NHS Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 12:15 – 15:45 on Wednesday, 3 July 2019
Ruffwood Suite, Clinical Education Centre, Ormskirk District General Hospital, L39 2AZ

V = Verbal D = Document P = Presentation

Ref Nº.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				**12:15**
TB123/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**12:15**
TB124/19 (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**		
TB125/19 (D)	**Minutes of the Meeting held on 5 June 2019** To **approve** the minutes of the Public Board of Directors, 5 June 2019	**Chair**		
TB126/19 (D)	**Matters Arising Action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB127/19 **(D/V)** **(P/V)**	**Patients and Engagement Issues including:** • **NEDs & Executives' Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Staff Story:** Plaster Room Re-launch & Patient Experience Impact To **receive** the Staff Story and **note** lessons learnt	**NEDs EDs** **Michelle Kitson**	**30**	**12:25**
STRATEGIC CONTEXT				**12:55**
TB128/19 (D)	**Chief Executive's Report** (signposting results re: Business Cases) To **receive** key issues and update from the CEO	**CEO**	**10**	**12:55**
QUALITY & SAFETY				**13:05**
TB129/19 (P/D)	**Quality and Safety Reports:** a) Summary of Complaints & Compliments b) Monthly Mortality Report	**MD/DoN**	**40**	**13.05**

	c) Quality Improvement Plan Update d) Safe Staffing: Monthly e) CQC Preparation Update To **receive** the presentation and reports			
TB130/19 (D)	**Engagement Strategy** To **receive** the report	**DoHR**	**10**	**13.45**
PERFORMANCE & GOVERNANCE				**13:55**
TB131/19 (D)	**1. Integrated Performance Report (IPR)** a. Introduction b. Executive Summary Presentation including a single page report identifying the total number of staff, available beds and deaths. **2. Vision 2020 Report** **3. Alert, Advise and Assure (AAA) Reports** • Finance, Performance & Investment Committee (**Jo Morgan**) • Hospital Management Board (**Silas Nicholls)** • Quality & Safety Committee (**David Bricknell)** • 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** **DCEO/ DoS** **Committee Chairs**	**30**	**13:55**
TB132/19 (D)	**Financial Position at Month 2, 2019/20** To **receive** the report	**DoF**	**15**	**14:25**
TB133/19 (D)	**Risk Management:** • **Board Assurance Framework (BAF) & Risk Appetite** • **Risk Management Strategy** • **Corporate Risk Register (CRR)** To **receive** the BAF and monthly corporate risk register reports and to **approve** the updated Risk Management Strategy	**CoSec/ DoN**	**30**	**14:40**
TB134/19 (D)	**Corporate Governance Manual** To **approve** the Manual and send a message to the Trust of its role in governance and awareness in light of Well Led and good practice	**CoSec**	**10**	**15.10**

TB135/19 (D/V)	**Items for approval/ratification** • Decision of the Remuneration & Nominations Committee to appoint an Associate Director of Corporate Governance/Company Secretary (**Chair**) • To **ratify** the decision of the Quality & Safety Committee to **approve** the Quality Accounts subject to some updates.(**DoN**) • To **approve** the minutes of the Extra-Ordinary Board, 22 May 2019 (**Chair**) • To **approve** an amendment to the Development and Management of Procedural Documents Policy (**CoSec**)	**Chair**	**10**	**15:20**
CONCLUDING BUSINESS				**15:30**
TB136/19 (V)	**Questions from Members of the Public**	**Public**	**5**	**15:30**
TB137/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**10**	**15:35**
TB138/19 (V)	**Items for Forward Agenda – 4 September 2019**	**Chair**		
TB139/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board	**Chair**		
TB140/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting	**Chair**		
TB141/19 (V)	**Date and time of next meeting:** **Wednesday 4 September 2019** Seminar Room, Clinical Education Centre, Southport Hospital, PR8 6PN	**Chair**		**15:45** **CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

NHS Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 5 June 2019

Seminar Room, Clinical Education Centre, Southport & Formby District General Hospital, Town Lane Kew, PR8 6PN

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

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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
Joanne Morgan, Non-Executive Director
Silas Nicholls, Chief Executive
Therese Patten, Deputy Chief Executive/ Executive Director of Strategy
Steve Shanahan, Executive Director of Finance
Gurpreet Singh, Non-Executive Director

In Attendance

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

Apologies:

Caroline Griffiths, NHSI

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB103/19	**Chair's Welcome and Note of Apologies**	
	Mr Masom, as Chair, opened the meeting by welcoming members, attendees and members of the public. He apologised for the moving of the time for the start of the Board and noted that that would also be the case in July 2019. The Chair highlighted four substantial topics for the Public Board to discuss in detail, they were: 1. Quality 2. Performance 3. Finance 4. Risk/Risk Appetite/Board Assurance Framework	
TB104/19	**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 be submitted to the Company Secretary. No interests were declared and no further additions were made to the Register.	
TB105/19	**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. Mr Birrell commented that some specific debate had not been captured within the minutes and Mr Charles responded that additional verbatim challenges would be included going forward. **RESOLVED:** The Board **approved** the minutes as an accurate record.	
TB106/19	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **TB013/19: Board Assurance Framework (BAF) & Corporate Risk Register.** Discussion had taken place and the BAF updated. **CLOSED** **TB090/19: Patient & Engagement Issues** The plan would be discussed with the Chair. **CLOSED** **TB092/19: Quality & Safety Reports** This would be processed and monitored via the Workforce Committee. **CLOSED** **TB092/19: Quality & Safety Reports** The newsletter was being finalised and would include Mortality, Get It Right First Time (GIRFT). **CLOSED**	
TB107/19	**Patient and Engagement Issues including:** • **Non-Executive Directors (NEDs) & Executives' Visits/Walkabouts** • **Patient/Staff Story: Winter Pressures – The Patient Experience**	
	• **NEDs & Executives' Visits/Walkabouts** Mr Christian undertook a night shift on 31 May 2019 as a Health Care Assistant (HCA). That had incorporated Accident & Emergency (A&E), Emergency Assessment Unit (EAU) and with the medical on-call Outreach Critical Care Team. He had been very impressed by staff members' tenacity, focus, friendliness, care and smiles. The Outreach Team was praised for improving the outcomes for staff and enabling a great experience by patients. Safe staffing had been evident and significant attempts were made to deliver consistency of care and nursing by committed and loyal staff. With regards to documentation there was evident frustration with the IT platform, which had impacted on efficiency.	

