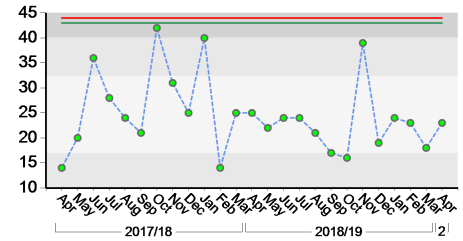
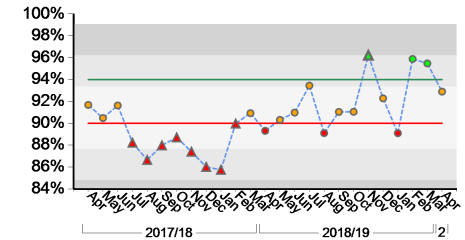
Effective

Indicator Name	Description	Narrative	Month Trend
Stroke - 90% Stay on Stroke Ward	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Please note: Indicator may change as a result of delayed validation.	April saw a significant improvement on the previous two months and continues to show a positive direction of travel. -	
Sepsis - Timely Identification	Sepsis Timely identification of sepsis in emergency departments and acute inpatient settings - National early warning score (NEWs) recorded within 1 hour of hospital arrival.	The Trust has again maintained its 100% compliance -	
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 was compliant in April - 23 out of 25 patients received their treatment within one hour of diagnosis	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

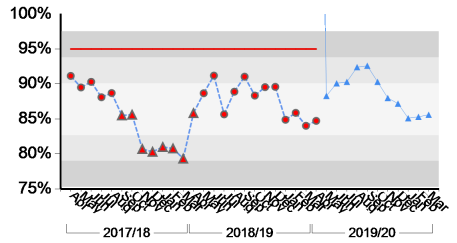
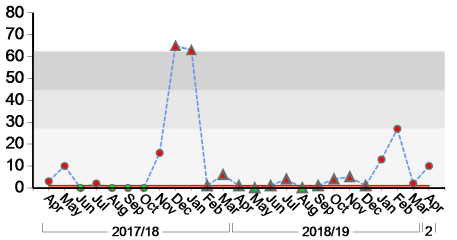
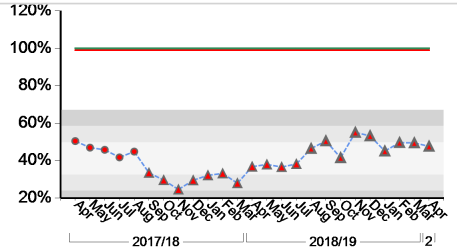
Caring

Indicator Name	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	Breaches remain at a high level. In April there were 32 breaches in total. Performance has improved since the February high number of breaches of 57 with improved performance over the past couple of months -	
Written Complaints	The total number of complaints received. A lower number is good.	- There were 18 complaints in March this is 5 lower than February 23 however this remains within normal range _ the themes are as follows 1. staff attitude/behaviour 2. clinical treatment issues 3. Communication The number of complaints received suggests that patients are aware of the complaints procedure. the complaints continue to be reported into the Quality and Safety reports for each Clinical Business Unit and in the integrated Governance Report presented at Q&S Committee for complaints analysis such as trends, themes and responsiveness.	
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance worse than previous months data. - Performance worse than previous months data with a decrease of 2.58%. Trust overall FFT response rate- has also decreased from 6.11% to 4.81%. Planned Care CBU- those that would recommend has decreased to 89.19% from 97.94%. Urgent Care CBU -those that would recommend has decreased to 89.47% from 93.08% Maternity -those that would recommend has decreased to 95.18% from 98.41%. Paediatrics- those that would recommend has increased slightly to 92% from 91.67% Those achieving 100% that would recommend are Spinal, 7A, 9B, 10B, G, H , MDU, F, T/Centre, MFU and CDU. Although it has to be noted that response rates for these areas are low. Results continue to be monitored on a monthly basis. Consideration of digital enhancement to improve response rates is still under consideration by senior teams. National survey results to be reviewed and action plans to be developed.	

Board Report - April 2019

Southport and Ormskirk Hospital NHS Trust

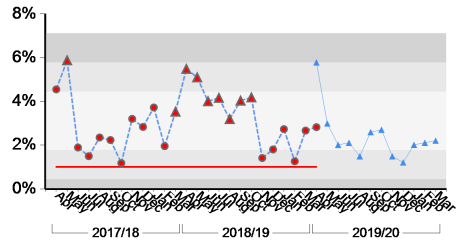
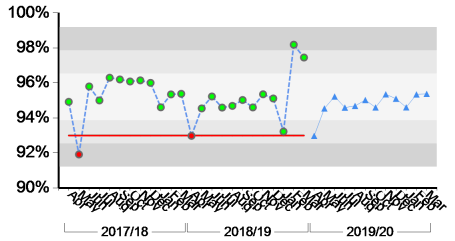
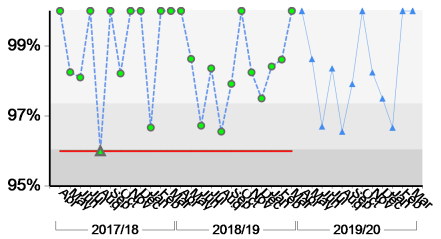
Responsive

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	- Performance against the 4-hour standard for April was a marginal improvement compared to March 2019. April saw a 12.3% increase in attendances (additional 585 patients). Of the total number of attendances, an additional 696 patients were classed as majors category compared to the previous year. April was a significantly challenging month bed-wise with a number of wards experiencing infection control closures due to norovirus, in addition to beds closed in the community, and there was a high reliance on escalation bed usage across the Southport site to maintain patient safety. ED and Medicine continued to enhance staffing levels wherever possible, with continued senior specialty inreach into ED to consider alternative pathways to admission. Despite the increase in attendances, the conversion rate from attendance to admission was 7% lower than April last year, as significant work up is undertaken in ED across specialties and diagnostic services to consider alternative pathways to admission. ED has 2 new consultants joining the team in Summer 2019 whilst Acute Medicine is back out to advert to recruit against the approved business case. Workstream 1 for PFIB reviewing front end processes, including triage, streaming, and workforce has been relaunched, whilst workstream 2 is reviewing in-hospital pathways.	
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 x10 12-hour breaches across the month of April as a result of bed pressures experienced on the Southport site. All occurred as a result of pressures on Monday and Tuesday following weekends. Full clinical timelines have been completed and RCAs are being presented through SIRG. April was particularly challenging as a result of the increase in activity levels, and the infection control pressures that resulted in closed beds both on the Southport site and also in a number of care homes. Towards the end of April, capacity was restricted further with a lack of community bed availability (particularly ICB). MADE reviews were held as part of pre and post Easter planning, with positive feedback from stakeholders regarding tracking of patients, in addition to the partnership working across clinical and community teams. The weekend daily discharge huddles continue to take place with input from 1st and Exec oncalls, and staffing has remained in place to enable escalation bed usage where clinically appropriate.	
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.	- 10% improvement in ambulance handovers within 15 minutes than April 2018. This is despite a total 12.3% increase in attendances (additional 585 patients). Of the total number of attendances, an additional 696 patients were classed as majors category compared to the previous year. There is a continued reduction in ambulances held over 30 minutes, which is heavily supported by the estates work and provision of dedicated cubicles for patients brought in by ambulance. Pressures continue to be experienced during periods of surge and bed pressures, and the impact that this has on timely release of ED cubicle capacity. NWAS have offered to run a 2 day pilot using autoclear for handover processes, which has been piloted in Aintree with positive results. The triage competency framework currently underway in ED will also support consistency in streaming, and in conjunction with NWAS, 'fit to sit' is being pursued.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

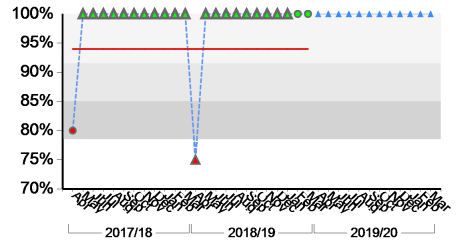
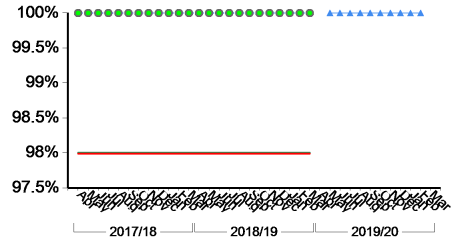
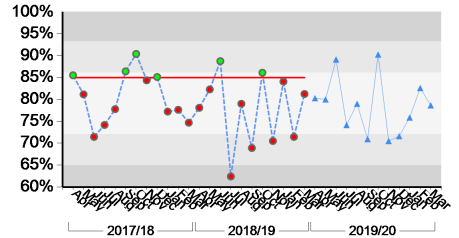
Responsive

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.	In April there were 93 breaches out of a total of 3294 patients. performance remains within a similar range to the last four months - Audiology - 3 patients (1.7%) - vacancies Cardiology - Echo - 14pts (3.2%) - patient choice/staff sickness Colonoscopy - 10pts (8.3%) - DNAs Gastroscopy - 2pts (1.6% - DNAs MRI - 3pts (0.5%) - patient choice Non-obs Ultrasound - 10pts (0.9%) patient choice/capacity Urodynamics (treatement ctre) - 40pts (74.1%) - capacity Urodynamics (Gynae) - 1pt (3%) - patient choice Video Urodynamics - 2pts (12%) - capacity Cystoscopy - 8pts (10.1%) - patient choice	
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.	Compliant with target - Working towards ESR and SCR link to allow cancer team to tack patients from referral date rather than first appointment sate that is worked to presently.	
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.	Compliant with target - RCA demonstrates patient choice as reason for one breach.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

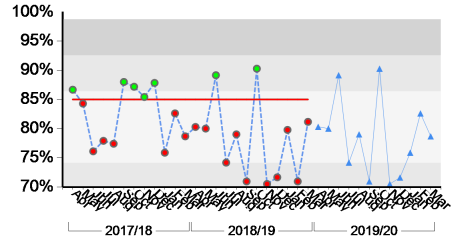
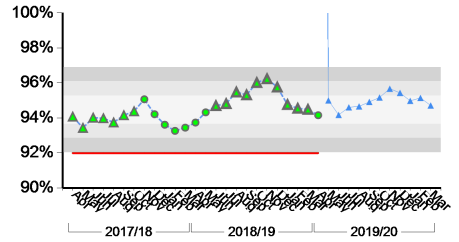
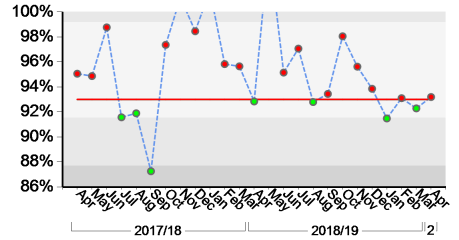
Responsive

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').	Compliant with target -	
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').	Performance remains on target at 100% -	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Cancer Improvement Group only now implemented. - The new Cancer Improvements Group will hold each individual work streams and tumour group to account over their individual action plans leading to overall cancer improvement.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

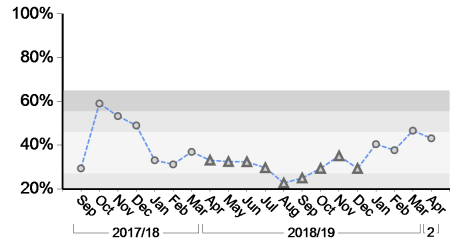
Responsive

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.	Performane deteriotated - Cancer Improvement Group only in infancy which in time will hold varying caner improvement work streams and tumour groups to account over individual cancer improvement plans.	
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.	RTT continues to perform at above 94%, which is ahead of the national target of 92%. - CBUs review performance at speciality level and report to COO on a weekly basis.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Southport bed occupancy was slightly non-compliant at 93.19% against a target of 93% but remains within the normal range - Performance is steady	

Board Report - April 2019

Southport and Ormskirk Hospital NHS Trust

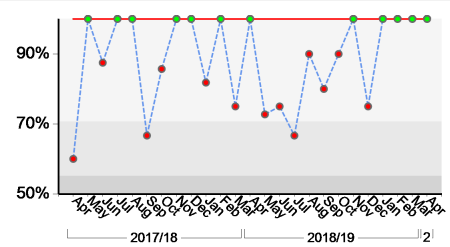
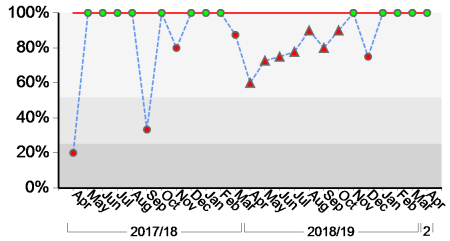
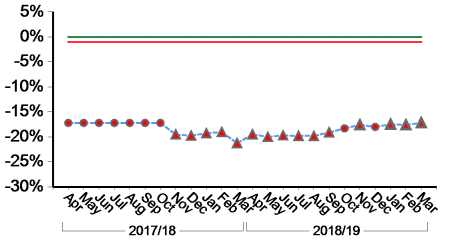
Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site. A lower percentage is good. Threshold is 93%.	Ormskirk bed occupancy remains within normal range at 43.14% -	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

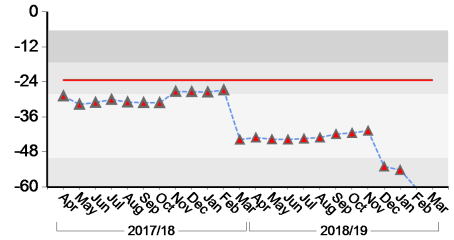
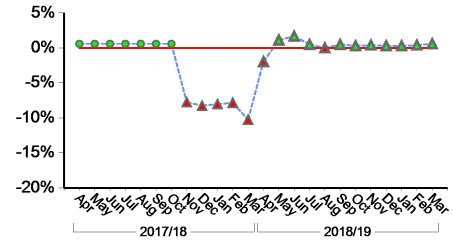
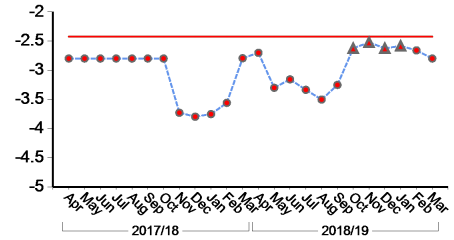
Well-Led

Indicator Name	Description	Narrative	Month Trend
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	Duty of Candour - Evidence of Letter - The Trust continues to be 100% compliant with this statutory duty	
Duty of Candour - Evidence of Letter	The proportion of patients who have received a letter of apology when something that has gone wrong with their treatment or care.	Duty of Candour - Evidence of Letter - The Trust continues to be 100% compliant with this statutory duty Staff are committed to ensuring patient / relatives are informed when harm occurs as per policy	
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Figures not available for April - April and May's figures will be input next month when the first full NHSI return is due.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

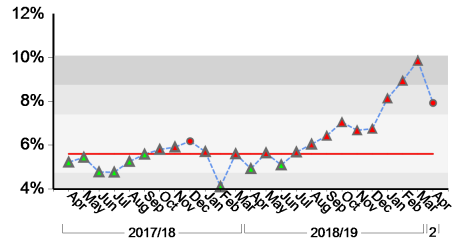
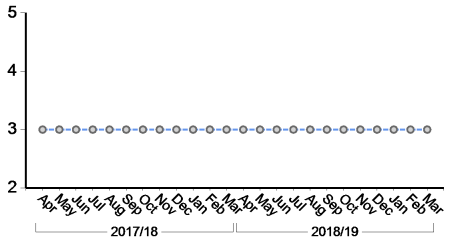
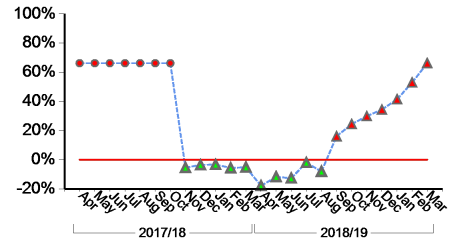
Well-Led