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	Vision 2020 was known widely as a 'big ticket' item; however, it was the small things which made the difference to patients and staff. He recommended that all Board members spend time as an HCA. *Mr Christian noted that a staff member would shortly be retiring after 50 years and requested that the Trust recognise it appropriately.* Mrs Gibson stated that in her role as Freedom to Speak Up Champion, she had recently met with staff in relation to Freedom to Speak Up and noted that staff were becoming increasingly confident in doing so. Mrs Royds had recently spent a day 'Back to the Floor' in Ophthalmology and Ear, Nose & Throat (ENT) Departments. She noted that HCAs were happy and were also being provided with extra training. She was welcomed and had a number of good conversations with staff and patients. Mrs Royds followed three patients throughout their journey within the department and had been invited to follow that up at their forthcoming cataract surgery, which she would further report back to the Board. She had also undertaken the 15 Steps visits to Theatres and Endoscopy at Ormskirk District General Hospital with Mr Singh and encountered a mix of happy and unhappy staff, particularly in relation to e-rostering and medical engagement. She noted that a locum whose tenure was ending had stated that if they were not returning to training; their preference would have been to permanently join the Trust. Mr Singh added that as he was well known amongst colleagues, their visits were frequently interrupted by staff wanting to speak with him. He concurred with Mr Christian that IT was an ongoing issue. Theatre staff had praised the work undertaken by Jenny Farley, the former Project Lead. Endoscopy had been impacted by management change and some leave had been cancelled due to incorrect use of the e-rostering system which directly affected some staff. Mr Christian and Ms Cosgrove acknowledged staff leave had been negatively impacted and they were also unhappy with a change in management. Mr Singh asked if sufficient communication and engagement had taken place with those staff and was assured that it had. They praised the hard work and commitment of the staff, evidenced by a single endoscopy session being cancelled in May 2019, compared to October 2018 when 25 were cancelled. Mrs Morgan had also undertaken a 15 Steps visit to the Short Stay Unit with Mr Nicholls, which was a very busy ward and was undertaking the Red 2 Green (R2G) process at the time of their visit. Staff had been willing to show them around, were open and receptive regarding improvement including suggesting improved prescribing. Significant storage issues were noted. There were no staff issues on the day and the experience was enjoyable. Mrs Gorry stated that she and Mr Shanahan would be undertaking	 **DoHR**

	further visits to Wards and it was useful to hear the experiences of colleagues. She suggested that the Board ensured that what staff had said had been listened to and action undertaken was communicated to everyone. Ms Patten had attended and delivered Town Hall meetings on both hospital sites and also met with the IT Team who were anxious about anticipated changes. She had also visited Theatres at Ormskirk which was very positive. Mr Nicholls had visited Ward 14a and joined the Ward Round with the Consultant of the Week. Concern was raised that an escalation bed had remained open on the ward in a potentially inappropriate environment and he had requested that all wards check and report on any open escalation beds with a view to closing them. Mr Christian confirmed that all escalation beds were closed and would remain so. He added that a Volunteers Event had taken place on 4 June 2019 for the first time as a thank you to all volunteers throughout the Trust. It was humbling to meet people who had given their time for free to support patients and staff. Mr Nicholls requested that each member of the Board made the effort to say hello and thank volunteers when they encountered them, including those in the Reception areas of both hospitals. The Chair had visited Ward 7a with Dr Hankin and had seen first-hand challenging issues relating to staffing and the clinical escalation route. He had also chosen to visit Ward 15a, following his family's recent experience of Geriatric/Dementia care at Stockport Hospital. Whilst the experience on 15a was better than 7a, he commented that it was not the serene, quiet experience that dementia patients needed. Dr Hankin added that there had been unexpected absence on the ward due to sickness and acknowledged the environment was challenging, crowded and cluttered which would be addressed. • **Patient/Staff Story: Dementia Patient Story followed by Improvement in Dementia Care** Miss Meg Langley, Head of Older People's Care Matron, Patient Experience, presented the experience of a Patient and Carer encountering services provided for people living with dementia. She stated that the patient's next of kin had given permission for the anonymised experience to be shared with the Board. Miss Langley began with the 'usual' experience within the Ophthalmology Department which had repeated tests already undertaken, followed by fast and complex instructions to the patient including the diagnosis. The Carer found it necessary to remind the Ophthalmologist and team that the patient was diagnosed with	

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	dementia, plus discussion about the ophthalmological diagnosis caused upset to the patient which would last several hours, resulting in distress. Following that, the Ophthalmologist leaned forward and placed drops which stung, into the Patient's eye. When the patient complained about the stinging they were ignored and eventually passed a tissue to wipe their eyes. The Carer, who was the son of the Patient, stated that he felt that the clinician could have displayed more sensitivity in dealing with a patient with dementia. Additional medication was prescribed and they were asked to book an appointment in six weeks' time. The Receptionist stated that an appointment would be sent in due course and upon challenging that and checking with the doctor, the Carer was advised that the appointment would be as soon as they could fit the patient in, which caused further anxiety given that additional medication had been prescribed. Despite a review being requested by the doctor, it appeared that there was no urgency or meaningful plan to do so. In a second experience the Patient and Carer attended for a chest x-ray and whilst the Patient was efficiently asked a series of questions including their address and date of birth, they were unable to answer correctly. The Carer commented that assistance had to be asked for and further added that dementia was not visible and if that had been a physical and visible disability the situation might have been handled differently. Following those experiences, the Carer met with Miss Langley who met the Director of Nursing to discuss the alleged poor experience the Patient had encountered. Miss Langley alerted the CT scanning team of a forthcoming attendance by the Patient and the feedback from that was, '*The scan was a breeze today, thanks so much'.* Unknown to Miss Langley, the Patient had attended the Treatment Centre at Ormskirk Hospital and the Carer fed back, *'I just thought you'd like to know that mum was currently at Ormskirk awaiting the cystoscopy. She was being assisted by an auxiliary nurse called Mary, who was treating mum in a very caring and sensitive manner. I do not know if that was standard or a result of your involvement, but it was very welcome.'* Work was on-going to improve the experience of patients with dementia including new dementia strategy objectives: • Patient, Family and Carer experience of care • Training & Education • Environment - Engagement • Environment - Physical • Pathways • Communication	

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Work had commenced on:

- New cognitive screening and assessment pathway rolled out (Obs, 9A, 9B, 7B, 14A, 15A)
- New Hospital Passport
- New Dementia Leaflet
- New Delirium Leaflet
- New Care Plan
- Testing of crockery with colour, shapes and sizes
- Creating easily accessible picture menus of foods which Patients enjoy
- Using moulds of difference shapes and sizes to create more interesting textured and colourful foods

Further work would be taking place including:

- Commencement of Dementia Education Strategy – Tiers 1, 2 and 3
- Recruitment to Admiral Nurse and Dementia/Delirium Team
- Continued development of discharge pathways with system partners
- Establishing formal Dementia Champions
- Requesting funds for Crockery

Ms Patten thanked Miss Langley and stated that Estates & Facilities would be undertaking a significant amount of work to support patients with dementia along with a Matron who would commence on 10 June 2019. There would also be support with food and menus which would incorporate catering assistants and porters, plus ward refurbishment. She asked Miss Langley to return to the Board in the future with the new Matron to present the changes which would have taken place and the impact of them.