Indicator Name	Description	Narrative	Month Trend
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Figures not available for April - April and May's figures will be input next month when the first full NHSI return is due.	
Distance from Control Total	Distance from Control Total.	Figures not available for April - April and May's figures will be input next month when the first full NHSI return is due.	
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.	Figures not available for April - April and May's figures will be input next month when the first full NHSI return is due.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

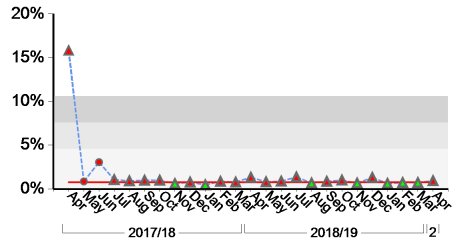
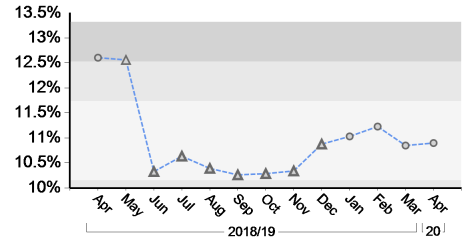
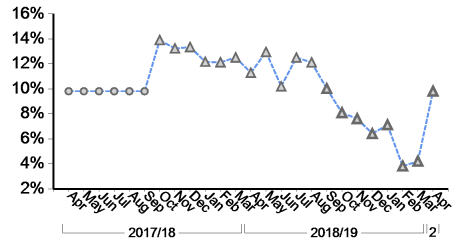
Well-Led

Indicator Name	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	Slight improvement but percentage is skewed due to April's pay award. - Although it appears that agency spend has reduced significantly it is skewed this month as the denominator of the calculation (total pay costs) is high due to the pay award and non-recurrent payments to those at the top of scale. Agency spend was £1.09m in March but has only reduced to £970k in April.	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Figures not available for April - April and May's figures will be input next month when the first full NHSI return is due.	
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Figures not available for April - April and May's figures will be input next month when the first full NHSI return is due.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

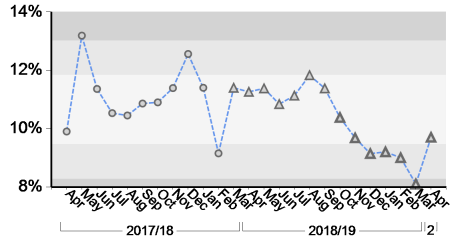
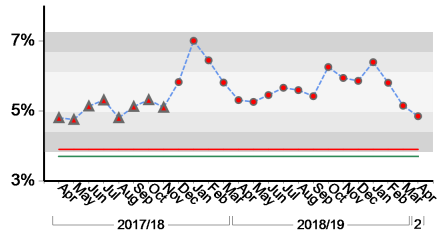
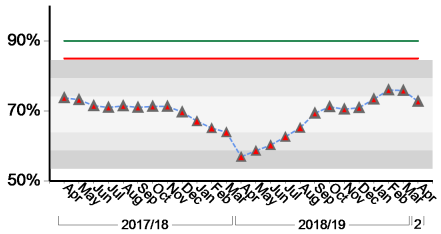
Well-Led

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 increased slightly in month and remains consistent within a small range - 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 remains consistent - 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. Clarification has been sought on the nationally supplied data and metric for all staff turnover KPIs, whether rolling or in month. All figures are based on staff numbers as recorded at the end of each month	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	-	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

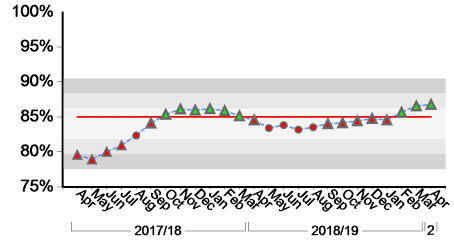
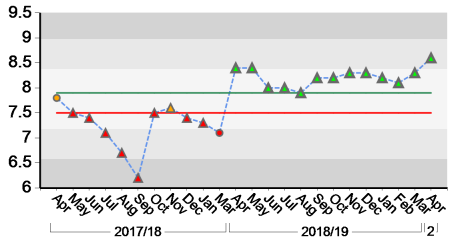
Well-Led

Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	-	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence has significantly decreased again in month to 4.85% which is the lowest levels since September 2017. - Sickness absence appears to be improving however until this has been consistently attained the Trust must monitor levels closely and continue the focused work around improving and support staff's attendance to work. Sickness spiked in January which was felt nationally however February, March and April saw a reduction in sickness absence to 4.85% the lowest levels since September 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 decreased by nearly 3% in month (April) to 72.17%. - PDR compliance is now at 72.71% for April 2019 which is nearly a 3% decrease from March 2019. This is the lowest compliance rate since January 2019 and has bucked the monthly improvement trend. All CBU's have revised their PDR improvement plans report to meet 85% improvement target by July 2019. Given the dip in performance in order to achieve the Trust target of 85% there would need to be a month on month increase of at least 5% over the next 3 months. There has been no more than a 3% improvement in a single month in the last 12 months therefore the attainment of this trajectory is ambitious at the moment. This will be escalated as an alert to the Board via the Trust's Workforce Committee.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

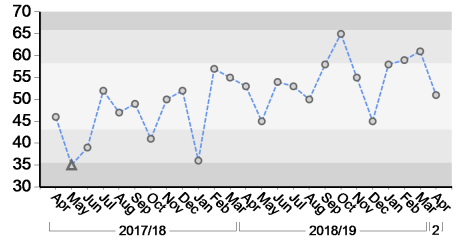
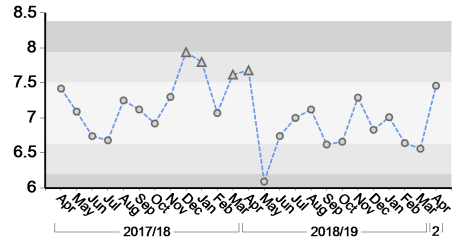
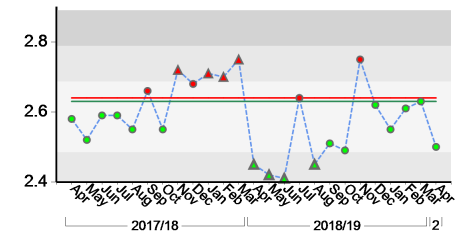
Well-Led

Indicator Name	Description	Narrative	Month Trend
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Core mandatory training continues on an upward trajectory to 86.77% - The core mandatory training action plan was reviewed at Risk & Compliance Group in April 2019. The action plan will commence in June once the Training Department has sufficient capacity to undertake projects alongside the business as usual service.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	The Trust remains continuously on target -	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

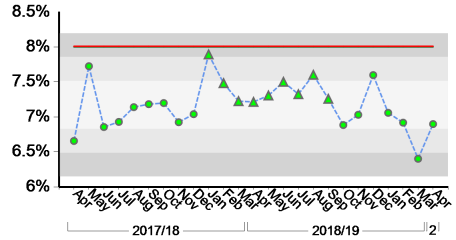
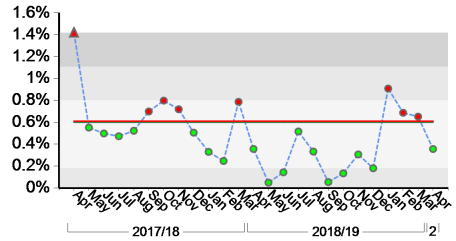
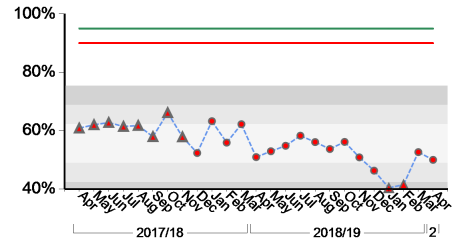
Efficiency

Indicator Name	Description	Narrative	Month Trend
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	Average Number of Daily Beds Lost In Month.Taken from A Daily Snapshot Of Patients Medically Fit For Discharge. Lower is better.	In April, on 51 daily beds were lost due to medically fit for discharge patients remaining in a bed - This is within the normal range for this metric - no target is set	
Length Of Stay	The average amount of time in days that patients spent as an inpatient from an emergency admission. Excludes ZERO Length of Stay.	Average length of stay increased in April to 7.46 days, compared to 6.56 days in March. - This is the highest length of stay recorded since April 2018, but it is within the normal range for this metric	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	Currently sitting at 2.5. - Currently sitting within target. best position since November 2018.	

Board Report - April 2019

NHS Southport and Ormskirk Hospital NHS Trust

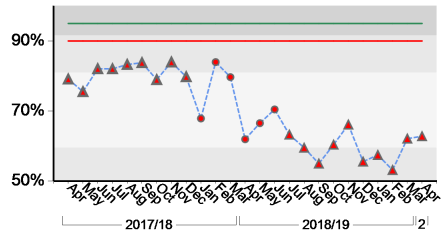
Efficiency

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.	Performance has fallen slightly from March performance - The Outpatient Improvement Group has decided to focus solely on the Access and Bookings. Included in this a continued focus on DNA rates and short notice cancellations. BI have produced KPI reports which drill down into Specialty level to show which specialties that require greater focus. Average DNA Rate is actually below national targets.	
Cancelled Ops	Percentage of Operations Cancelled.	trust is performing favourably at 0.36% which is below the target of 0.6%. - Data from a 6 week review of on the day cancellations is currently being analysed for trends as part of the theatre utilisation group.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Theatre utilisation at SDGH has fallen from March to 49.96%. - The trust continues to cancel on the day at SDGH due to bed pressures. Work in under way to address the golden and silver patients for the theatre lists for all lists including emergency and trauma lists to improve start times and maximise the use of the theatre capacity.	

Board Report - April 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.	Theatre utilisation at ODGH has increased on march figures. - review of cancellations on the day at ODGH is underway to improve on utilisation. Role out of the golden and silver patient project has also commenced. Analysis of theatre lists from previous week has commenced to challenge re listing of activity. Discussions have also commenced at speciality level.	

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

Following the Well Led Review the Programme is being revised 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 also did one on 1 May Board. They will lead a discussion on Board Skills Mix after which appropriate sessions will be planned to meet members' needs.

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

Governance Framework
The terms of reference for the statutory and assurance committees have been reviewed along with annual business cycles and the July 2019 Board will be asked to approve them.

The Trust's reviewed statutory instruments were discussed at the Audit Committee and approved. They were being reviewed as per good practice leading into 2019/20 and the June Board will be asked to ratify the decision of the Audit Committee.

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
Infection Prevention - Reviewed governance arrangements for Infection Prevention & Control (IPC) and commenced monthly IPC meeting with Matrons in March

Further focused core service reviews are being planned for theatre, IPC and medicines management

Quality Improvement Delivery Group – weekly meetings set up to review progress against the Completing and embedding any outstanding CQC Must any Should do Actions ,addressing and closing down any Key Lines of Enquiry (KLOES) identified during the recent PIR, preparing for Use of Resources, CQC unannounced core services and Well Led Reviews

Southport & Ormskirk Nursing Assessment & Accreditation System (SONAAS) –draft to be shared with Nursing & Midwifery Group in May 2019, prior to sharing with Ward Manager & Matrons.

Safeguarding – Bi-monthly safeguarding assurance groups with CCG have now been established.
Work is developing relating to the introduction of a separate CAS card for under 18 year olds attending adult A&E
MCA/DoLS – work has begun to streamline the documentation and referral process to ensure that every referral is also sent to the safeguarding team, and this is linked to the CCG work around the quality of the reporting

Older Persons Care – Nutrition- commenced the launch of the new education module for all registered staff on 10B with new care plan aligned to new Malnutrition policy with enhanced dietetic support for staff & patients. Dementia & Delirium – new clinical guidelines approved, roll-out of new care plan and assessment pathway will commence in early June 2019. Mouth Care – Five multi professional staff are attending the 'Mouth Care Matters' ' train the trainer' programme late May 2019 and will return to commence a Quality Improvement Project on mouth care provision across the Trust.

Documentation Review Group – Preliminary meeting planned to scope the project

Improving Medicines Management – KPIs have been developed and are highlighted in the draft Quality Improvement Strategy. NHSI Pharmacy lead has offered continued support around this area. Dr Hankin is currently developing this work.

2b – QI Methodology
QI Days planned for June 2019

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
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 April 2019 (94.5%).
Performance in Harm Free Care (Safety Thermometer) - 96.3%
VTE – 98.3%

Assured/Most Improved

Duty of Candour again reporting 100% in April 2019 for documentation of the discussion and letter. A Duty of Candour resource has been developed and is being delivered to all areas.

Safeguarding Prevent training at level 3 to 5 is up to 90% which is on target

Staff information relating to preparing for the forthcoming CQC inspection is being distributed across the Trust – 'Your time to shine' booklets give information and also encourage teams to share their good practice, highlights the Trust investments and also shows pictures of the leadership teams across Board and CBUs.

Not Assured/Most Deteriorated
Three incidents were referred to StEIS in April 2019 Eight grade 2 pressure ulcers have been reported in April 2019 Delivering single sex accommodation breaches have decreased to 32 pt. for April 2019, this was due to waits for beds from critical care environments There has been three C. Diff. infections reported in April 2019 against a trajectory of two per month. Safeguarding training and compliance with the training remains a concern, the team have worked hard and the figures are at 84% with a target of 90%. Patient Falls Prevention: 9A & 9B are using the new Pt. falls Prevention bundle, risk assessment & care plan. Staff will have access to the RCN 'e-learning' module to improve knowledge & skill in falls prevention management and risk factors to consider when caring for our vulnerable patients. This includes the safe and appropriate use of 'bed rails'. In addition these two wards are using the new bed rails risk assessment & care plan. Following a trial period this will be rolled out to Orthopaedics ward. There was 1 pt fall in April being graded as moderate or above harm. Friends & Family Test (FFT) response rate continues to be low, however the likely to recommend in April 2019 was 93% Continued expenditure in nurse Bank & Agency due to vacancies, sickness and additional capacity across the Trust.

Executive's Assessment Of Overall Position	Executive: Medical Director	AMBER

Overview

Vision 2020

To develop and implement a Quality & Safety plan which will address CQC 'inadequate rating' by the next 'Well Led' Inspection (est. March 2019) and establish an improvement trajectory for exiting CP status for Quality and a Good rating in core services

Meet or exceed the national standards for patient mortality.

SHMI & HSMR: Trust is actively working to reduce both HSMR and SHMI values to bring them within acceptable parameters by 2020.
The rolling HSMR shows a successive fall, down to 109.9 for November
The SHMI is down to 1.11 for December 2018
Hospital deaths increased Nov-January in line with increased activity, and crude death rates since April 2018 remain below target.
Varies between 17.4 and 30.4
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, now reached target of 90%.

.

Not Assured/Most Deteriorated

Mortality screening requires improvement.
LRTI and Bronchitis HSMR remains unacceptably high, diagnostic criteria remain unclear. Further evaluation underway
NOF SHMI 1.6, revised NOF action plan and impact of improved performance awaited. Lack of Ortho-geraitric input remains a risk.