In response to Mrs Gibson's question regarding how training relating to Dementia was accessed, it was confirmed that the Dementia Education Strategy training would be available via the Electronic Staff Record (ESR) system.

Miss Langley agreed to share the presentation directly with Dr Hankin who would share it with the Ophthalmology Team.

The Chair, on behalf of the Board, thanked Miss Langley for sharing the patient and carer's experiences and asked her to convey the thanks of the Board.

RESOLVED:

The Board **received** the presentation and **noted** the lessons learned

STRATEGIC CONTEXT		
TB108/19	**Chief Executive's Report**	
	Mr Nicholls presented the report. **£1m Investment in Nurse Staffing**	

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	An additional £1m would be spent on nurse staffing during 2019/20 following an in-depth nurse establishment review which was equivalent100 extra staff including ward clerks. **Trust no longer outlier for patient mortality** The Trust remained committed to improving patient mortality through the Reducing Avoidable Mortality Project which had the overriding aim of reducing avoidable patient deaths to within agreed statistical limits by April 2019. Mr Nicholls was very pleased to report the December 2018 national figures for Standardised Hospital Mortality Indicator (SHMI), demonstrated for the first time in three years, that the Trust was no longer a national outlier and had returned to within the expected range which was a significant milestone. **Orthopaedic Consultant of the Week Brings Patient Benefits** In March 2019 the Orthopaedic team introduced Consultant of the Week (CoW) as part of the Getting It Right First Time (GIRFT) project. CoW was an on-call rota for surgeons, in line with national best practice. The surgeon who was the CoW was 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 was having a positive and noticeable impact on patient care and the quality of the patient experience. Specific improvements that had been noted to date were that trauma for orthopaedics no longer impacted on elective care for orthopaedics. There had also been a significant positive impact on the timeliness of treatment for patients with a fractured neck of femur. **Dementia Strategy** A dementia strategy was published in May 2019 which aimed to deliver excellent, person-centred care for people living with dementia, and their families and carers as outlined earlier in the Patient Experience by Miss Langley. **Preparations for Care Quality Commission (CQC) Inspection** Preparations were ongoing and a redoubling of efforts to de-clutter and update noticeboards etc. would be taking place on 24 June 2019. **RESOLVED:** The Board **received** the report.	
TB109/19	**Vision 2020**	
	Ms Patten presented the final version of Vision 2020 which consolidated all the improvement work the Trust had embarked on and set it within the context of the five year transformation programme. Assurance templates were included which would be reviewed and	

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	progress reported at the Public Board on a monthly basis. **RESOLVED:** The Board **received** the final version of the document	
QUALITY & SAFETY		
TB110/19	**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	
	The reports were sign-posted via a presentation by the Director of Nursing and Medical Director. Ms Cosgrove gave an overview of the Quality Improvement programme which included: • Quality Strategy • Older Persons' Care, including nutrition, dementia & delirium and mouth care • Infection Prevention and Control (IPC) • Core Service Reviews planned for Theatre, IPC and Medicines Management o IPC: more Clostridium Difficile (C-Diff) cases had been attributed to the Trust from April 2019 due to categorisation, not an actual increase in cases o Theatres: concerns regarding staffing were raised following CQC preparation Quality Improvement training had been scheduled for 11 June 2019, facilitated by Dr Brian Dolan who was considered a guru in this field. 23 staff were due to attend and Board members were offered the opportunity to attend sessions. Dr Bricknell added that the Quality & Safety Committee would be focusing on those priorities and selectively deep diving into specific areas. **CQC Update** PIR was submitted and minimal feedback had been received. The Deputy Chief Inspector of Hospitals visited the Trust week commencing 27 May 2019 to introduce their incoming replacement. Whilst on site, they visited A&E, Elderly Medicine and Ward 14a and saw significant evidence of improvement. Of the '*Must and Should Dos'* CQC actions, 94 had been completed, 20 were on track to deliver and zero were 'not progressing to plan'. Detailed briefing packs were scheduled for distribution week commencing 10 June 2019 to ensure Board members were up to speed prior to CQC visits and interviews. Informal and formal	

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	practice interviews with Julie King would be scheduled. Mrs Gorry added that focus should be on the positive aspects of the Trust's journey and how it compared historically. **Complaints and Compliments** The volume of compliments received continued to increase and the number of complaints was decreasing, along with the seriousness of the issues raised. National Audit for Care at the End of Life (NACEL) assessment had evidenced the Trust performing better than national scores. Dr Bricknell considered the Board could be assured by this recognising there remained scope for improvement. Ms Cosgrove acknowledged that the survey of bereaved families had, understandably, received a limited response. In response to Mrs Gibson's query relating to complaints regarding staff attitude, Ms Cosgrove stated that this could have resulted from narrow coding, however any complaint regarding staff attitude was dealt with at the time or via Human Resources. The majority of staff responded empathetically when asked how they would feel if they had been the recipient of a particular attitude and were apologetic, which was subsequently conveyed to complainants. That was not a systematic issue. In response to Mr Singh's query relating to the weighting of the complaints themes identified and if any patient harm had occurred as a result of 'Possible missed diagnosis', Ms Cosgrove replied that all complaints were thoroughly investigated and *the question regarding weighting within the report would be clarified.* All instances of system failures or patient harm were examined at the Quality & Safety Committee. **Gosport Audit** Following an investigation by Kent police at Gosport War Memorial Hospital relating to opioid administration without medical justification which may have shortened the lives of 450 patients and 200 further potentially affected, the Trust had conducted a review. The conclusions were: • To date there was no indication that there was a systemic issue with opioids at Southport & Ormskirk Hospitals • Appropriate local and network guide lines were in place • Ongoing education & monitoring was required The actions to be taken were**:** • Clear clinical indication documentation for all opioids (plus all drugs) • Ongoing review of diagnostic labelling of lower respiratory tract infection & death certification	**DoN**

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Safe Staffing
The Trust reported that the overall fill rate in April 2019 was 94.45% which was a slight improvement on the previous month, with a vacancy rate of 11.8% which reflected the increased establishment resulting from the business case approval.

The overall Care Hours per Patient Day (CHpPD) for the Trust was 8.6 hours and slightly above the national average. Some wards had reported a low CHpPD against the national average of 7-8 hours. A review of Trust's submission data was being undertaken as part of the Model Hospital work stream.

Mortality
As reported by Mr Nicholls, the SHMI measure for the Trust had evidenced that the Trust was no longer a national outlier and was within the expected range. SHMI performance had improved from 1.18 in December 2018 to 1.11 in January 2019. Dr Hankin commented that high mortality did not preclude being an outstanding organisation and the SHMI measure was not a measure of quality care.

The rolling Hospital Standardised Mortality Ratio (HSMR) had also reduced from 123.4 in December 2018 to 109.9 in January 2019.

Crude Hospital death rates varied between 30.4% and 17.4% against a target of 33% maximum.