Executive's Assessment Of Overall Position	Executive: Chief Operating Officer	AMBER

Overview

Constitutional standards

- The Trusts reported 4 hour A&E performance in April was 84.5%. The Trust was ranked 53 of 129 Trusts (improved national ranking position against previous month)
- The Trusts reported 18 week RTT performance in April was 94.5%. The Trust was ranked 4 of 129 Trusts (improved national ranking position against previous month).
- The Trust reported Cancer treatment within 62 days of urgent GP referral performance in March was 81.2%. The Trust was ranked 71 of 131 Trusts (improved national ranking position against previous month)
- The Trusts reported Diagnostics waiting time percentage >= 6 weeks - All Tests performance was 2.82% in April. Urodynamics is the area of most concern with 43 waiters over 6 weeks (due to workforce challenges)

Is assured

Improving Operational Efficiency (IOE) - The aim for April was to establish improvement groups for the IOE priorities and confirm improvement targets and the priority action that will realise the performance improvement. Whilst the COO is requesting improved pace on delivery the critical actions for April have been completed (in terms of setting up of project groups and teams)

- Patient Flow Improvement programme (PFIP) – PFIP meets fortnightly and chaired by COO. The aim of the programme is to deliver a 0.5 day reduction in average Length of Stay by 31st March 2020, showing month on month improvement. The PFIP has developed two work streams that have a managerial and clinical lead agreed and improvement actions now identified and signed off. A key element of PFIP will be the roll out of SAFER to improve ward and internal hospital processes.
- Theatre efficiency – The theatre efficiency group meets fortnightly and chaired by COO. The aim of the programme is to deliver an 85% utilization by 31st March 2020, showing month on month improvement. The focus of the programme will be the introduction and roll out of the Golden Patient approach and 6-4-2 scheduling with developing clinical ownership of lists. This also includes Endoscopy which is progressing. The average cancellation of lists due to staff availability has reduced from 25 (per month) to 6 9per month) attributed to improved oversight of scheduling and rostering. An organisational change is underway to ensure sustainability of the performance.
- Cancer Improvement Programme – cancer improvement group meets fortnightly and chaired by COO. The aim of the programme is to deliver improved performance against the 62 day standard against trajectory. A minimum requirement is to ensure each month of 2019/20 is better than the same month's performance of 2018/19. Each tumor group has an improvement plan and meetings are in the process if being completed whereby tumor group leads meet MD and COO to review progress, issues and priority actions.
- Outpatient productivity – the outpatient productivity group meets fortnightly and chaired by COO. The programme has reset its focus and is initially concentrating on Patient Access and Booking processes. In the last 2 weeks the project teams have identified a 10 point plan. The aim of the programme is to ensure the DNA rate is no greater than 8%.

Winter Planning for 2018/19

- The COO has setup weekly "configuration planning" meetings with clinical and managerial leads of the Trust to review right sizing the Trust to ensure we can optimise patient flow and overall productivity across winter 2019/20. This will involve improving the utilization of the Ormskirk site and will align and take into consideration current discussion & thinking through GIRFT and acute sustainability. A proposal will be presented to CE by the beginning of June to ensure appropriate time is set to plan & implement for 1st October 2019.

- The COO has worked closely with the system to source the support from an external consultancy (Venn) to undertake a health economy wide capacity & demand modelling. This will determine the gaps across the system and ensure an evidence based set of recommendations will be adopted and delivered to support winter planning for 2019/20. The system will also introduce a programme executive director who will have the autonomy and responsibly to implement the recommendation set out. This commences from May 2019.

Not Assured/Most Deteriorated

Length of Stay

- Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 7.47 days in April, with patients on assessment wards staying an average of 8 hours. This is slightly increased on previous months. The below 3 issues continue to impact on sustained improvement in LoS:
- **Medical workforce instability**: A hospital Trust operating an effective urgent and emergency care pathway is reliant on critical foundations and functions in terms of workforce with an absolute need to ensure Anaesthetics, Radiology, Acute Medicine, Emergency Medicine, Stroke and Older people services provide a strong service offer that is consistent and avoids unwanted variation. Across the six service lines described above the Trust has only one that is fully established and in the remaining services we have significant vacancy gaps. Whilst agency is being sourced to ensure we comply against safe staffing the temporary nature of the staffing establishment makes it incredibly hard to drive improvements in LoS and once delivered sustain.
- **Beds closed for Infection, Prevention & Control Issues**: April proved to be a challenging month regarding norovirus outbreaks. The root cause behind the issues is high prevalence across the community of Southport & Formby and West Lancashire. The continued and prolonged nature of the outbreak adversely impacts on Length of Stay performance as patients may become unwell to be discharged and / or care (residential and nursing) homes will not accept patients who are symptomatic. The added challenge has been limited side room availability in a hospital Trust that operates a high occupancy levels. The impact of the outbreak has led to the continued usage of escalation beds. This restricts the productivity of the workforce as the Trust has to cope with more beds than its resource allows. The table graph below captures the added pressure the outbreak has had on the Trust which impacts not only on effectiveness but also the financial performance.
- **The Medically Optimised for Discharge (MOfD**) rate continues to operate at 50 patients (or higher) occupying a hospital bed. The health and social care system around the Trust has failed to commission the adequate provision of services to respond to the increased demand for services within the Urgent and Emergency Care system. Across April the community services, like the Trust, were operating at occupancy levels greater than 90% and flows across the system was challenging.

Southport and Ormskirk Hospital NHS Trust

Executive's Assessment of overall position	Executive: Director of Finance	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 1

Month 1 financial performance is a deficit of £2.025 million resulting in an adverse variance of £123,000 against the plan.

Assured/Most Improved

- Model hospital workstreams progressing with NHSI input and will assist with CIP programme.
- Trust activity within 0.6% of month 1 activity plan (although non-elective plan over and elective plan under).
- Reduction in April's agency spend following steady increase throughout 2018/19 culminating in high agency spend in Quarter 4.

Not Assured/Most Deteriorated

- Underlying expenditure levels have not reduced from Quarter 4 (2018/19) levels which are not funded in the financial plan.
- Although April's agency spend (£970,000) has reduced from March's spend (£1.1 million) this remains well above sustainable levels. Medical and nursing staff remain the significant areas.
- 2019/20 financial plan dependent on commissioner income which has not yet been agreed; Agreement reached with Sefton CCG's (Southport & Formby CCG and South Sefton CCG) but the contract with West Lancashire CCG remains unresolved.
- 2019/20 initial CIP plan dependent on £4.5 million expenditure reduction but it is likely that this will rise to £6 million following conclusion of the contract negotiations. CIP schemes not yet fully developed/approved through the CIP governance framework and there is currently a significant gap. Month 1 achievement of £53,000 which was £224,000 behind plan.

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 as improvements need to be consistent over a significant period of time.

Assured/Most Improved

Sickness Absence

Sickness absence has significantly decreased again in month in April 19 to 4.85% which is the lowest levels since September 2017. Sickness absence appears to be improving however until this has been consistently attained the Trust must monitor levels closely and continue the focused work around improving and support staff's attendance to work. In line with national trends, sickness spiked in January to 6.39% however February, March and April saw a reduction in sickness absence to 4.85% the lowest levels since September 2017.

Core Mandatory Training

Core mandatory training rates continue to steadily increase and improve each month. In April, the overall Trust rate was 86.77%.
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 is discussed on a quarterly basis at the Risk and Compliance Committee. A new SOP will ensure any future training which requires competency management on OLM will undergo a full training needs analysis including a cost & impact to service analysis.

Reducing Agency Spend

The continued Trust escalation position has seen a sustained requirement for temporary staffing. Temporary staffing requirements

within Nursing & Midwifery continue to be monitored on a daily basis; enhanced controls for off framework utilisation have been implemented and as at 19 May a 97% reduction for off framework night shifts and a 27% reduction for off framework day shifts have been achieved. The Trust has engaged with the CPC procurement framework and has met with potential tier 2 agencies with plans to implement by end May. The Trust continues to work at a Cheshire & Merseyside system level on alignment of agency spend continues however this work has been impacted by the removal of project support funding and may therefore be delayed in its delivery.

Recruitment Service

The recruitment service and time to hire has been identified as a priority project for the QI programme commencing in June. Early streamlining and efficiency opportunities have been identified and implemented with improvements in availability for booking of ID checks and new starter booking processes. Focused support to recruiting managers in high time lapse recruitment stages has delivered an early reduction in time in stage

- Time to approve vacancy request 9.5 days average April 19 delivering an improvement of 5.4 days (14.9 Q4 average)
- Time to advertise vacancy 7.5 days average April 19 delivering an improvement of 19.7 days (27.2 Q4 average)
- Time to shortlist 12 days average April 19 delivering an improvement of 14.1 days (26.1 Q4 average)
- Time to update interview outcomes 2.7 days average April 19 delivering an improvement of 0.8 days (3.5 Q4 average)
- Time to check references 6.9 days average April 19 delivering an improvement of 4.3 days average (11.2 Q4 average)

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 was due to be developed during April, however due to TUPE and the Health and Wellbeing Manager not being part of the process this work stream has been delayed. Plans are in place for the Acting Health and Wellbeing Manager to pick this up with the HR Lead June/July.

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. NHSI train the trainer course to be attended by members of the Health and Wellbeing and HR team in June 2019.

'Mental Health First Aid Training' for our staff is took place 25th and 26th March, with a second training event on 30th May and 1st April. This training provide support for staff experiencing symptoms of mental health and enable signposting and assistant to appropriate services in a timely manner. Feedback from those that attended was very positive.

Organisational Development

Following work with NHS Elect, the Trust will launch a new programme of staff engagement events in June 2019 called the Meeting Place "Live". This theme works in conjunction with the success of the staff only Facebook Group and takes the conversation out of the virtual world and brings it to life. The staff engagement events will be a combination of workshops, "big brews" held in the staff restaurants, an online survey and paper copies so that all staff have an opportunity to provide feedback to the Board. A monthly feedback report will be provided to Board with communications back to staff via the Trust's communication channels.

Staff survey feedback sessions will be held at both staff restaurants in June 2019, to engage with staff about how we can increase the number of staff completing the survey. Staff feedback will help inform our future communications & engagement campaign.

NHSi will deliver a 2 day Introduction to QI training event in early June 2019 to apply QI approaches to the following projects: food waste, nutrition & hydration and the recruitment process. The key Project Leads along with their respective Executive Team have been invited.

Leadership and Talent Management (TM)

The Shadow Board programme has been rescheduled for September 2019, 9 delegates have been identified to date.

A meeting with the Deputy CEO on 29th May is scheduled to plan a TM Masterclass for the Board followed by a half day practical session with the Executive Team. These sessions will update the Board on the regional TM picture and trigger discussions about what TM means for our Trust. The Exec practical session will introduce a new talent conversation toolkit to support talent conversations with the aim of increasing the number of delegates for the Shadow Board to a full complement of 15.

The Trust will then work with NHS Elect to shape a new Leadership & Talent Management Strategy informed by the above discussions and to align with Vision 2020.

Initial funding bids have been submitted to NHSi to request funding for development programmes for the following target groups:
1) Senior triumvirate teams, 2) New Consultants and 3) Senior Clinical Leaders – CD's / Consultants / SAS

Medical Education – removed

Not Assured/Most Deteriorated
Personal Development Reviews PDR compliance is now at 72.71% for April 2019 which is nearly a 3% decrease from March 2019. This is the lowest compliance rate since January 2019 and has bucked the monthly improvement trend. All CBU's have revised their PDR improvement plans report to meet 85% improvement target by July 2019. Given the dip in performance in order to achieve the Trust target of 85% there would need to be a month on month increase of at least 5% over the next 3 months. There has been no more than a 3% improvement in a single month in the last 12 months therefore the attainment of this trajectory is ambitious at the moment.

NHS
Southport and Ormskirk Hospital
NHS Trust

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

Overview

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, improvement and sustainable to enable the full programmes of work to be viewed as one.

A draft Terms of Reference to develop a Pre Consultation Business Case has been shared with CMHCP and NHSE/I for review agreement has been given in principle to release £500 to support the development of the PCBC and all associated work.

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. Work has begun on applying a fragility test to all Trust specialities.

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 has begun to meet 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.

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 28 May 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)

- there is still a significant gap between identified Cost Improvement Programme schemes and the target. Removal of the scheme to increase income from compliance with the Best Practice Tariff has increased the savings to be made from reducing expenditure.
- agreement has not been reached on the 2019/20 contract with West Lancashire CCG so this could become the subject of an Arbitration Panel.
- an exercise to assess the staffing required to provide a safe emergency care service is underway. It is anticipated that this will highlight a number of potential gaps.

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)

- despite the national challenge in recruiting Consultant Geriatricians, the Trust now has its Frailty Practitioners in post and it was reported that they are having a positive impact. The Committee asked that a review of their effectiveness be undertaken bearing in mind that their importance may grow if recruitment remains difficult.
- work to reduce reliance on off-framework nursing agencies is progressing.
- options for improving the Trust's use of text messaging are under consideration and it is hoped that the preferred option will support the collection of Friends & Family Test data.
- there is a continuing problem in staffing the in-house IT team, with an inevitable impact upon project management.

ASSURE

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

- the Committee was pleased to note that the Trust is 9th out of 136 providers in the Procurement League Table.
- following discussions on the format and content, more detailed and informative Emergency Care and Length of Stay reports were presented, including detailed action plans.

New Risks identified at the meeting

Review of the Risk Register

Alert, Advise, Assure (AAAs) Highlight Report

Committee/Group:	Hospital Management Board
Meeting date:	16 May 2019
Lead:	Silas Nicholls, HMB Chair

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The Director of Finance presented his report; there had been a short reporting framework this month, however, the Trust had not hit the target for Month 1 and currently off plan by £123k. Agency spend was just short of £1m the cost of Thornbury nursing agency was a contributing factor
- Concern was expressed that Month 2 would be worse and planning required to make preparations to be in a better place in time for Month 3.

- Urgent and focused action is required from all project leads to complete CIP documentation, including completion and approval of a QIA so that schemes can be implemented to deliver the necessary savings. The fundamental driver is the CBU CIP meetings; current attendance across the board is inadequate need to adhere to process and deadlines.
- Tony Ellis, Communications & Marketing Manager presented a proposal to re-launch the Trust Charity. A Charity Consultant has been appointed to re-brand the existing Charity. The aim will be to drive up income overall. The existing underlying fund structure will not change but the new-look charity will have five public-facing funds:
    - Sunshine Fund
    - Children & Maternity Fund
    - Cancer Care Fund
    - Dementia & Elderly Care Fund
    - Spinal Injuries Fund

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)

- HMB considered the recommendation from BDISC regarding the Business Cases and were happy to approve the recommendations with the exception of the Recruitment Management & HR Resourcing Business Case this would require further work to help understand the data. Jane Royds is leading the Workforce Improvement Group which will help to forge the process and provide the additional information required to support approval of the Business Case.