Areas of concern as identified by disease-specific SHMI were:

- Acute Bronchitis (SHMI 1.56)
- Fractured NOF (SHMI 1.6)
- Pneumonia
- Chronic Obstructive Pulmonary Disease (COPD)

The ongoing actions to address those areas of concern were:

- Case note review of Lower Respiratory Tract Infection (LRTI) / Acute Bronchitis to identify clinical issues
- Neck of Femur Pathway to be launched and embedded with on-going frailty work
- Embedding the Pneumonia Pathway and improving access to point of care diagnostics such as chest x-ray and pro-Brain Natriuretic Peptide (BNP) to ensure patients were on the correct treatment strategies
- Improving acute pain guidance and support
- Embedding sepsis, Acute Kidney Injury (AKI) and pneumonia packages within clinical education

In response to Mr Birrell's question regarding the number of deaths screened, Dr Hankin responded that achieving 100% compliance was ambitious. It was part of the junior doctors' role to submit the

	electronic Coroner's Form and training was being provided to ensure this took place, along with a senior doctor to take responsibility if the junior doctor was unavailable. **Seven Day Services Self-Assessment Return to NHSE** Dr Hankin stated that the return would be submitted with 'red' areas as the Trust had achieved all requirements by utilising senior staff to conduct reviews when consultants were not available. **RESOLVED:** The Board **received** the monthly report and approved the Seven Day Services Self-Assessment Return to NHSE	
TB111/19	**Maternity & Neonatal Safety Collaborative**	
	Mrs Janet Calland, Matron – Maternity Services & Mrs Josie Hughes, Clinical Lead Midwife Delivery Suite attended the Board to present the Maternity & Neonatal Safety Collaborative which was a national three year safety programme covering all 134 NHS Trusts and launched in February 2017. The aim was to '*improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across England'* The ambition was for each organisation, local maternity system and network to have: • Significant capability and capacity for improvement • Detailed knowledge of the local safety culture • Understand their priorities and gaps, and develop a Local Improvement Plan • Make significant improvement to the local service and system quality and safety • Share data with their Board, staff and commissioners that reflected these improvements. This would help create the conditions for a safety culture and a national maternity and neonatal learning system Southport & Ormskirk Hospitals' primary driver was to improve the early recognition and management of deterioration of either mother or baby during labour and early *post-partum* period. The project background was: • An audit of early warning scores for both high and low risk women revealed that only 10% had been completed in line with the current guideline • The Trust CQC report from March 2018 highlighted issues with Modified Early Obstetric Warning Score (MEOWS) and National Institute for Care & Health (NICE) Guidelines • A proportion of the babies admitted to the Neonatal Unit for treatment of hypoglycaemia were otherwise well and the hypoglycaemia was low grade • To prevent unnecessary separation of mother and baby through implementing Avoiding Term Admissions into Neonatal Units	

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	(ATAIN) programme.and British Association of Perinatal (BAPM) Guidelines The project aimed: • To achieve 90% or > documented early warning scores in line with the current Maternity and Neonatal services guidelines for all women and babies - December 2018 • 90% of the identified cohort of clinical staff to have received training in the recognition of the deteriorating mother in labour and the early postnatal period. Training included understanding the rationale for MEOWS scoring - November 2018 • To demonstrate that abnormal early warning scores had been recognised and escalated appropriately in 100% of cases - December 2018. • 90% of the identified cohort of clinical staff to have received training in the recognition of the deteriorating neonate. To include understanding the rationale for Newborn Early Warning Trigger & Track (NEWTT) scoring - November 2018 • To prevent potentially unnecessary separation of mothers and babies by improving the detection of hypoglycaemic babies requiring treatment on the neonatal unit by 50% - February 2019. • To achieve 90% or > documented maternal observations in labour in line with current Maternity Services Guidelines - December 2018 Benefits to Patients and Staff • Early recognition of deterioration • Assurance that staff are competent • Appropriate escalation of abnormal MEOWS and NEWTTS • Reduced incidents • Reduced separation of mother and baby • Increased job satisfaction • Earlier discharge of mothers and babies • Implementation of transitional care which will reduce admissions to the Neonatal Unit (NNU) Improvement Approach • Raise awareness of project • Recruit Home Team • Collect data (co-opt Information Department to assist, CQC reports, review audits) • Identify areas for improvement • Ask – Are the processes right? • Generate improvement ideas What we did • Reviewed guidelines for MEOWS and NEWTTS • Plan to implement observation rounds on Maternity Ward • Midwives raised concerns over staffing and capacity for one midwife to focus on observation rounds	

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	• Plan for Maternity Support Workers to undertake rounds • Gaps in knowledge identified between support workers • Review of MSW job roles • Additional training days provided for Maternity Support Workers (MSWs) • Still gaps in confidence, so additional support put in place until competencies signed off Measurement • Outcome measure was to count number of observations per woman that were completed in accordance with guideline • Process Measure was the percentage of completed observations that were compliant with the guideline • Balancing Measure was the effect of the changes on the staff Achievements • Compliance of MEOWS observations • A greater awareness of MEOWS and NEWTTS • Upskilling of Maternity Support Workers • Engaging staff in the improvement process • Introduction of Neonatal Hypoglycaemia care pathway • NEWTT chart revised so it is clear what observations are required on babies with different risk factors, clinical signs or diagnosis. • Devised pocket prompt card detailing frequency of observations • Improved collaboration between Maternity and Neonatal Continuing • Measure Compliance with MEOWS scores • Collect data on admissions to NNU for hypoglycaemia • Make a safety culture improvement plan based on staff feedback and ideas generated at debrief of the SCORE Survey • Engage with staff Next Steps • Continue to monitor and sustain MEOWS above 90% • Measure and improve compliance with NEWTTS • Work to improve and embed a proactive safety culture • Continue to meet as an improvement team to sustain momentum on focused improvement work • Keep on using life QI tools and Matneo portal for our improvement work The Chair thanked Mrs Calland and Mrs Hughes for their presentation. Mr Birrell congratulated them on the fantastic clinical outcomes which would potentially reduce the stay on wards prior to discharge. Mrs Calland stated that the Unit was perceived by expectant mothers as friendly and safe. Ms Cosgrove and Mr Christian concurred and commended the entire team for their excellent work and commitment. **RESOLVED**	

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	The Board **received** the presentation	
PERFORMANCE & GOVERNANCE		
TB112/19	**Assurance & Performance**	
	Integrated Performance Report (IPR) Mr Christian stated as part of his summary that the IPR would measure performance against the ambition and trajectory. The Chair agreed and added that clear performance targets were set and the IPR would define the variance against the targets as absolute measurements. **Most Significant Deteriorating Indicators** **A&E 4 Hour Standard** In April 2019, the Trust was 52nd of 129 trusts nationally and 1st of 20 within the north west. Three months of continual improvement had taken place with the same day emergency pathway being enhanced and developed by clinicians. Ambulance Handover over 60 minutes and Corridor Care had seen significant improvement year on year. Increased demand across both CCGs from the older population presenting later in the day as primary care referrals had impacted on same day discharge as this group of patients were more likely to be admitted. **Workforce** Medical vacancies had increased from 7% to 10% and some of the most fragile of services were anaesthetics and radiology. Agency staff were utilised to fill the gaps which resulted in undesirable variation. **Length of Stay** Patient 4 hour flow had been impacted and in April 2019, norovirus continued to impinge upon bed capacity by closing beds and inhibiting the discharge of otherwise well patients who could not be admitted by care homes. **Referral to Treatment** A decline in performance was seen from 96% in October 2018 to 94% in April 2019. In context, the Trust was ranked 4th of 129 trust nationally, which was an improvement on March 2019; however a prolonged winter had impacted upon this. The challenges faced were contract management including Service Level Agreements and PBR including Community Paediatrics; workforce of general medicine including gastroenterology and cardiology and the general surgical impact of winter pressures requiring cancellation of surgery, to which recovery was being built in.	