ASSURE

(Detail here any areas of assurance that the Committee/Group has received)

- With regard to the Financial target above and agency spend**,** Steve Shanahan and Juliette Cosgrove to establish a Tier 2 nursing band which would remove the need for Thornbury nurses
- The Acute Sustainability Programme Board has developed a suite of projects to stabilise, improve and sustain acute services for the populations of Southport and Formby and West Lancashire

Assurance should be taken that the HMB also discussed the following:

- CQC Well Led
- Maternity & Neonatal Safety Collaborative
- Annual Report
- Quality & Safety Report from Planned Care focusing on Replacement of Ageing Autoclaves, Compressor & Steam Generators. Report tabled by Praph Chohan Decontamination / Sterile Services Manager. Three autoclaves in the Sterile Services Department sterilise medical devices for the Trust and external customers. They are 20+ years old and had a face lift with the electronic fascia/printers in 2010.
- Quality Improvement Plan
- Update received on 7 Day Cancer Pathway Project Update Report. A Cancer Improvement Group has been set up and each individual Tumour Group has been invited to meet with the Chief Operating Officer and the Medical Director to discuss their improvement plan and any barriers to success and progress against the Regional Optimal Pathways

New Risks identified at the meeting:

(*State new risks here **OR** state 'None identified' if there is none)*

NONE

Review of the Risk Register:

(List any risks reviewed at the Committee meeting and state any adjustments to the scores, why they were adjusted and any actions agreed for improvement)

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 23rd May 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)

Sickness Absence
Whilst sickness absence levels have decreased, the level will still have an impact on target savings in the CIP.

PDR Compliance
PDR compliance is now at 72.71% for April 2019 which is nearly a 3% decrease from March 2019. This is the lowest compliance rate since January 2019 and has bucked the monthly improvement trend. It was agreed at May's WFC for the Director of HR and OD and the Chief Operating Officer to meet and agree the objectives to jointly drive progress from a human resources and operational perspective.

Nursing Fill Rates
Nursing fill rate remains a concern with 44% of requested shifts filled by bank and 41% of requested shifts filled by agency; nursing bank fill deteriorated by 2% compared to March. NHSP are still not meeting their KPI's.

ADVISE

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

Sickness Absence
Sickness absence has significantly decreased again in month to 4.85% which is the lowest levels since September 2017. Sickness absence appears to be improving however until this has been consistently attained, the Trust must monitor levels closely and continue the focused work around improving and support staff's attendance to work. Theatres in particular have made a significant improvement where levels have dropped from 17% to 6-5%. NHSI expectations have been exceeded.

Business Case
The HR business case is awaiting approval to support, in particular, the staffing required to support the level of recruitment activity.

Appointment Advisory Committee (AAC) Panels
There are currently 13 active, substantive consultant posts awaiting recruitment, which all require AAC panels. The Recruitment Team are struggling to get availability from Executives and Non-Executive Directors to sit on the panels. This is an appeal to support wherever possible.

ASSURE

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

Safe Staffing
For the month of April 2019 the Trust reports safe staffing against the national average (90%) at 94.45%. This is compared to March 2019 which was 92.8% and February 2019 that was 91.34%.

There has been an increase in approx.19 wte registered nurse vacancies within the Trust – this is aligned to budget changes to establishments through business case agreements. These vacancies are active within the recruitment process.

Equality and Diversity
Significant progress has been made from a "behind the line" start and the Chair and Committee commends the work completed by Bob Davies.

EDS2 Assessment
The Trust has seen a significant improvement in goals 1 and 2 which are patient focused with 8 of the 9 outcomes progressing from developing to achieving in 2018-2019.

Mandatory Training
Mandatory training rates have now exceeded the Trust target of 85% where Trust compliance is now at 86.77%. Work is ongoing to support managers to ensure rates are monitored and staff are encouraged and given the opportunity to undertake mandatory training. In order to ensure there is a continuous focus, especially in terms of content and delivery, mandatory training will now be discussed on a regular basis at the Risk and Compliance Committee.

New Risk identified at the meeting	Sickness absence impact on target savings.

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

5 June 2019

Agenda Item	**TB113/19**	**Report Title**	**Financial Position at Month 1 – 2019/20**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Steve Shanahan, Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Trust signed up to its 2019/20 deficit control total of £8.296 million (£26.567 million deficit before non-recurrent funding of £18.271 million).

This report contains the month 1 performance against the plan submitted to NHSI on 4th April 2019.

A deficit of £2.025 million has been delivered against a plan of £1.902 million resulting in £123,000 adverse against plan.

The main commissioner contract with Sefton CCG's (Southport & Formby CCG and South Sefton CCG) has been agreed. At the time of writing the contract with West Lancashire CCG contract remains unresolved.

Monthly pay expenditure levels incurred in Quarter 4 of 2018/19 were not budgeted for in the 2019/20 financial plan. These higher expenditure levels have continued into April and are not sustainable. The 2019/20 deficit control total will not be achieved unless this can be addressed.

The CIP programme delivered £53,000 in month which was £224,000 lower than the £277,000 target.

There is a risk that the month 1 deficit position could deteriorate following contract agreement as income could be lower than both plan and actual.

Recommendation

The Board is asked to **receive** the Month 1 Director of Finance 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

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

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

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

Director of Finance Report – April 2019

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 1 (the financial period ending 30th April 2019).

1.2. The report also includes an update on the 2019/20 contract discussions and the current status of £3.1m worth of business cases approved in the 2019/20 financial plan.

2. Executive Summary

2.1. The Trust did sign up to its 2019/20 deficit control total of £8.296 million (£26.567 million deficit before non-recurrent funding of £18.271 million).

2.2. The non recurrent funding consists of Provider Sustainability Funding (PSF) of £3.464 million and Financial Recovery Fund (FRF) of £14.807 million.

2.3. This report contains the month 1 performance against the plan submitted to NHSI on 4th April 2019.

2.4. A deficit of £2.025 million has been delivered against a plan of £1.902 million resulting in £123,000 adverse against plan.

2.5. The main commissioner contract (Sefton CCG's) has been agreed. At the time of writing the West Lancashire CCG contract is unresolved. Therefore, there is a risk that the month 1 position could deteriorate following contract agreement as income could be lower than plan (see section 3).

2.6. The CIP programme delivered £53,000 which was £224,000 lower than the £277,000 target.

2.7. Expenditure levels incurred in April are not sustainable and the 2019/20 control total will not be achieved unless this can be addressed.

2.8. Monthly pay expenditure rose in January 2019 and continued throughout Quarter 4. After accounting for the 2019/20 pay award these higher levels have continued into April. This level of expenditure has not been budgeted for in the 2019/20 plan and, therefore, is the main contributor to the adverse performance in month.

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

I&E (including R&D)	Annual Budget £000	In Month		
		Budget £000	Actual £000	Variance £000
Operating Income				
Commissioning Income	166,893	13,810	13,730	(80)
PP, Overseas & RTA	1,090	91	61	(30)
Other Income	30,049	1,877	1,939	62
Total Income	**198,031**	**15,778**	**15,730**	**(48)**
Operating Expenditure				
Pay	(140,563)	(11,866)	(12,238)	(372)
Non-Pay	(53,648)	(4,799)	(4,491)	308
Total Expenditure	**(194,211)**	**(16,665)**	**(16,729)**	**(64)**
EBITDA	**3,820**	**(887)**	**(999)**	**(112)**
Non-Operating Expenditure	(12,149)	(1,026)	(1,029)	(3)
Retained Surplus/(Deficit)	**(8,329)**	**(1,913)**	**(2,028)**	**(115)**
Technical Adjustments	33	11	3	(8)
Break Even Surplus/(Deficit)	**(8,296)**	**(1,902)**	**(2,025)**	**(123)**

3. 2019/20 Contract discussions

3.1. At the private meeting on 1st May 2019 the Board received an update on the latest contract discussions.

3.2. The Trust plan includes a contract settlement of £135.0 million from the three CCG's. This is consistent with the Operational Plan submission on 4th April 2019.

3.3. Following a number of discussions between Chief Financial officers of the Trust and CCG's there have been further adjustments to the contract value and Trust's expenditure plans.

3.4. On 3rd May 2019 the Trust decreased its contract ask to £133.0 million on the basis that the Trust:

- Reduced the business case commitment (in year slippage from planned £3.1 million) - £0.8 million.
- Reassessed reserves required to fund 2019/20 pay award - £0.3 million
- Removed contingency - £0.9 million.

3.5. A meeting, chaired by the System Turnaround Director, was held between the three Chief Financial Officers on 15th May 2019 to discuss the £4 million contract gap.

3.6. The Trust agreed to reduce the contract plan by £1.5 million in respect of Best Practice Tariffs (BPT). As there is no expenditure within the plan associated with BPT the impact of this adjustment is to increase the £4.5 million expenditure CIP target to £6.0 million.

3.7. The table below illustrates the impact of this on the Trusts' CIP:

	Operational Plan £M	**Revised Plan £M**
Income (BPT)	1.8	0.3
Expenditure	4.5	6.0
CIP Total	**6.3**	**6.3**

3.8. The additional £1.5 million CIP target will focus on unfunded services in a joint piece of work with CCG's.

3.9. It is proposed that the remaining £2.5 million gap will be addressed as follows:

- Two way split
  - Sefton CCG's £1.25 million
  - West Lancashire CCG £1.25 million

3.10. Discussions are ongoing at the time of writing this report so a verbal update will be provided at the Board meeting.

4. Business Cases

4.1. The 2019/20 financial plan includes £3.1 million expenditure in relation to prioritised Statement of Case (SOC) for investment.

4.2. Each of the SOC's have to go through the relevant governance processes before expenditure can be incurred.

4.3. As described in section 3.4 above the SOC investment has been reduced to £2.3 million to account for in year slippage.

4.4. None of the business cases resulting from the SOC list have been funded in the month 1 position. Any proposed investment will only be sanctioned providing the financial performance (including CIP) allows.

5. Income Performance

5.1. Until contract discussions have been concluded the Trust's commissioning income budget is consistent with April's operational Plan submission.

5.2. The Trust has underperformed against April's commissioning income budget by £80,000 (0.6%).

5.3. As explained in section 3 it is likely that the Trust's income plan (and actual) will reduce as part of these discussions.

Commissioning for Quality and Innovation payments (CQUINS)

5.4. There has been a change to the way CQUIN is funded in contracts in 2019/20.

5.5. In 2018/19 the Trust's income plan included £3.2 million (2.5%). In 2019/20 half of CQUIN funding has been built into the tariff. The other half (1.25%) is a non-recurrent addition to the contract.

5.6. As part of the agreed contrac the Trust will receive 1.25% CQUIN as planned.

Sanctions

5.7. As the Trust has signed up to the deficit control total this year sanctions can only be applied against a limited number of standards. The total sanction applicable for April is £8,000. No sanctions have been brought into the month 1 income position as contract negotiations have not been finalised.

6. Expenditure

6.1. Current expenditure levels are unsustainable. Monthly pay expenditure has continued at the high levels experienced in Quarter 4 of 2018/19.

6.2. The 2019/20 financial plan was based on average monthly expenditure levels from months 6-9 inclusive. Monthly pay expenditure then rose in January 2019 as a result of escalation beds and winter pressures and continued at this higher level throughout Quarter 4. The monthly average in Quarter 4 was circa £400,000 higher than months 6-9.

6.3. After adjusting for the 2019/20 pay award (and 2018/19 business case investments) these higher levels have continued into April. This level of expenditure has not been budgeted for in the 2019/20 plan and, therefore, is the main contributor to the adverse performance in month.

6.4. The increased run rate has mainly been driven by higher agency costs (£984,000 average in Quarter 4 compared to months 6-9 average of £738,000). This increase has been incurred alongside higher bank and substantive expenditure.

6.5. April's pay expenditure includes the 2019/20 pay award for Agenda for Change staff. April budgets have been funded at 1.1% plus the non-consolidated award for the staff on the maximum point of the salary scale at March 2019.

6.6. £488,000 of April's expenditure relates to the 2019/20 Agenda for Change pay award as follows:

- 1.1% recurrent pay award - £70,000
- Non consolidated award - £418,000

6.7. The total impact of the award is 2.8% with annual increments included. There is a separate reserve for the incremental drift throughout the year to cover the additional 1.7%.

6.8. The Medical and Dental pay award has yet to be agreed; a 2.8% award has been assumed for this staff group and accrued in reserves in April (£57,000).

6.9. Medical and Nursing staff groups continue to overspend which is a reflection of the increased escalation beds opened throughout April along with the high level of vacancies and the necessity to fill shifts at premium rates.

6.10. Nursing is overspent by £332,000 in month. A significant element of the CBU overspend will be addressed once the funding associated with the nursing establishment business case has been implemented.

6.11. However, some of the overspend will remain if escalation beds are still in operation as these are not part of the establishment review.

6.12. Additionally, posts in the business cases agreed during 2018/19 have contributed to the overspend as some of these have been filled by agency until substantive staff have been appointed.

7. Agency spend

7.1. The Trust spent £970,000 on agency staff in April (9.4% of the substantive payroll) and is mainly across medical and nursing staff although spend on Admin & Clerical posts continues.

7.2. Monthly agency expenditure had increased steadily from August 2018 onwards with a step change in Quarter 4 which coincided with winter pressures and the necessity to staff additional escalation beds which has continued into April. Nurse agency spend has seen a slight reduction this month as a result from the following changes:

- Establishing Tier 2 agencies through a framework to avoid use of non-framework suppliers.
- Continuing to work with 'cascade' agencies to fill 'long-day' bookings.
- Utilising a block booking for Frail & Elderly ward & EAU through NHSP.
- Working closely with NHSP to increase the number of 'Allocate on Arrival' shifts.
- Utilising 'enhanced rate of pay' for Bank staff via 'Allocation on Arrival' on selected wards
- Ceasing HCA agency.
- Reduced the number of authorised 'golden key' users.
- Re-enforcing the authorisation process which is through the Deputy Director of Nursing only.

7.3. Nurse agencies spend for April was £372,000 with the main area being Emergency Care (£200,000), General Medicine (£38,000) and General Surgery (£70,000).

7.4. The key areas of medical staff agency spend for April 2019 are Anaesthetics £71,000 and General Medicine £189,000

7.5. Other medical staff high spend areas are General Surgery £128,000, General Medicine £53,000 and A&E £33,000.

7.6. An agency target cap of £4.891 million has been set by NHSI for 2019/20. The Trust's Operational Plan submission did not plan to achieve the cap given the level of spend in Quarter 4 of 2018/19.

8. Cost Improvement Plan (CIP)

8.1. The Trust's I&E plan assumes a £6.3 million CIP is delivered in 2019/20 from both increased income and reduced expenditure.

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

	Annual	YTD					
	Plan £000	Plan £000	Actual £000	Var £000	CYE £000	FYE £000	FOT £000
19/20 Plan - Expenditure	4,514	186	53	(133)	631	613	3,600
19/20 Plan - Income (BPT)	1,800	91	0	(91)	0	0	300
18/19 Balance to FYE	372	31	31	0	0	372	372
Total	6,686	308	84	(224)	631	985	4,272

9. Cash

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

9.2. A rolling 13 week cash forecast is updated monthly and sent to NHSI, usually in the second working week of the month; this forms the basis of any cash draw downs in the future month. April's cash flow was sent on 13th March 2019.

9.3. The Trust borrowed £2.456 million in February.

9.4. Note the Trust has agreed its control total with NHS Improvement and interest charges are now at the normal 1.5% rate.

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

Description	Target £000	Actual £000	Comments
Opening balance	1,000	1,042	Brought forward balance.
Cash inflows	16,908	17,728	Majority of the difference relates to an agreed early payment from West Lancs CCG of £600,000
Cash outflows	(16,908)	(14,381)	At year-end was able to pay early March's national insurance bill (normally due mid April and pay all suppliers completely up to date. This assists the Trust going into April and so cash outflows were lower than planned.
Closing balance	**1,000**	**4,389**	

10. Capital

10.1. In month spend is £286,000 against a plan of £196,000.

10.2. Based on discussions at Capital Investment Group it is likely that the plan will need to be revisited to accommodate spinal isolation facilities (budget £150,000 but tender price is £232,000) and potential investment in a new car parking system.