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	Diagnostics The waiting time percentage of greater than six weeks was reported for all tests as 2.82% in April 2019. Urodynamics, Radiology and Endoscopy were not fully resourced. Pension changes relating to consultants would have an immediate financial benefit; however it would impact on the numbers of consultants available. Endoscopy was being managed by training Endoscopy Nurses. **Personal Development Reviews (PDR)** Compliance for April 2019 was 72.71% which was nearly a 3% decrease from March 2019. **Most Significant Improving Indicators** **Sickness Absence** The rate had improved and was the lowest since October 2017. This demonstrated that the new policy was effective and was being implemented by managers. Mrs Morgan questioned why agency spend was increasing if sickness rates were reducing. Mr Nicholls responded that that was due to medical agency spend, not nursing and was systems related. Ms Cosgrove concurred, stating that additional costs could be driven by unplanned activity. Mr Shanahan added that a new contract would be put in place to remove high-cost agencies such as Thornbury. **Efficiency Programme Diagnostics:** **Did Not Attend** Whilst performance was down from the previous month the Trust performance of 6.9% was within local targets and continued to perform better than peers. **Theatre Utilisation** Performance was 85% of capacity with zero cancellations *Mr Birrell requested a single page report identifying the total number of staff, available beds and deaths etc. to be added to the report and Mr Christian agreed that the right metrics needed to be developed along with statutory requirements and drivers for income.* **Alert, Advise and Assure (AAAs) Reports from:** **Finance, Performance and Investment Committee** Mr Birrell, in his role as Chair of the Finance, Performance and Investment Committee, presented the AAAs report. The Committee alerted on: • An exercise to assess the staffing required to provide a safe emergency care services was underway. It was anticipated that	**COO**

	this would highlight a number of potential gaps. The Committee advised on: • work to reduce reliance on off-framework nursing agencies was progressing. • options for improving the Trust's use of text messaging were under consideration and it • was hoped that the preferred option would support the collection of Friends & Family Test The Committee assured on: • the Committee was pleased to note that the Trust was 9th out of 136 providers in the Procurement League Table. **Hospital Management Board** Mr Nicholls in his role as Chair of the Hospital Management Board presented the AAAs report and stated all areas had been covered within the Board meeting. **Quality & Safety Committee** Dr Bricknell, in his role as Chair of the Quality & Safety Committee, presented the AAAs report and stated all areas had been covered within the Board meeting. **Workforce Committee** Mrs Gibson, in her role as Chair of the Workforce Committee, presented the AAAs report: The Committee advised on: • There were currently 13 active, substantive consultant posts awaiting recruitment, which all required AAC panels. The Recruitment Team were struggling to get availability from Executives and Non-Executive Directors to sit on the panels. There was an appeal to support this wherever possible. **RESOLVED:** The Board **received** the IPR and the highlight reports from the assurance committees and the Hospital Management Board	
TB113/19	**Financial Position at Month 1**	
	Mr Shanahan presented the report and key highlights. The Trust had 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). The report contained the month 1 performance against the plan: • A deficit of £2.025 million had been delivered against a plan of £1.902 million resulting in £123,000 adverse against plan. • The main commissioner contract with Sefton CCGs (Southport &	

<table>
<tr><td></td><td>Formby CCG and South Sefton CCG) had been agreed. At the time of the Board, the contract with West Lancashire CCG contract remained unresolved.
• Monthly pay expenditure levels incurred in Quarter 4 of 2018/19 were not budgeted for in the 2019/20 financial plan. The higher expenditure levels continued into April and were not sustainable. The 2019/20 deficit control total would not be achieved unless that could be addressed.
• The CIP programme delivered £53,000 in month which was £224,000 lower than the £277,000 target.
• There was a risk that the month 1 deficit position could deteriorate following contract agreement as income could be lower than both plan and actual.

Mr Christian responded to Mr Birrell's question regarding how £4.3m of CIP could be achieved in year, by stating that the Project Leads of the 59 schemes were being offered support to undertake the implementation of the plans to achieve the cost savings. Careful monitoring would be taking place and any scheme which had not been planned correctly would be escalated to the Chief Operating Officer and Project Lead. There would be further escalation to the Chief Executive if this process remained incomplete.

RESOLVED:
The Board received the report</td><td></td></tr>
<tr><td>TB114/19</td><td>Risk Management:
Board Assurance Framework (BAF) and Risk Register</td><td></td></tr>
<tr><td></td><td>Mr Charles presented the BAF report.

Following feedback at the workshop of 1 May 2019, the BAF and Risk Appetite Statement were updated and subsequently circulated to Executive's to examine and cull the controls and assurances relating to their risks where appropriate.

The Risk Appetite Statement had been expanded to incorporate all risks areas and then a single over-arching Risk Appetite agreed for each risk.

The BAF and Risk Appetite had been reviewed at all assurance Committees and Mr Charles thanked each Executive and the Committees for their input.

Three gaps remained within the current BAF which would be addressed once the Senior Datix Analyst had returned from leave:

1. Risk Rating Tracker
2. Review update description
3. Never Events being linked to relevant risks

It was agreed that each Executive Lead should meet with Julie King who was supporting the Trust in CQC preparation, in relation to their</td><td></td></tr>
</table>

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	BAF risk and ensure that the correct balance was achieved. 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 on risks discussed. Mr Birrell stated that the Risk Appetite Statement could have gone further as it would not be applicable across the whole organisation. The Chair commented that as it stood it was a step in the right direction and agreed with Mr Nicholls that that of the BAF as it stood should be considered for the next few months with a review by the Audit Committee and further refinement where necessary. *It was agreed to incorporate the Risk Appetite matrix in the Annual Governance Manual booklet as part of looking forward to 2019/20.* **RESOLVED:** The Board **received** the BAF and Risk Register reports	**CoSec**
TB115/19	**Litigation & Claims Report**	
	Mr Charles presented the report which set out the following correlations between the Trust's Litigation activities and Claims management: • 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 Total legal advice had been £55,983.00 for 2018/19. The Trust was signed up to a number of Schemes which were managed via NHS Resolution. They were: • 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 were set out in the report. The Chair expressed surprise that the item had been considered for the Public Board and *it was agreed that the full report should be redacted and re-published.* *The Chair requested that the Audit Committee schedule the Claims & Litigation report as part of its Annual Cycle of Business.*	**CoSec** **CoSec**

	Discussion took place regarding the influence the Trust did or did not have in relation to influencing NHS Resolution to settle or fight a claim based upon its potential costs. **RESOLVED:** The Board **received** the position statement and protocol for seeking legal advice and the position on claims handling and associated costs	
CONCLUDING BUSINESS		
TB117/19	**Questions from Members of the Public**	
	There were no questions from members of the public.	
TB118/19	**Any Other Business**	
	Mr Nicholls stated that the Southport & Ormskirk Improvement Board was now being chaired by David Leavey (Medical Director of North West England) and setting a distinct, professional tone. The Chair commented that the forthcoming 24-48 hours would see a significant amount of activity relating to the contracts with commissioners and requested that the Board of Directors be updated promptly. He outlined if there was a need for an Extra-Ordinary Board to support this that would be facilitated.	
TB119/19	**Items for Forward Agenda – 3 July 2019** • Engagement Plan	
TB120/19	**Message from the Board**	
	• Trust no longer an outlier for on key national SHMI mortality indicator • Trust dementia strategy launched • Trust receiving fewer, less serious patient complaints and more compliments • Reducing trend of staff sickness continuing	**Communications**
TB121/19	**Meeting Evaluation**	
TB122/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 3 July 2019, 11.30 Ruffwood Suite, Clinical Education Centre, Ormskirk District General Hospital, L39 2AZ	

There being no other business, the meeting was adjourned

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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	✓	✓	✓									
Mike Poullis			✓									
Audley Charles	✓	✓	✓									
Steve Christian	✓	✓	✓									
Jane Royds	✓	✓	✓									
A = Apologies ✓ = In attendance												

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Public Board Matters Arising Action Log as at 3 July 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
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	Jul 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 **July 2019** The MD is attending to this and will update at the next Board.	**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	Jul 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 **July 2019** The MD is attending to this and will update at the next Board.	**GREEN**

Public Board Matters Arising Action Log
as at 3 July 2019

NHS Southport and Ormskirk Hospital NHS Trust

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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. **July 2019** Trajectories for KPIs (where applicable) are in place **Completed**	**GREEN**

Public Board Matters Arising Action Log as at 3 July 2019

NHS Southport and Ormskirk Hospital NHS Trust

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB070/19	Apr 2019	**Chief Executive's Report**	IT implementation to be reported to Board in May 2019.	**DoF**	May 2019	Jul 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 **July 2019** Item on July Board. **Completed**	**GREEN**
TB072/19	Apr 2019	**Assurance & Performance - IPR**	IPR should relate to the Trust's performance and include the explicit impact for system failure on the community, primary care, the third sector and the Walk-In Centres etc.	**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. Due in August.	**GREEN**

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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	Jul 2019	**June 2019** To be considered at July Private Board. **July 2019** Report on Private Board Agenda	GREEN
TB107/19	June 2019	**NEDs & Executive's Visits/Walkabouts**	Mr Christian noted that a staff member would shortly be retiring after 50 years and requested that the Trust recognise this appropriately	**DoHR**	Jul 2019	Jul 2019	**July 2019** The DoHR is attending to this and will update at the next Board.	GREEN
TB110/19	June 2019	**NEDs & Executive's Visits/Walkabouts**	Clarify whether the list of complaints is weighted	**DoN**	Jul 2019	Jul 2019	**July 2019** The list of complaints is not weighted **Completed**	GREEN
TB112/19	June 2019	**Integrated Performance Report**	A single page report to be created identifying total number of staff, available beds, deaths etc	**COO**	Jul 2019	Jul 2019	**July 2019** Included within the IPR update **Completed**	GREEN
TB114/19	June 2019	**Board Assurance Framework**	Add the Risk Appetite Statement to the abridged Annual Report for the 2019 Annual General Meeting.	**CoSec**	Jul 2019	Jul 2019	**July 2019** Added **Completed**	GREEN

Southport and Ormskirk Hospital NHS Trust

Public Board Matters Arising Action Log as at 3 July 2019

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OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB115/19	June 2019	**Claims & Litigation Report**	The Audit Committee to schedule the Claims & Litigation report as part of its annual business cycle	**CoSec**	Jul 2019	Jul 2019	**July 2019** Added **Completed**	GREEN

Public Board Matters Arising Action Log as at 3 July 2019

NHS Southport and Ormskirk Hospital NHS Trust

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COMPLETED ACTIONS

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

Public Board Matters Arising Action Log as at 3 July 2019

NHS Southport and Ormskirk Hospital NHS Trust

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COMPLETED ACTIONS

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	**TB128/19**	**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

- Improving performance and care for patients
- Staff help launch quality improvement journey
- Getting the conversation started …
- Visit of Prof Brian Dolan

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

CQC KLOEs	**GOVERNANCE**

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

CHIEF EXECUTIVE'S REPORT TO BOARD – July 2019

Improving performance and care for patients

The Trust has made big strides over the past year to improve performance and the care it gives to patients.

From being one of the most challenged hospitals in the English NHS, we're now stable and improving.

A&E performance, in particular, has improved dramatically with the Trust consistently in the top half of English trusts. We are also the only A&E in Cheshire and Merseyside not receiving enhanced monitoring from the NHS.

Patient mortality was also a significant concern but dedicated team work across the Trust has turned this round too. We are no longer an outlier on the SHMI (summary hospital-level mortality indicator) measure of mortality. The improvement in the HSMR (hospital standardised mortality rate) measure has been even more dramatic. We have also:

- Fewer, less serious patient complaints and more compliments
- Staff reporting more incidents with fewer in the serious category
- Patients failing to attend appointments better than NHS average (6.5% v 8%)
- Ward safe staffing on an upward trend
- Staff sickness falling
- Mandatory staff training at more than 85%
- More than 100 apprentices making us the best performer in the local NHS
- Been a consistent top five performer among English trusts for referring patients to treatment within 18 weeks

Staff help launch quality improvement journey

We launched our quality improvement journey with the support of colleagues from NHS Improvement and members of the Trust executive team, who are helping us to create the Southport and Ormskirk Way of Quality Improvement.

The executive lead for Quality Improvement is Chief Operating Officer Steve Christian who was joined at the launch event by our Director of Nursing Juliette Cosgrove and Director of HR and Organisational Change Jane Royds. They, along with the Medical Director Terry Hankin, are executive sponsors for the quality improvement projects.

Staff involved in delivering some of the improvement projects that support the Trust's Vision 2020 strategy attended two introductory sessions in June to learn new skills to help deliver some key changes to improve the quality and safety of the services that we provide.