10.3. There may be further adjustments required within IT to ensure that overall spend on these projects is contained within the £2.08 million annual capital IT budget.

11. Recommendations

11.1. The Board is asked to receive the month 1 Director of Finance report.

List of Appendices

1. Activity
2. Income
3. Expenditure run rate by month
4. Whole Time Equivalent (WTE) by month
5. Statement of Financial Position (Balance Sheet)
6. Capital

NHS
Southport and Ormskirk Hospital
NHS Trust

	2018/19												2019/20
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1
AandE	6,706	7,226	6,927	7,144	6,651	6,918	7,309	7,328	6,896	7,269	6,756	7,595	7,065
Day Case	1,713	1,750	1,823	1,868	1,823	1,616	1,906	1,984	1,444	1,878	1,731	1,854	1,704
Elective	199	227	194	178	221	179	212	189	138	180	175	179	145
Non Elective (Including Short Stay)	1,784	2,235	2,244	2,177	2,351	2,482	2,654	2,679	2,644	2,741	2,480	2,646	2,370
Non Elective Non Emergency	211	226	237	255	261	273	239	233	285	241	254	262	264
Outpatients (Including Procedures)	13,289	14,149	14,301	14,792	13,696	14,307	16,515	15,871	12,855	14,926	14,462	15,302	14,809

Southport and Ormskirk Hospital NHS Trust

Income Analysis

Income	Annual Budget £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000	In Month Budget £'000	In Month Actual £'000	In Month Variance £'000
Operating Income							
Commissioning Income	166,893	13,810	13,730	(80)	13,810	13,730	(80)
PP, Overseas & RTA	1,090	91	61	(30)	91	61	(30)
Other Income	30,049	1,877	1,939	62	1,877	1,939	62
Total Income	**198,031**	**15,778**	**15,730**	**(48)**	**15,778**	**15,730**	**(48)**

Analysis - PP, Overseas, RTA	Annual Plan £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000	In Month Budget £'000	In Month Actual £'000	In Month Variance £'000
PP, Overseas, RTA							
Private Patients	84	7	6	(1)	7	6	(1)
Overseas Patients	90	8	2	(6)	8	2	(6)
RTA Income	916	76	53	(23)	76	53	(23)
Total Income	**1,090**	**91**	**61**	**(30)**	**91**	**61**	**(30)**

Other Income	Annual Plan £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000	In Month Budget £'000	In Month Actual £'000	In Month Variance £'000
Other Income							
Training & Education	5,493	458	458	**0**	458	458	**0**
Income Generation	2,719	216	224	**7**	216	224	**8**
Services to Other Bodies	222	19	24	**5**	19	24	**5**
R&D	244	15	23	**8**	15	23	**8**
Other Income & Charges	21,371	1,170	1,212	**42**	1,170	1,212	**42**
Total Income	**30,049**	**1,877**	**1,939**	**62**	**1,877**	**1,939**	**62**

Operating income

Commissioning income - Income plan based on Trust's submission to NHSi, until 19/20 Contracts agreed.

PP,Overseas, RTA income

RTA - 2019/20 income budget has been reduced to reflect the 2018/19 performance .

Other income

Other income & charges - included under other income the Financial Recovery Fund of £740k and the provider sustanability fund of £173k at month 1 . Total £913,000.

NHS
Southport and Ormskirk Hospital
NHS Trust

Staff Group	Staff Type	2018/9 Month 1 Actual £000	Month 2 Actual £000	Month 3 Actual £000	Month 4 Actual £000	Month 5 Actual £000	Month 6 Actual £000	Month 7 Actual £000	Month 8 Actual £000	Month 9 Actual £000	Month 10 Actual £000	Month 11 Actual £000	Month 12 Actual £000	2019/20 Month 1 Actual £000
Consultants	Substantive	1,251	1,275	1,302	1,346	1,258	1,346	1,319	1,299	1,319	1,395	1,324	1,118	1,238
	Bank	106	85	80	106	63	70	50	40	70	101	78	104	98
	Agency	91	131	86	69	96	109	110	154	187	179	206	272	279
	Total	1,448	1,491	1,468	1,521	1,417	1,525	1,479	1,493	1,576	1,675	1,608	1,494	1,615
Other Medical staff	Substantive	1,113	1,129	1,147	1,114	1,220	1,165	1,243	1,202	1,263	1,319	1,307	1,245	1,320
	Bank	154	97	155	136	157	129	129	163	142	137	115	167	165
	Agency	234	222	246	318	279	240	226	217	208	244	273	316	256
	Total	1,501	1,448	1,548	1,568	1,656	1,534	1,598	1,582	1,613	1,700	1,695	1,728	1,741
Nurses & Midwives	Substantive	3,530	3,529	3,567	3,588	3,879	3,600	3,628	3,604	3,570	3,703	3,672	3,388	3,955
	Bank	482	522	496	494	660	544	529	565	543	595	588	684	609
	Agency	137	181	156	191	250	291	367	294	262	427	415	436	372
	Total	4,149	4,232	4,219	4,273	4,789	4,435	4,524	4,463	4,375	4,725	4,675	4,508	4,936
Scientific, Technical &Theraputic	Substantive	1,296	1,268	1,252	1,272	1,375	1,320	1,331	1,330	1,307	1,320	1,319	1,271	1,453
	Bank	3	3	4	13	16	12	11	13	12	9	12	12	7
	Agency	16	18	13	22	17	17	16	20	15	12	8	14	4
	Total	1,315	1,289	1,269	1,307	1,408	1,349	1,358	1,363	1,334	1,341	1,339	1,297	1,464
Other Staff	Substantive	1,868	1,847	1,859	1,962	2,183	1,989	2,010	2,040	1,981	1,965	2,008	1,731	2,284
	Bank	30	27	30	34	37	24	31	7	28	27	19	34	38
	Agency	53	58	50	16	46	48	63	51	58	59	50	54	59
	Total	1,951	1,932	1,939	2,012	2,266	2,061	2,104	2,098	2,067	2,051	2,077	1,819	2,381
Reserves	Substantive	397	394	357	125	(199)	0	0	(35)	(184)	(232)	(798)	176	57
Apprenticeship Levy	Substantive	33	43	38	38	40	38	39	44	39	41	40	47	44
	Total	430	437	395	163	(159)	38	39	9	-145	-191	-758	223	101
Total Pay	Substantive	9,488	9,485	9,522	9,445	9,756	9,458	9,570	9,484	9,295	9,512	8,872	8,976	10,351
	Bank	775	734	765	783	933	779	750	788	795	869	812	1,001	917
	Agency	531	610	551	616	688	705	782	736	730	921	952	1,092	970
	Total	**10,794**	**10,829**	**10,838**	**10,844**	**11,377**	**10,942**	**11,102**	**11,008**	**10,820**	**11,301**	**10,636**	**11,069**	**12,238**
Non-Pay														
Supplies & Services Clinical		2,102	2,287	2,174	2,140	2,290	2,260	2,317	2,291	2,228	2,249	2,227	2,413	2,264
Supplies & Services General		176	186	222	183	182	222	204	214	200	203	199	212	186
Establishment Expenses		213	257	250	230	273	291	288	352	295	298	292	268	213
Premises & Fixed Plant		950	1,002	929	1,002	830	936	990	943	993	953	917	790	1,018
Miscellaneous		675	652	662	656	637	625	616	632	659	638	654	595	707
Services From Other NHS Bodies		249	268	239	280	251	269	279	293	209	287	253	328	103
Non Operating Expenditure		938	935	935	935	938	954	920	939	942	939	940	411	1,031
Total		**5,303**	**5,587**	**5,411**	**5,426**	**5,401**	**5,557**	**5,614**	**5,664**	**5,526**	**5,567**	**5,482**	**5,017**	**5,522**
Total Expenditure		**16,097**	**16,416**	**16,249**	**16,270**	**16,778**	**16,499**	**16,716**	**16,672**	**16,346**	**16,868**	**16,118**	**16,086**	**17,760**

2019/20 notes

HR contract now in pay wef April 2019 which accounts for some of the increae in "other staff". Also impacts as a reduction in "services from other NHS bodies"

2019/20 Agenda for Change pay award in April 2019 which includes non recurrent amount of £418,000 for staff on top of scale

NHS
Southport and Ormskirk Hospital
NHS Trust

WTE by month for 2019/20
(Worked)

		2018/19												2019/20
Staff Group	Staff Type	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Consultants	Substantive	95	94	101	99	93	98	100	103	102	94	99	97	96
	Bank	7	5	5	6	3	2	2	2	4	4	5	5	5
	Agency	5	6	6	4	4	4	5	8	9	8	10	12	12
	Total	106	105	112	109	100	104	107	114	115	107	114	115	114
Other Medical staff	Substantive	199	195	186	193	198	203	207	207	215	218	224	222	221
	Bank	13	9	11	15	10	10	10	11	10	9	10	11	13
	Agency	20	18	21	26	21	19	18	19	18	21	24	28	20
	Total	232	223	219	235	229	231	235	236	242	249	258	261	254
Nurses & Midwives	Substantive	1,090	1,092	1,088	1,087	1,080	1,076	1,097	1,101	1,098	1,094	1,101	1,110	1,106
	Bank	153	167	160	185	206	158	161	171	161	172	176	208	178
	Agency	25	35	27	30	34	39	48	44	42	62	59	69	63
	Total	1,269	1,294	1,275	1,302	1,320	1,273	1,305	1,315	1,302	1,329	1,336	1,387	1,347
Scientific, Technical &Theraputic	Substantive	410	405	395	394	391	406	410	403	402	402	407	405	409
	Bank	2	1	2	3	4	4	3	2	2	2	3	2	2
	Agency	3	4	3	4	4	3	3	4	3	3	2	2	1
	Total	415	410	401	401	399	413	417	410	407	407	411	410	412
Other Staff	Substantive	767	756	764	764	764	772	775	774	771	760	772	773	810
	Bank	17	15	15	15	15	15	12	15	12	9	11	14	15
	Agency	9	8	7	7	8	7	9	14	11	7	10	8	8
	Total	793	779	786	787	787	794	797	803	793	777	793	795	833
Total Pay	Substantive	2,562	2,542	2,534	2,538	2,527	2,555	2,589	2,589	2,588	2,569	2,603	2,608	2,642
	Bank	191	197	193	225	237	189	187	200	190	198	205	240	213
	Agency	63	71	65	71	71	72	84	89	82	102	104	119	103
	Total	**2,815**	**2,811**	**2,792**	**2,834**	**2,835**	**2,816**	**2,860**	**2,878**	**2,860**	**2,868**	**2,912**	**2,967**	**2,959**

2019/20 notes

Statement of Financial Position (Balance Sheet)

Southport & Ormskirk Hospital NHS
NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	30/04/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	122,759	(308)	(308)
Other assets	966	1,052	86	86
TOTAL NON CURRENT ASSETS	**124,033**	**123,811**	**(222)**	**(222)**
CURRENT ASSETS				
Inventories	2,382	2,323	(59)	(59)
Trade and other receivables	11,678	12,541	863	863
Cash and cash equivalents	1,042	4,389	3,347	3,347
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**19,253**	**4,151**	**4,151**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(27,174)	(4,403)	(4,403)
Provisions	(199)	(209)	(10)	(10)
PFI/Finance lease liabilities	(1,153)	(1,153)	0	0
DH revenue loans	(411)	(400)	11	11
DH Capital loan	(20,487)	(40,031)	(19,544)	(19,544)
Other liabilities	(1,025)	(993)	32	32
TOTAL CURRENT LIABILITIES	**(46,046)**	**(69,960)**	**(23,914)**	**(23,914)**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(50,707)	(19,763)	**(19,763)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**73,104**	**(19,985)**	**(19,985)**
NON CURRENT LIABILITIES				
Provisions	(207)	(198)	9	9
DH revenue loans	(82,953)	(65,260)	17,693	17,693
PFI/Finance lease liabilities	(13,831)	(13,774)	57	57
DH Capital loan	(1,000)	(800)	200	200
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(80,032)**	**17,959**	**17,959**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(6,928)**	**(2,026)**	**(2,026)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,214	0	0
Retained earnings	(112,432)	(114,458)	(2,026)	(2,026)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(6,928)**	**(2,026)**	**(2,026)**

In month material movements are as follows:

Note that the Trust is operating with a negative balance sheet due to the value of loans it has taken out over a number of years.

Variances between the audit closing balance sheet and month 1 can look odd as there are numerous presentation changes of the balance sheet that happen at year-end which are then not carried forward into the normally monthly balance sheet.

Of note then is that cash positon was good in April as suppliers were paid up fully in March plus there was an early payment of March's national insurance. This provided a cushion going into April.

A loan for £20m is due for payment in April 20 and this has been re-classified as current.

The adverse movement on the balance sheet of £2.026m is consistent with the in-month deficit.

Source of information from Financial se\controlxxYY\balance sheets

NHS Southport and Ormskirk Hospital NHS Trust

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M1 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0090	1,000	25	7	18	6		1,000	13	987
	Beds / Trolleys	G0060				0			0	0	0
	Sub total MEDICAL DEVICES		**1,000**	**25**	**7**	**18**	**6**	**0**	**1,000**	**13**	**987**
IM&T	Electronic Patient Record Bluespier	G0100	111	0	0	0			111	0	111
	Electronic Patient Record PDS	G0101	69	12	0	12			69	0	69
	Electronic Patient Record Careflow	G0102	149	0	0	0	277		149	277	(128)
	Vitalpac	G0007	10	0	0	0			10	0	10
	Patient Service Signposting	G0103	184	46	184	(138)			184	184	0
	eDMS Evolve	F6447	80	0	51	(51)			80	51	29
	Windows 10 Project	G0104	318	0	0	0			318	0	318
	Telephony System Replacement	G0059	50	0	0	0			50	0	50
	Baby Tagging	G0105	50	0	0	0			50	0	50
	Cyber Security	G0071	80	20	(3)	23			80	(3)	83
	Fixed Network Infrastructure	F6498	120	10	0	10			120	0	120
	PAS Replacement	F6409		0	6	(6)			0	6	(6)
	Data Storage Infrastructure	G0106	25	0	0	0			25	0	25
	Wireless Network Upgrade	G0073		0	1	(1)			0	1	(1)
	IM&T Contingency	G0107	450	0	0	0			450	0	450
	Sub total IM&T		**1,696**	**88**	**239**	**(151)**	**277**	**0**	**1,696**	**516**	**1,180**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	350	0	0	0			350	0	350
	6 Facet Survey	G0150	90	0	0	0			90	0	90
	Nurse Call System	G0151	100	0	0	0			100	0	100
	Upgrade Ventilation Plants	G0152	100	0	0	0			100	0	100
	Fire compartmentation	G0052	100	0	0	0			100	0	100
	Fire Precautions - Fire Doors	G0019	100	0	0	0			100	0	100
	Legionella Prevention	G0153	50	0	0	0			50	0	50
	Spinal Lift & Ramp	G0154	85	0	0	0			85	0	85
	Spinal isolation works	G0099	150	50	0	50			150	0	150
	Ward Refurbishments	G0155	600	0	0	0			600	0	600
	Library Extension	G0156	145	10	0	10			145	0	145
	Capital Team	F6305	160	13	16	(3)			160	16	144
	CCTV	G0157	50	0	0	0			50	0	50
	UPS Theatre	G0053		0	1	(1)			0	1	(1)
	Southport A&E	G0068		0	1	(1)			0	1	(1)
	Sexual Health Accomodation	G0079		0	3	(3)			0	3	(3)
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,080**	**73**	**21**	**52**	**0**	**0**	**2,080**	**21**	**2,059**
FACILITIES	Catering equipment	G0026	75		18	(18)	0		75	18	57
	Vehicle Replacement	G0145	50			0	0		50	0	50
	Sub total FACILITIES		**125**	**0**	**18**	**(18)**	**0**	**0**	**125**	**18**	**107**
	CONTINGENCY	**F6301**	**202**	**10**	**1**	**9**	**40**		**202**	**41**	**161**
	Capital plan excluding donations and IFRIC 12		**5,103**	**196**	**286**	**(90)**	**323**	**0**	**5,103**	**609**	**4,494**
OTHER	Donated assets	000000	100			0			100	0	100
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,214			0			1,214	0	1,214
	Sub total Donations and IFRIC 12		**1,314**	**0**	**0**	**0**	**0**	**0**	**1,314**	**0**	**1,314**
	TOTAL CAPITAL SPEND		**6,417**	**196**	**286**	**(90)**	**323**	**0**	**6,417**	**609**	**5,808**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB114/19**	**Report Title**	**Board Assurance Framework and Risk Appetite Statement**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Board Assurance Framework's (BAF) risk have been discussed at the assurance committees and executive risk owners have reviewed, culled or updated their controls, assurances and action plans. They have also updated their areas of risks on the Risk Appetite Statement and assigned appetites to each area.

This report includes:

- All six risks updated
- A completed Risk Appetite Statement

There are two areas against which narrative will be added as risk owners familiarize themselves with the new format and will be included in the the next report.

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 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

A report will be brought to the Quality & Safety Committee on a quarterly basis and six monthly to the Board

Previously Presented at:

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

TB114/19a RISK APPETITE AGAINST KEY AREAS OF STRATEGIC PRIORITY 2019/20

	OBJECTIVES	RISK APPETITE CATEGORY	AREA OF RISK	RISK APPETITE	STRATEGIC BLUEPRINT	PRINCIPAL RISKS
Quality	**Improve clinical outcomes and patient safety to ensure we deliver high quality services**	**CAUTIOUS**	Recognition management of the deteriorating patient	**Cautious**	We will protect people from harm, provide effective care and make sure that they have a good experience of care. We will collect appropriate information on quality and share this information quickly with the people who are best placed to improve care. We will empower our people to get things done and will be constantly vigilant in keeping quality standards high. We will take every opportunity to compare ourselves with other providers so that we continue to strive for excellence. We will put patient experience at the heart of what we do and report consistently high quality experiences.	**If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.**
			Care of the older person	**Cautious**		
			Infection prevention and control	**Cautious**		
			Medicines management	**Cautious**		
Operations	**Deliver services that meet NHS constitutional and regulatory standards**	**OPEN**	Achievement of quality targets for ED	**Moderate**	Our service users and carers will tell us that our services are of high quality. Our local GP colleagues will recommend us to family and friends. We will be respected by our commissioners and other providers as a co-producing partner in shaping new service models that deliver our aligned strategies. We will have achieved a national reputation for excellence and will build a multi-region secure services business.	**If the Trust cannot achieve its key performance targets it may lead to loss of services.**
			Achievement of quality targets for RTT	**Open**		
			Achievement of quality targets for cancer	**Moderate**		
			Achievement of quality targets for diagnostics	**Moderate**		
Finance	**Efficiently and productively provide care within agreed financial limits**	**OPEN**	Deliver our control total	**Open**	We will operate at, at least our current scale. We will provide services that offer excellent value for money without compromising financial stability. Local accountability and decision-making will enable services to sustain margins to fund investment. We will be outwards looking and actively seeking business opportunities to expand and serve new geographies, whilst concentrating on things that add value for our customers and for local people. We will succeed by competing on quality.	**If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question**
			Maximize capacity using transformative efficiency and productivity tools within the specified timeline as set out in the BAF	**Open**		
Workforce	**a. Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated** **b. Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values**	**OPEN**	Culture – organisational development	**Hungry**	We will have effective and appreciative leadership throughout the organisation, creating a high performance environment. Out people will be clear about what is expected on them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, supported to reach their potential and embrace change. People will want to work here.	**a. 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.** **b. If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted**
			Staff Recruitment & Retention	**Open**		
			Employer of Choice	**Open**		
			Staff Engagement	**Hungry**		
			Workforce Transformation	**Open**		
Strategy	**Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire**	**HUNGRY**	Engage with partners to develop opportunities for joint working	**Hungry**	We will deliver integrated mental and physical health care services. We will reduce waiting times across all services and localities. We will deliver increased volume to meet demand and increase productivity. We will focus our efforts on key services and initiatives and change services that do not deliver agreed outcomes. We will ensure patients are cared for in appropriate environments and services and will pilot innovative services earlier in patient pathways.	**There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services**
			Develop an affordable, sustainable acute services model	**Hungry**		

Averse	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.	**Cautious**	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	**Moderate**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**Open**	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	**Hungry**	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	**1**	**Risk Description**	***If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety*** **Cause**: • Significant number of clinical staff vacancies • Clinical capabilities and competence, recruitment and retention problems, trust location and estate • Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies • Failure of national performance target (cancer, RTT) • Failure to reduce delayed transfers of care in the changing NHS environment **Potential Effect**: • Reputational damage leading to difficulty in recruitment. • High numbers of people waiting for transfer from inpatient care, particularly older people • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience feedback via Friends and Family Test and National Surveys • Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services **Potential Impact:** • On reputation. • Failure to meet contractual requirements. • Inability to deliver the best clinical outcomes for patients • Increased patient safety incidents, increased levels of patient harm, loss of commissioner and patient confidence in provision of services, enforcement action, prosecution, financial penalties, and reputational damage.

Risk Appetite:	**CAUTIOUS**	**Risk Scores:**	**Initial**	**16** **4x4** **(Likelihood x Consequence)**	**Current**	**12** **3x4** **(LxC)**	**Target**	**8** **2x4** **(LXC)**
DATIX Code:	TBC	**Risk Rating Tracker**						
Executive Director	Director of Nursing/Medical Director							
Assurance Committee	Quality & Safety Committee							
Strategic Objective	**SO1** – Improve clinical outcomes and patient safety to ensure we deliver high quality services							

Controls		**Sources and Level of Assurance**	**Action Plan / Progress Notes**
1. Quality Improvement Plan in place identifying four priorities for 2019/20 2. Reducing Avoidable Mortality Project including compliance with the National Structured Judgement Review method designed by the Royal College of Physicians 3. Training programme (mandatory and non-mandatory) 4. Clinical Policies in place. 5. Governance processes around policies and guidelines 6. Management of NICE guidance and clinical audit 7. Engagement with the GIRFT programme 8. All medical staff have work plans agreed with CDs and MD.	**1**	**Management assurance** 1. Local and National Audit Programme/Audit Strategy 2. MDT approach to patient management 3. Directorate performance reviews 4. Monthly and Annual Mortality Reports to Mortality Operational Group and Trust Board 5. STEIS and Incident Reporting 6. Monthly CBU Quality and Safety Reports 7. Reports to Patient Flow Improvement Board 8. Clinical Revalidation	1. Further improvements to be made in relation to support for clinical teams to be involved in clinical audit 2. Further enhance the shared learning across relevant Business Units from incidents, complaints and audits 3. Consultants job plans to be finalised (including allocated time for clinical and educational supervision) 4. Put in place a system to show empirical evidence of consistent assurance that clinicians are following best practice 5. Engage in Research and Development and benchmarking data of specialist services provided

9. Application of Patient Safety and other safety alerts. 10. Analysis of incidents, complaints and claims to identify areas of risk. 11. Supervision and education of clinical staff across all professions. 12. Application of clinical pathways and guidelines. 13. Increasing R&D involvement across the organisation 14. Regulatory information provided to staff in update sessions. 15. An integrated approach between corporate, operational and governance teams. 16. Quality Impact Assessments for all service changes and CIPs that are considered 17. Professional standards 18. Risk Management Strategy and culture 19. Quality and independence of QIAs by DoN and MD 20. Freedom to Speak Up Champions in place across the Trust		9. Patient feedback (FFT/Patient Surveys) 10. Quality Visits/Senior Walkabouts including focus on Patient Safety 11. Maintenance of CQC registration 12. Exec and NED leads in place for key quality areas	6. Put in place systems to test action plans following audits to ensure they lead to embedded change. 7. Delivery against all measurable for the four improvement areas (Care of the Deteriorating Patient, Care of Older People, Infection Prevention & Control and Medicines Management) 8. Work streams to plan for winter 2019/20 9. Implement Recommendations of Culture Review 10. Operational Plan 19/20 to be developed to include all specialities with plans for sustainable delivery in future. 11. Develop, implement, embed and review Strategic Plan 12. Deliver the Reducing Avoidable Mortality Action Plan 13. Deliver the External Mortality Review Action Plan.
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Monthly Mortality Reports to Q&S and Board 2. Mortality metrics 3. Never events 4. Incident data 5. Quality Strategy metrics 6. CQUINS 7. Performance data 8. Internal audit metrics 9. High level performance metrics 10. Serious Incident Reporting Group 11. Freedom to Speak Up 12. Speak Up Champion (NED appointed by Board) 13. Integrated Performance Report 14. Quality Improvement Plan 15. Monthly Safe Staffing Report 16. Mortality Report 17. Quarterly and Annual Guardian of Safe Working Report	
	3	**Independent / semi-independent** 1. External Audit Plan (Mazars) 2. Internal Audit Plan (MIAA) 3. GMC / NMC Reports 4. Royal College Reports / Visits. 5. SHMI / RAMI 6. CQC Outlier Alerts 7. National Audits 8. Peer Reviews and accreditation. 9. R&D Performance 10. CQC inspection visits 11. Regular meetings with NHSI/E/CQC 12. Engagement meetings with CQC 13. Weekly Catch-up conversations with CQC 14. CCG monthly quality and performance meetings 15. Internal Audit Report 16. Quality Account	
Gaps in Controls		**Gaps in Assurances**	**Review Update Description**
1. High bed occupancy and reduced patient flow 2. Issues with the quality of documentation 3. Additional work required against 4 key quality improvement areas (Care of the Deteriorating Patient, Care of Older People, Infection Prevention & Control and Medicines Management) 4. Limited support for clinical teams to be involved in clinical audit 5. Evidence of lessons learned from incidents, complaints and audit 6. Availability of allocated time and people to undertake and provide clinical and educational supervision. (indicated time is allocated in Consultant job plans for this activity) 7. Clinical workforce plan not fully developed.		1. Difficult to gain consistent assurance that clinicians are following best practice 2. Lack of available benchmarking data across all services 3. Lack of testing of action plans following audits to ensure they lead to embedded change.	
Number of linked Risks	Risks from Corporate Risk Register	**Number of linked Incidents**	**Add:**	**Last Review Date 16/05/2019**	**Next Review Date 31/07/2019**

	relating to **Objective 1**		SUIs and Never Events from Datix	April 2019	5 June 2019

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	**2**	**Risk Description**	***If the Trust cannot achieve its key performance targets it may lead to loss of services*** **Cause:** • Failure to deliver NHS Constitutional Targets • Failure to deliver the quality aspects of contracts for the commissioners • Patients experience indicators show a decline in quality • CQC rating of 'Require of Improvement' **Potential Effect**: • Poor patient outcome and standards of care • Inaccurate or inappropriate media coverage or reputational damage • Duplication of services with negative impact on CIP **Potential Impact:** • Potential breach of provider license • Potential loss of reputation • Financial penalties may be applied • Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial**	**16** **4x4** **(Likelihood x Consequence)**	**Current**	**16** **4x4** **(LxC)**	**Target**	**12** **3x4** **(LxC)**
DATIX Code:	**TBC**	**Risk Rating Tracker**						
Executive Director	Chief Operating Officer							
Assurance Committee	Finance, Performance & Investment Committee							
Strategic Objective	**SO2** - Deliver services that meet NHS constitutional and regulatory standards							

Controls	Sources and Level of Assurance		Action Plan / Progress Notes
1. Constitutional Standard: Accident & Emergency - 4 hour compliance 2. Constitutional Standard: Accident & Emergency - 12+hour trolley waits 3. Constitutional Standard: Ambulance Handovers <=15 mins 4. Constitutional Standard: Diagnostic Waits 5. Constitutional Standard: 14 day GP referral to Outpatients 6. Constitutional Standard: 62 day GP referral to treatment (and associated Cancer Standard measures) 7. Regular meetings with NHS Improvement 8. Monitoring of the Activity Plan for 2019/20 with regulatory functions 9. Maintenance of CQC registration 10. Regulatory information provided to staff in update sessions. 11. Committee structures in place to monitor compliance. 12. Board assurance visits.	**1**	**Management assurance** 1. For Clinical CBUs an Integrated Performance Report and slide pack presented at monthly Performance Review Boards 2. For the Corporate CBU a slide pack presented at Quarterly Performance Review Board for Estates & Facilities, Finance and HR 3. Programme and Project Highlight reports presented to Vision 2020 Improvement Boards for Operational Efficiency, Quality and Safety and Workforce 4. Performance Management and Accountability Framework 5. Sickness Absence Policy approved.	1. Regular review of compliance position 2. Provide assurance to CQC in relation to risks with appropriate information 3. Delivery against the Trust internal improvement plans for each standard – Patient Flow Improvement Programme / Elective Care Programme / Cancer Improvement Programme 4. IT Strategy to be developed 5. Address issues with diagnostic waiting times 6. Work with HR and Clinical team to develop sustainable workforce plans 7. Work within the system through LAEDB to improve UEC and patient flow performance. 8. Continue to develop accountability and assurance through the CBU Performance Review Boards

13. An integrated approach between corporate, operational and governance teams. 14. Quality Impact Assessments for all service changes and CIPs that are considered 15. Professional standards 16. Trust policies and procedures 17. Risk Management Strategy and culture 18. National audits 19. Local audits 20. Ward accreditation scheme pilot commencing in April 21. Quality and independence of QIA's by DoN and MD 22. External peer reviews 23. Completion and Submission of Annual Quality Report 24. Exec and NED leads in place for key CQC areas 25. Patient Safety included in Exec , NED and senior staff walk rounds	**2**	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Integrated Performance Report 2. Vision 2020 Priority Area Highlight Reports to Hospital Improvement Board 3. Internal audit metrics 4. High level performance metrics	
	3	**Independent / semi-independent** 1. Internal Audit Report (Mar-17) 2. CQC Inspection Report (2018) Good' for the Trust 3. CQC Visit 4. CCG Meetings monthly 5. NHS Improvement monthly returns	

Gaps in Controls	**Gaps in Assurances**	**Review Update Description**
1. Benchmarking data can make the trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention 2. Workforce strategy - recruitment of key delivery posts 3. Service Improvement methodology - no consistent approach to a S&O way to deliver continuous and sustainable improvement 4. System partnership working	1. A&E 4 hour target/trolley waits/ambulance handovers 2. Sickness absence amongst the worst rates of all acute Trusts. 3. Mixed sex accommodation – due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready to be moved to a general ward. 4. Diagnostic waiting times not met 5. Communication and Engagement Strategy not in place 6. 62 day cancer performance-some improvements have been realised but underlying issues within certain tumour groups remain 7. Mortality: above expected limits for some time	

Number of linked Risks	Risks from Corporate Risk Register relating to Objective 1	**Number of linked Incidents**	**Add:** SUIs and Never Events from Datix	**Last Review Date**	**Next Review Date**
				April 2019	5 June 2019

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	**3**	**Risk Description**	***If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*** **Cause**: • Being able to deliver the required levels of CIP. • Being able to control agency costs. • Ability to service outstanding historic debt • Being able to agree controls that provide sufficient income to support cost base **Potential Effect**: • Additional CIPs may need to be identified and delivered. • Lack of financial stability • Inability to invest in services and new technologies • Continued borrowing to meet operational expenses resulting in significant debt **Potential Impact:** • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention. • External interventions and financial special measures.