The full programme extends across 14 weeks and will enable many more staff be involved in delivering these small changes that will make a difference to our staff and patients.

Each of the 17 “inch wide, mile deep” projects have a project lead, executive sponsor and improvement coach. The projects have a clear aim of what they want to achieve during the 14 weeks with the final reports coming back to the celebration event planned for September.

Getting the conversation started …

We are engaging and involving staff across the Trust is in our quality improvement journey.

Under the strapline “what makes a good day at work?”, we are asking staff to tell us what they think, what it is like to work at the Trust and what ideas they have to shape our future.

These “Big Conversations” and “Big Brews” are programmed for the rest of the year. Big Conversations are 90-minute workshops while Big Brews are short, more informal “pop-up” sessions held in our restaurants.

We are also offering bespoke sessions to teams who need us to fit round their shifts and service needs.

The feedback will help us focus on the things that make the Trust a better place for our staff and patients.

Visit of Prof Brian Dolan

Prof Brian Dolan, founder of End PJ Paralysis and the Last 1000 Days movements, met hundreds of staff on a visit to the Trust last month.

He gave two lectures and walked around both hospitals meeting and being introduced to staff.

By focusing on a patient’s last 1,000 days, he aims to help draw attention to where time is wasted, and what could be done differently for patients who time is limited.

End PJ Paralysis focuses on encouraging patients to stop wearing their nightwear during the day in hospital and get them up and moving.

Brian says that for every 10 days of bed-rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80-years old.

In brief …

Staff awards. We celebrated the achievements of some of our nurses over the past year with a presentation of certificates and badges in the Boardroom at Southport. Those receiving recognition were nurses who have completed the Mary Seacole leadership qualification; preceptees completing their first year; and new Advanced Paediatric Nurse Practitioners, Assistant Practitioners and Nursing Associates.

Volunteers celebrated. As part of National Volunteers Week, we celebrated the contribution to Trust life of our volunteers with a tea party. We will expand volunteering opportunities over the next 12 months, with the introductions of pharmacy volunteers delivering medication to wards; patient experience volunteers who will visit patients at the point of discharge and help them to complete their Friends and Family Test cards; and, an increase in support for the wards and staff with dining companions, patient befrienders and general ward volunteers.

People's Health Hero Award. The award made by the public in our staff awards, the Time to Shine Awards, was launched in June. It is an opportunity for individuals or families to show their appreciation to a staff member or team who are a jewel in the Trust. They will have shown drive, enthusiasm or good sense of humour, inspiring those around them, especially in times of difficulty or stress. Nominations can be made on our website until Friday 12th July.

NHS Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
3 July 2019

Agenda Item	**TB129/19a**	**Report Title**	**Complaints & Compliments**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Mandy Power, Associate Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This report provides a breakdown on the number of compliments, complaints, concerns received in the month of May 2019.

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.

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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)*

Continue to monitor complaints and compliments.

Weekly complaints review meeting to review all complaints over 40 day response target.

Previously Presented at:

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

Complaints & Compliments

May 2019

1.0 Introduction

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

2.0 Compliments

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

Planned care received the most compliments with 83 in total and the Day Case Ward receiving 25 compliments in the month.

The Urgent Care Business Unit received 32 Compliments, with the Short Stay Unit receiving the highest number (10).

The Women & Children's Business Unit received 8 compliments, 2 for the Maternity Assessment Suite, 2 for Paediatric A&E and 2 for Neonatal.

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.

A total of 25 formal complaints were received in May.

The Urgent Care business unit received the most complaints (12), with Ward 11B accounting for the highest number (3). Specialist Services received 7 complaints and Planned Care received 6.

The following themes were identified:

- Co-ordination of medical treatment
- Lack of clear explanations
- Failing to inform next of kin when patient discharged
- Basic care i.e. mouth care/washing/dressing/assistance with feeding
- Unacceptable times to wait for an appointment
- Discharge i.e. patient unfit for discharge/support after discharge

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

Improvements identified

There have been 25 complaints closed during the month of May, there has been some key areas of improvement work been identified through the complaints process. The following are areas were improvement has been highlighted

- Patient information regarding DNAR to be given to wards and departments and information to be given to staff on revoking DNCPR. Processes to be reviewed to ensure that patients who commence DNACPR in A&E are reviewed prior to

discharge and that patient is aware of reasons for DNACPR even if it was discussed in A&E.

- Documentation and information has been highlighted in a number of complaint improvement areas which are being addressed.
    - Assistance with oral hygiene and transfers of patients
    - Clinical pathways.
    - Safeguarding and written feedback when safeguarding issues not taken forward.
    - Mental Health pathways
    - CHC assessments
    - Use of discharge to assess placement
    - Discharge information and policy
    - Family communication sheets to be included in all records and used
    - Regular audits of documentation to take place

- Training of staff has featured
    - Convene training identified.
    - Documentation
- Business case to be developed for Ward Hosts/Hostesses following completion of trial.

- Volunteer Co-ordinator post now in place.

- Explore tick list of patient issues to be attached to blood request forms to ensure clear communication of any issues when taking blood samples.

- Identify process to ensure MDTs are undertaken as soon as possible after discharge and within 10 days of a patient being identified as medically optimised for discharge. .
- 72 hour reviews of incidents on Ward 9B relating to self harm to be reviewed at SIRG to ensure escalation as is required under Serious Incident Framework.
- Management of acute delirium
    - Policy to be reviewed
    - Daily safety huddles to have a reminder to be vigilant during the assessment of patients displaying signs of acute delirium.
    - Case scenario on delirium to be presented at Monthly Medical Risk Meeting

- Matron to facilitate reflective/ coaching conversation with nursing staff and nurses to utilise feedback for revalidation

- Implement SAFER model to standardise board and ward rounds and improve communication between teams

2.2 Concerns

There have been a total number of 55 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.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	TB129/19	Report Title	Monthly Mortality Report
Executive Lead	Dr Terry Hankin, Medical Director		
Lead Officer	Dr. Chris Goddard, Associate Medical Director of Patient Safety Rachel Flood-Jones, Project Delivery Manager Richard Boydell, Deputy Head of Information		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Committee is asked to receive the report for assurance the measures for mortality alongside detail of the activity supporting the improvement of quality of care and performance.

1.0 Mortality Data and Analysis

- Hospital-level Mortality Indicator (SHMI) – (Rolling) to December 2018 - 1.11
- Hospital Standardised Mortality Ratio (HSMR) – (Rolling) to January 2019 – 109.9
- Hospital Standardised Mortality Ratio (HSMR) in month for January 2019 – 98.3
- Disease-Specific Mortality Ratios – January 2019 – detailed herein

In Summary for June 2019:

- The trend for improvement in national mortality indicators continues. The SHMI (reported in the main body rather than the summary table) has reduced to within the expected range.
- Monthly performance based on HSMR continues to be improved, although this is yet to include the spring period which in previous years has been challenging to flow and mortality.
- From a disease specific perspective, AKI and bronchitis/LRTI remain a challenge and work is ongoing through the AKI steering group to improve this position. Changes have already been made which are expected to be reflected in the coming months in data reported through AQ.