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial**	**16** **4x4** **(Likelihood x Consequence)**	**Current**	**16** **4x4** **(LxC)**	**Target**	**12** **3x4** **(LxC)**
DATIX Code:	**TBC**	**Risk Rating Tracker**						
Executive Director	Director of Finance							
Assurance Committee	Finance, Performance & Investment Committee							
Strategic Objective	**SO3** - Efficiently and productively provide care within agreed financial limits							

Controls		**Sources and Level of Assurance**	**Action Plan / Progress Notes**
1. Financial model produced giving early indication of issues 2. Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger 3. Early and continuing dialogue with NHS Improvement and NHS England 4. PMO Governance improved with roles and responsibilities CIP lead appointed 5. Cash support through agreed loan arrangements 6. Annual Financial Plan including target to reduce underlying deficit within Vision 2020 7. Financial governance arrangements in place at a number of levels: FP&I Committee/CBU's 8. Monthly governance meeting and performance meetings with Execs 9. Monthly Directorate Meetings (budget scrutiny at this level)	**1**	**Management assurance** 1. Operational Plan approval (Board (BoD) – Nov 2014) 2. Future Generations Clinical Strategy and Business Plan 3. Sustainability Plan 4. SOC for preferred option proved by Board – Sep 17 5. 2019/20 budget approval (BoD – May' 2018) 6. Budget holder training manual and attendance records 7. Performance & Finance Report (monthly to FP&I and BoD) 8. Finance & CIP achievement (monthly to FP&I) 9. Executive Team & Board oversight 10. Internal audit report provides assurance 11. Hospital Management Board 12. Trust Board 13. Fortnightly Acute Sustainability Programme Board	1. Delivery of control total in 2019/20 2. Delivery of CIP for 2019/20 3. Achieve NHSI Use of Resources Risk Rating – 3 4. Manage Agency Spend vis a vis NHSI cap

10. Revised CIP planning processes and PMO co-ordination of planning and delivery. 11. Weekly CIP review meetings 12. Turnaround Director in post with Trust governance, grip and control measures implemented, including Discretionary Spend Policy, CQUIN Group, Business Development Group & Investment sub-Committee (BDISC), People & Activity Group (PAG) 13. CIP plan for 2019/20 in place 14. Internal Audit Plan		14. Finance, Performance & Investment Committee 15. Southport & Ormskirk Improvement Board meets monthly 16. BAF-Quarterly to Board and Audit Committee 17. 13 week rolling cash flow forecast agreed by NHSE 18. CIP Reviews through fortnightly Sustainability Scrutiny Meetings 19. Internal and External audit reports and opinion at Audit Committee 20. Monthly Performance Review Boards 21. Executive Team Meeting Weekly Update	
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Monthly formal data submission 2. Long term financial projections	
	3	**Independent / semi-independent** 1. CCG Pre Consultation Business Case, approved by CCG Committees in Common 2. Northern Clinical Senate Report recommendations 3. Monthly reports to NHSI with feedback 4. Internal audit review of budgetary controls 5. External audit opinion	

Gaps in Controls	**Gaps in Assurances**	**Review Update Description**
1. Future Clinical Model not finalised 2. 5 Year long term financial model (LTFM) to be updated to reflect current financial performance and future financial plan 3. 2018/19 CIP plan underachieving 4. Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate 5. Modelling of Acute Sustainability into 5 year LTFM to provide savings from any reconfiguration in line with Sefton Transformation Board Strategy	Agency costs exceed the NHSI cap Financial Recovery Plan that delivers break-even I&E positon by 2023/24	

Number of linked Risks	Risks from Corporate Risk Register relating to Objective !	**Number of linked Incidents**	**Add:** SUIs and Never Events from Datix	**Last Review Date**	**Next Review Date**
				April 2019	5 June 2019

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	**4**	**Risk Description**	***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*** **Cause**: • Difficulty recruiting and retaining high-quality staff in certain areas • Low levels of staff satisfaction, health & wellbeing and engagement • Insufficient provision of training, appraisals and development **Potential Effect**: • Low levels of staff involvement and engagement in the Trust's agenda. • Higher than average vacancy rates. • Failure to deliver required activity levels / poor staff productivity • Higher than average sickness rates • Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care • Insufficient junior medical staffing numbers to ensure patient safety and workforce wellbeing. • Insufficient numbers to facilitate all junior doctors training. • May result in unsafe care to patients. • May result in funding withdrawn from HEN if junior doctor training not met. • May result in increased sickness absence and clinical incidents. **Potential Impact:** • Poor patient experience and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation • Reduced ability to deliver high quality service • Poor response to NHS Staff Survey

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial**	**12** **3x4** **(Likelihood x Consequence)**	**Current**	**12** **3x4** **(LxC)**	**Target**	**8** **2x4** **(LxC)**
DATIX Code:	TBC	**Risk Rating Tracker**						
Executive Director	Director of Human Resources & Organisational Development							
Assurance Committee	Workforce Committee							
Strategic Objective	**SO4** - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated							

Controls		**Sources and Level of Assurance**	**Action Plan / Progress Notes**
1. Annually agreed funding contract with HEN 2. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. 3. Effective electronic rota management system implemented in 2015. 4. New Guardian of Safe Working Hours appointed in 2019	**1**	**Management assurance** 1. Quarterly reporting by Guardian of Safe Working to JLNC, PPF and the Lead Employer. 2. Annual report to Board by the Guardian of Safe Working.	1. Clinical & nursing roles being developed and enhanced to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANPs, Consultant Nurses, ER Practitioners. 2. Regional Training Programme Directors manage the junior doctor

5. Junior Doctor Forum held quarterly for concerns to be raised. 6. Monitoring exercises undertaken on annual basis to ensure compliance on junior doctor rotas 7. National Medical Revalidation process ensuring competent doctors 8. Annual Workforce Planning exercise with operational and clinical teams 9. Shared decision making and review of risks with Joint Local Negotiating Committee 10. Quality Strategy 11. Organisational Development Strategy 12. Health and Wellbeing strategy and action plan 13. Staff engagement and awareness programme in place 14. CBU Staff induction 15. Corporate staff Induction 16. Education and development processes in place 17. Appraisal compliance and training attendance monitored 18. Mandatory training 19. PDR 20. Robust employment checks (FPPT) 21. Disclosure Barring Service 22. Quality Visits by NEDs and EDs 23. Professional Bodies Checks and Balances for clinicians (NMC/GMC) 24. Duty of Candour/Safe Care 25. Staff Survey & Quarterly Staff FFT/Survey 26. Sickness Absence Policy 27. Speak Up Champion & Guardian 28. Recruitment Strategy 29. Retention Strategy 30. Annual staff Appraisal 31. Freedom to Speak Up Guardian appointed 32. Equality & Diversity Lead appointed 33. OD Manager appointed 34. NHS Elect support for staff engagement, values and behaviour 35. NHSI Nursing Retention Programme 36. NHSI Health and Wellbeing Project 37. Workforce and OD Strategy 38. Partnership Working 39. Nursing Retention Improvement Plan		3. Escalation process in place for Exception Reporting to the Medical Director 4. DME reports to HEN on an annual basis in relation to junior doctor training 5. Jr Dr work plans 6. Junior Medical Staff – annual internal staff survey 7. Annual GMC Survey 8. ~~Annual Staff Survey~~ 9. ~~Friends and Family Test~~	rotation programme and highlight shortages to the Lead Employer 3. Director of Medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN 4. New programme for recruitment of Drs from India for Gynaecology 5. Operational Plan for increased number of consultants
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Exception reporting data 2. FTSUG reports 3. Absence Data 4. Turnover Data 5. Vacancy Rate	
	3	**Independent / semi-independent** 1. GMC Revalidation process. 2. HEN visit – regular 3. GMC Medical Staff survey – annual 4. Winter Planning and Length of Stay discussed at weekly Performance Improvement Board (PFIB) 5. Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board 6. Weekly activity data reported to CBUs 7. Endoscopy Project in place to deliver endoscopy diagnostic targets 8. Finance Performance and Investment Committee 9. Southport & Ormskirk Improvement Board (SOIB) 10. Monthly Mortality Operational Group 11. Monthly Performance Review Board (PRB) for each CBU 12. CBU Governance meetings 13. QIA process to approve all CIPs 14. Monthly contract meeting with Commissioners 15. Engagement of EY to address patient flow 16. Monthly Report to FP&I committee 17. Monthly Report to Q&S Committee 18. Monthly report to Workforce Committee 19. Report to Mortality Operational Group (MOG) 20. Reports to Workforce Improvement Board (WIG) 21. Monthly Trust-level and CBU-level dashboard for performance forum 22. Monthly Reports presented to CBU governance meetings 23. Performance against A&E 4 hour target report to Board monthly 24. Hospital Management Board 25. Improvement Board 26. Performance Review Boards	

			27. IPR indicators demonstrate compliance against 14 day cancer target, 31 day cancer treatment target and RTT		
Gaps in Controls		**Gaps in Assurances**		**Review Update Description**	
1. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer 2. Further utilisation of the rota management system 3. Director of Medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN 4. Delays in recruitment of staff to be addressed through improved time to hire rates 5. Lack of local in year feedback in relation to staff views / staff surveys 6. Lack of focused resource for staff engagement 7. Recruitment and retention strategy 8. Appraisal Rates below target 9. Low attendance at Essential Skills Training Programmes		1. New Exception Reporting system and process working effectively. 2. A&E 4 hour target/trolley waits/ambulance handovers longstanding issues in relation to poor patient flow and subsequent impact although improving 3. Sickness absence above target but improved to 4.8% 4. Mixed sex accommodation –due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready to be moved to a general ward. 5. Diagnostic waiting times not met 6. 62 day cancer performance-some improvements have been realised but underlying issues within certain tumour groups remain 7. Mortality: above expected limits for some time		
Number of linked Risks	Risks from Corporate Risk Register relating to Objective!	**Number of linked Incidents**	**Add:** SUIs and Never Events from Datix	**Last Review Date** May 2019	**Next Review Date** 5 July 2019

Board Assurance Framework Report

Southport and Ormskirk Hospital NHS Trust

Risk ID:	**5**	**Risk Description**	***If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*** **Cause**: • Lack of sustained, long-term leadership • Less than optimal management practice • Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust **Potential Effect**: • Low staff morale • Poor outcomes & experience for large numbers of patients • Less effective teamwork • High levels of staff absence • High staff turnover **Potential Impact:** • Poor quality of patient service • Poor recruitment and retention of staff • Negative impact on quality of patient care • Potential for regulatory action and reputational damage

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial**	**12** **3x4** **(Likelihood x Consequence)**	**Current**	**12** **3x4** **(LxC)**	**Target**	**8** **2x4** **(LxC)**
DATIX Code:	**TBC**	**Risk Rating Tracker**						
Executive Director	Director of Human Resources & Organisational Development (other Executives)							
Assurance Committee	Workforce Committee							
Strategic Objective	**SO5** - Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values							

Controls	**Sources and Level of Assurance**		**Action Plan / Progress Notes**
1. Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff 2. Consultant revalidation process 3. Reward and recognition processes to be reviewed 4. Retirement Intentions annual exercise to be explored 5. Pay progression for AFC to be developed by end of 2019. 6. Targeted OD intervention for areas in need of support 7. Management Development Training Programme 8. Aspirant Talent Programme for aspiring ward managers and matrons 9. Programme of health and wellbeing initiatives 10. All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	**1**	**Management assurance** 1. National Staff surrey (annual) 2. Quarterly Staff Friends and Family survey 3. Monthly KPIs for controls 4. Performance Reports (monthly) 5. Quarterly Speak up Guardian Reports 6. Report from Guardian of Safe Working – Quarterly to Board	1. Aspirant Managers programme being rolled out via Shadow Board 2. Executive Team and Non-Executive Directors quality visits/walkabouts 3. Develop Talent Management Programme 4. Monitor sickness absence 5. Engagement sessions with a cross section of staff to ask for feedback and priorities in relation to staff survey. 6. Meeting Place – Live which is facilitated by NHS Elect in order to engage the workforce and seek views on the S&O way, values and behaviours.
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Increase in managers attending training programmes 2. Mandatory training data	

11. Extensive mandatory training programme available 12. Value-based recruitment & induction planned now that recruitment is now in house. 13. Workforce planning processes to be reviewed in line with delivery of safe staffing 14. Quality Strategy 2017-2020 15. Staff engagement programmes via NHS Elect 16. Freedom to Speak Up Guardian and Champions 17. Whistleblowing Policy/Raising Concerns 18. Guardian of Safe Working in post 19. Trust's Vision 20/20 and promotion of Trust values. 20. Single Leadership Plan accepted by NHSI 21. Substantive Board appointments in 2018. 22. Training, education and development (TED) strategy & programmes based on training needs analysis. 23. Leadership and people management policies, processes & professional support (including management training & toolkits) 24. Staff support and occupational health and wellbeing arrangements at Trust, CBU and Service levels 25. Monthly and quarterly monitoring of workforce performance 26. Deep dive reports to Committee investigating specific issues when required 27. Staff communication via meeting place on Facebook, Trust news and Trust magazine, Town Events, Breakfast with Execs etc. 28. Grievance & Disciplinary Policies 29. Data Protection Policy (General Data Protection Regulations) 30. Staff Survey 31. Employment checks 32. FPPT & Code of Conduct 33. PDRs 34. Non-Executive directors' (NED) Skills mix - academic & professional qualifications 35. Unitary Board: Non-Executive and Executive directors are jointly responsible for decisions taken by board 36. Governance Structure 37. Board Development Sessions planned throughout the year. 38. Board Timeout Sessions planned throughout the year 39. HR Governance Meetings 40. Valuing our People meetings 41. Workforce and OD Committee 42. Healthcare Leadership Model (-self-assessment tool 360 degree appraisals/- Edward Jenner online leadership programme/Management & Leadership Apprenticeships) 43. Essential HR skills for managers provided on a rolling basis 44. Substantive E&D Manager in post 45. Substantive OD posts in post 46. Trust wide staff survey action plan 47. CBU staff survey action plans 48. Staff friends and family test + pulse check questions 49. Workforce and OD Strategy 50. Model Hospital support		3. Absence data 4. Turnover data 5. FTSU Guardian data 6. Staff Engagement Scores 7. Sickness data 8. Guardian for Safe Working Exception Reports **Independent / semi-independent** 1. CQC regulatory inspection in 2017 2. National Workforce and Wellbeing Charter - 2018 3. NHS Staff Survey 2018 4. Winter Planning and Length of Stay discussed at weekly Performance Improvement Board (PFIB) 5. Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board 6. Weekly activity data reported to CBUs 7. Turnaround Director in post 8. Endoscopy Project in place to deliver endoscopy diagnostic targets 9. Finance Performance and Investment Committee 10. Southport & Ormskirk Improvement Board (SOIB) 11. Monthly Mortality Operational Group (MOG) 12. Monthly ED&I update to Workforce Committee 13. Monthly Performance Review Board (PRB) for each CBU and Corporate Service. 14. CBU Governance meetings 15. QIA process to approve all CIPs 16. Monthly contract meeting with Commissioners 17. Engagement of EY to address patient flow 18. Monthly Report to FP&I committee 19. Monthly Report to Q&S Committee 20. Monthly Report to Workforce Committee 21. Report to Mortality Operational Group 22. Monthly Trust-level and CBU-level dashboard for performance forum 23. Monthly Reports presented to CBU governance meetings 24. Performance against A&E 4 hour target report to Board monthly 25. Hospital Management Board 26. Workforce Improvement Board (WIB) 27. Performance Review Boards 28. IPR indicators demonstrate compliance against 14 day cancer target, 31 day cancer treatment target and RTT	

Gaps in Controls	Gaps in Assurances	Review Update Description
1. Quality and number of appraisals being carried out. 2. Lower than expected attendance at non-mandatory training eg. leadership training 3. Requirement for further development of middle managers 4. Talent management programme – being planned 5. Succession Planning 6. Ongoing challenges of engaging effectively with all staffing groups due to rota patterns 7. Poor response rates in relation to staff views / staff surveys performed quarterly 8. IPR to include information in relation to vacancy levels by CBU and by staff group 9. Recruitment & Retention of staff	1. Staff Survey Engagement score not significantly improved in year 2. PDR compliance currently below target 3. Sickness absence above target but reducing 4. Staff Engagement Strategy 5. Some processes need embedding within CBUs and across the organisation to ensure robust Ward to Board communication and escalation	

Number of linked Risks	Risks from Corporate Risk Register relating to Objective!	Number of linked Incidents	Add: SUIs and Never Events from Datix	Last Review Date	Next Review Date
				May 2019	5 June 2019

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	**6**	**Risk Description**	**There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services** 6a) By October 2019 develop a robust partnering strategy to enable development of a range of clinical and non-clinical joint working opportunities 6b) By October 2019 develop a blueprint and roadmap for the acute sustainability programme					
Risk Appetite:	**HUNGRY**	**Risk Scores:**	**Initial**	**15** **3x5** **(Likelihood x Consequence)**	**Current**	**15** **3x5**	**Target**	**9** **3x3**
DATIX Code:	TBC	**Risk Rating Tracker**	To be completed					
Executive Director	**Deputy CEO/Director of Strategy**							
Assurance Committee	Finance, Performance & Investment Committee							
Strategic Objective	**SO6** - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire							

Controls	**Sources and Level of Assurance**		**Action Plan / Progress Notes**
1 Robust system governance in place, including: -Sefton Transformation Board -Cheshire & Mersey STP (includes acute sustainability) -Provider Alliance -SOIB - leading Vision 2020 2 Robust internal governance in place, including: -Acute Sustainability Programme Board -HIB - leading Vision 2020 and Single Improvement Plan 3 Documentation in place; -S&O Operational Plan 2019/20. -STP 5 year plan in development for submission summer 2019 (date TBC)	**1**	**External assurance** ▪ Programme of work in development to align partners - chaired by Merseycare CEO ▪ Clinical Leadership Group development of clinical models across four work streams ▪ Clinical Senate Report in place - confirming the case for change and clinical direction **Internal Assurance** ▪ Vision 2020 updated and agreed at Board ▪ Single Improvement Plan in development to be signed off by Board	1. Develop, implement, embed and review Communication and Engagement Strategy 2. Develop Plans to deliver Transformational CIP Schemes 3. Consider the need for review of strategic planning 4. Produce reports on Operational Plan to the Board 5. To conduct an objective setting and strategic planning exercise with the Board. 6. Review of the strategic plan and associated risk management processes (BAF)

		2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Performance monitoring of patient experience and clinical outcomes 2. Incident Data (including SIs / Never Events) 3. CEO's reports to Board 4. Deputy CEO reports to Board 5. Single Improvement Plan reports to Improvement Board 6. Single Improvement Plan reports within IPR		
		3	**Independent / semi-independent** 1. CQC Inspection Report (2017) 2. Clinical Senate Reports 3. Finance Reports include contractual and commissioning issues, where relevant reported to Board		
Gaps in Controls		**Gaps in Assurances**		**Review Update Description**	
1. Financial constraints for delivery of facilities improvements 2. Whole system engagement - support from key health and social care partners to address increased demand on the non-elective pathway and helping reduce LoS for patients not requiring acute hospital care 3. Operational plan in development 4. Communication and Engagement Strategy 5. Delay in delivering Transformational CIP Schemes		1. CEO's reports to Board 2. Director of Clinical Services reports re review of services reported to Board. 3. Finance Reports include contractual and commissioning issues, where relevant reported to Board 4. Progress of agreeing contracts reported via Finance to Board annually 5. Business Cases involving commissioners reported, where these occur, reported to Board 6. Minutes of Network/Alliance meetings 7. Update reports from Community Partnership Network 8. Minutes of Monthly Contract Review Meetings 9. Monthly CEO Patch Meetings 10. Quarterly review against plan (Titration system) 11. Monthly meetings with CCGs		To be completed	
Number of linked Risks	Risks from Corporate Risk Register relating to Objective 6	**Number of linked Incidents**	**Add:** SUIs and Never Events from Datix	**Last Review Date**	**Next Review Date**
				April 2019	5 June 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB114/19b**	**Report Title**	**Corporate Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Senior Information Analyst & Datix Lead Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

Since the last meeting, no new risks have been escalated onto the risk register.

Since the last meeting, no new risks have been removed from the risk register.

There are currently 6 risks on the High Level Risk register. These are:

- **1688** - Inadequate Staffing Levels in Anaesthetic Department
- **1902** - Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC
- **1917** - Quality of Older Peoples Care
- **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

Risk 1917 - Quality of Older Peoples Care will be reviewed and re-written before the next Board to reflect the work now in place and the actions outstanding.

Risk 1942 - Eradicating the Trust's deficit by 2023/24 has not been reviewed since the last meeting due to no changes. This will be updated following Trust Board.

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)*

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

MAY 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 23/05/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-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	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	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↘
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	12↓	=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	=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	16↓

TRUST RISK PROFILE AS AT 23/05/2019

	CONSEQUENCE (impact/severity)				
LIKELIHOOD (frequency)	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)					
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** **1987 - Haem / Oncology, reduction in medical capacity following resignation of consultant**	
Possible (3)					**1688 - Inadequate Staffing Levels in Anaesthetic Department**
Unlikely (2)					
Rare (1)					

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective	SO1 – Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 – Deliver services that meet NHS constitutional and regulatory standards							Link to BAF	
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 May 2019 NHSP contract 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 Safe staffing report to W Force Comm. & Trust Board on a monthly basis						**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	13/05/2019	07/06/2019
Assurance	Workforce data (sickness & AL) Dedicated H roster Lead for N&M Establishment review process SOP ratified by HMB - May 2019 CQC inspection Monthly staffing report mandatory training Complaints Incident reporting Quality and safety reports Bi annual staffing reports						**Gaps in Assurance**	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 Completed
Latest Month Progress	Nursing & Midwifery Establishment Review SOP approved at HMB Awaiting Nurse Establishment review business case at May extraordinary Trust Board Training sessions for Ward Coordinators commenced. Local recruitment continues									

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			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	20/05/2019	20/06/2019

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**	10/06/2019 10/06/2019 10/06/2019 10/06/2019 10/06/2019 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	Malnutrition policy approved. ESR Bapen training module tested and compliant. Agreed launch on ward 10B, all RNs on 10B now have the module uploaded to their ESR and are being supported by the ward manager and matron to complete. The Dietitians are going to spend additional time on the wards starting June 2019 to roll out the new care plans and policy as well as educating staff on MUST scoring and actions to take as well as the new referral criteria. Continence stakeholders identified and contacted, first Continence strategy meeting to formally scope the improvement work and establish the group booked for 25/6/19. Business case for enhanced Care of the Elderly Workforce agreed in principle and recruitment strategy meeting to commence recruitment planned for 21/05/2019. EOL project underway with development of an accreditation system with QCH and a questionnaire for measuring the baseline confidence and knowledge of the staff in EOL care before using this to develop the education strategy/plan for staff. No response from Charitable funds for Estates work; forms to be resubmitted, meeting booked for early June to plan progress with dementia friendly environment with money remaining from previous successful bid. Therapy scoping session for 'Creating an Enabling Environment' completed and awaiting identified leads for specific work streams around environment/equipment, MECC, education, Red2Green, Get Up Dressed and Moving, Fit 2 Sit. Individual projects now to be planned. Home First Pathway continuing to be used, more consistency with good engagement from Teams to identify patients - ongoing monitoring of success and feedback via the AED subgroup highlight report. Currently ceased attempting to use S&F Pathway due to the lack of care and crisis service, focusing on WL pathway only with support from Age UK.				

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 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	Link to BAF	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
19/09/2018	1902	Director of Nursing & Quality	Paul Jebb	Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC

Description	If we fail to comply with regulatory framework then this will result in breach of the Trust regulation and potential legal action, poor patient experience, unsafe and poor quality of care, and lack of public confidence in the Trust

Controls	enhanced team to support DoN deliver expectations Improvement plans developed and agreed with trust Board Improvement groups developed across Trusts, including CBUs commitment to run a shadow CQC process over 12 weeks Identified Executive and management leads for Performance, quality, people and use of resources development of a shared drive to enable evidence to be uploaded development of awareness raising and preparation for key leaders at Board and CBU level identified support from PMO with project management Well-led work ongoing with AQUA CQC Programme Manager in post working to Assistant Director of Quality PIR completed and submitted 03.05.19	Gaps in Controls	CQC identified 96 MUST AND SHOULD DO actions following November and December 2017 inspection Lack of pace and assurance regarding progress of action plan

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	16	Extreme risk	12	High Risk	16/05/2019	16/06/2019

Assurance	committee structure regular engagement meetings assurance at quality and safety & committee CBU monthly governance meetings development of a single quality improvement action plan engage and gain support for validation from HealthWatch, CCG and other regulators Core service review identified some areas of improvement including openness of staff, Staff are caring, compassionate and there are examples of good practice, stability of leadership and no areas were considered to be 'inadequate' on both days Internal assurance panels Following submission of PIR - Preparation Plan Updated and KLOEs identified QUID Meeting to be re-established	Gaps in Assurance	Engagement of key leaders from 'ward to board' reduced understanding of expectations of regulator prior, during and after inspections A number of gaps identified during core services review, these are being addressed through Quality Improvement Plan.

Action Plan	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.	Action Plan Due Date	31/05/2019 31/07/2019 28/06/2019 31/07/2019 31/05/2019	Action Plan Rating	Moderate Progress Made Moderate Progress Made Moderate Progress Made Actions Almost Completed Moderate Progress Made

Latest Month Progress	Significant improvement has been made against the Must and Should do CQC recommendations from the previous inspections. At this stage, all recommendations previously identified as red have progressed to on track (amber) or completed (green), subject to review of supporting evidence by the assurance panels. 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 now meets on a weekly basis 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 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	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 an 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.	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
	Likely (4)	Major (4)	20	16	Extreme risk	4	Moderate risk	16/05/2019	16/06/2019

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. Work with Aintree to ensure locum commences with the Trust WLI clinics to be approved at PAG	Action Plan Due Date	01/05/2019 14/06/2019 27/03/2019	Action Plan Rating	Moderate Progress Made Moderate Progress Made Completed

Latest Month Progress	WLI due to start beginning of June 2019. Awaiting proposal from Clatterbridge and Aintree with regards to what additional support could be offered to support the service, Weekly tele-con in place in place with Clatterbridge and Aintree to discuss issues and highlight patient wait times. Locum sourced by Trust for 2 week cover has withdrawn. Time critical patients are being accommodated through WLI clinics run on Saturdays.

Strategic Objective		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					Link to BAF		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
13/11/2017	1688	Chief Operating Officer	Mandy Marsh	Inadequate Staffing Levels in Anaesthetic Department					
Description	Staffing Levels of anaesthetic department affecting capacity and safety of emergency/ICU/Maternity cover. Lack of emergency cover for on call / ICU / maternity both sites. This would result in the closure of high risk patients presenting to A&E for both adult and children and the inability to staff ITU. Update - High level meetings with COO and the anaesthetic team to seek solution. Business case produced for review at next BDISC meeting. Restructure and appoint new cohort of staff required to deliver the service and sustain long term. Short term proposal also put forward for approval to ensure safe staffing levels now.								
Controls	Internal/external Locums anaesthetists to cover shortfall caused by vacancies People to work additional hours to fill extra sessions Elective lists cancelled to ensure cover when needed Change to on-call system to ensure full coverage; 1st on call onsite & 2nd on call supporting within core hours Interim support from staff pain management shortfall Agency locums being sought to support gaps						**Gaps in Controls**	Availability of staff to cover vacant shifts at a minimum due to burn out/sickness/annual leave Lack of agency staff within capped rate 6 vacancies remain in service 1 consultant taken out of core theatre sessions to run pain activity; back filling those sessions with WLI's which has been approved to the end of the year by SS		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	16/05/2019	14/06/2019
Assurance	Monthly Planned Care governance meetings PC risk review meeting with ADO/HoN						**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. 17.04.19 Still awaiting final approval Update;16.05.19 - Business case for final sign off at HMB on 22.05.19						**Action Plan Due Date**	18/12/2017 13/06/2019	**Action Plan Rating**	Completed Completed
Latest Month Progress	Business case approval deferred. Advert to go out for posts within current establishment.								

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	No further update since May Trust Board. Risk will be updated following Trust Board June 2019.									

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

5 June 2019

Agenda Item	**TB115/19**	**Report Title**	**Litigation and Claims Report**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary Adam Kitchen, Claims Manager (Claims)		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

There should be correlation between the Trust's Litigation activities and Claims management. This report sets out the following:

- A protocol for accessing external legal advice
- A report on legal spend for the year 2018/19
- A Claims Management Report for 2018/19 including financial settlements

It is proposed in line with good practice that legal advice should first be sought internally before accessing it externally. This is best managed if there is one conduit through which such advice is sought which should be the Company Secretary or equivalent. (*In an emergency or if out of hours the On-Call Director must be contacted for authorization)*

A report on legal expenditure should ideally include expenditure on claims settlement.

Managers and members of staff may require legal advice relating to among others, the following:

- Capacity, consent and treatment – adults and children
- Corporate governance and public law matters
- Clinical governance and healthcare law, health and social care, mental health
- Corporate finance, partnership
- Employment law
- Contract and commercial law Equality and Human Rights Acts
- Health and Safety including corporate manslaughter
- Information Governance – data protection, freedom of information, access to records
- Property transactions

For the 2018/19 period the total legal spend was £55,983.00

Claims Management is managed in conjunction with NHS Resolution (NHS R) whose purpose is to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care. A number of Schemes are managed via NHS R ; they are:

- Clinical Negligence Schemes for Trusts (CNST)
- Property Expenses Scheme (PES)
- The Existing Liabilities Scheme (ELS)
- Risk Pooling Schemes for Trusts (RPST)
- Liabilities to Third Parties (LTPS)

- Public Liability
- Employer's Liability

Costs associated with Claims are set out in the report below.

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

A report will be brought to the Quality & Safety Committee on a quarterly basis and six monthly to the Board

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

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

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

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