Mortality screening is an area that requires improvement, the approach to this is multi-faceted including education, improving the clarity of the process and improvement in access to IT.

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

3.0 Appendices
Appendix 1: Mortality Dashboard, June 2019
Appendix 2: Distribution Performance Graph, April 2019

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

Strategic Objective(s) and Principal Risks(s) (*The content provides evidence for the following Trust's strategic objectives for 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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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 Report

Executive Summary

In Summary for June 2019:

- The trend for improvement in national mortality indicators continues. The SHMI (reported in the main body rather than the summary table) has reduced to within the expected range.
- Monthly performance based on HSMR continues to be improved, although this is yet to include the spring period which in previous years has been challenging to flow and mortality.
- From a disease specific perspective, AKI and bronchitis/LRTI remain a challenge and work is ongoing through the AKI steering group to improve this position. Changes have already been made which are expected to be reflected in the coming months in data reported through AQ.
- Mortality screening is an area that requires improvement, the approach to this is multi-faceted including education, improving the clarity of the process and improvement in access to IT.

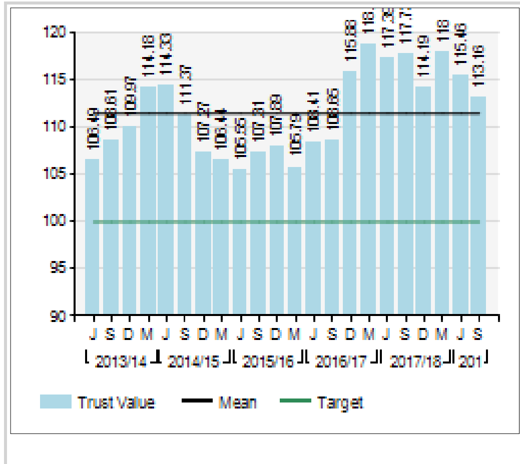
Key national and local mortality indicators

	2018/19											Target
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Rolling 12 Month HSMR	120.6	118.3	117.5	116.0	114.8	112.8	112.3	110.6	104.5			*100.0*
Monthly HSMR	125.6	98.9	123.5	96.1	99.1	75.7	91.3	100.0	86.3			*100.0*
SHMI		115.5			113.2			111.1				*100.0*
Local HSMR Bronchitis	161.6	154.5	169.7	157.8	152.8	136.6	136.6	138.3	135.2			*100.0*
Local HSMR LRTI	163.0	155.9	171.2	159.1	154.0	137.6	137.4	139.1	136.4			*100.0*
Local HSMR Pneumonia	135.9	133.0	135.8	126.2	128.8	121.7	122.1	118.1	114.8			*100.0*
Local HSMR Septicemia	92.5	90.1	87.1	87.3	87.7	89.9	89.7	89.2	80.4			*100.0*
Local HSMR Stroke	136.6	127.7	123.5	126.1	114.8	107.9	110.1	110.4	100.5			*100.0*
Local HSMR UTI	127.5	126.1	125.0	112.6	116.4	114.9	123.5	118.3	108.5			*100.0*
Local HSMR Acute Renal Failure	109.0	108.0	108.6	104.2	96.8	96.1	107.4	127.9	132.4			*100.0*
Mortality Screens - %	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	9	*0*
2nd Review					0	2	2	0	2	0	0	*0*
In Hospital Deaths	85	65	77	66	72	59	69	81	94	60	72	*77*

In Hospital Deaths Crude Rate	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	1	1	0	1	0	0	0	0	0	0	0	*1*
Steis Incidents	5	9	4	8	1	10	2	3	4	6	3	*5*

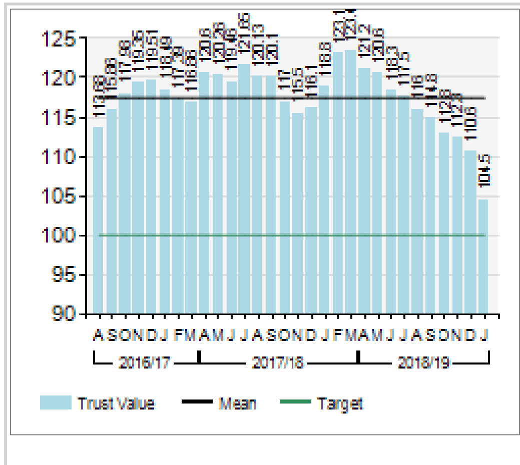
Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

SHMI - Summary Hospital Level Mortality Indicator



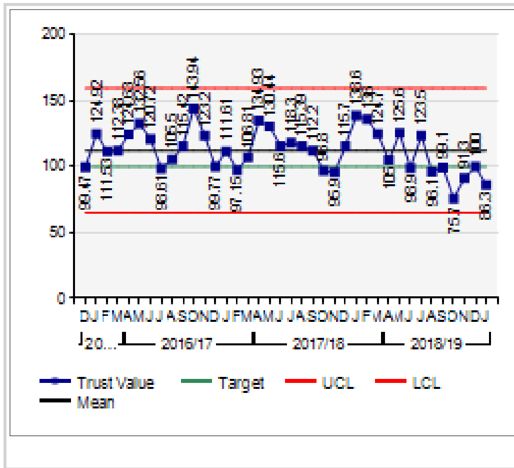
The most recent SHMI (not reported on the adjacent graph) is 111 (or 1.11). This is within the expected range. The factors driving this improvement are the better collection of co-morbidity data, which therefore reflects the health of the hospital population more accurately, improved patient flow, and a focus on the deteriorating patient and high risk pathways of care (Sepsis and AKI particularly, although AKI performance is deteriorating – see below).

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



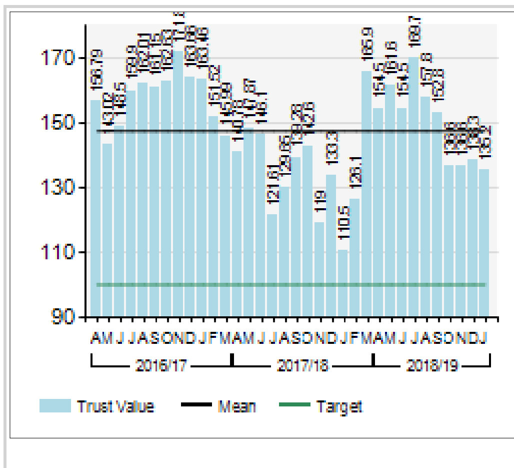
The Rolling HSMR is on an improving trajectory. This is underpinned by the factors outlined for SHMI, but also by the better identification of patients receiving palliative care. (40% of all deaths in the last month). Due to how the statistic is constructed changes in HSMR tend to occur before changes in SHMI.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



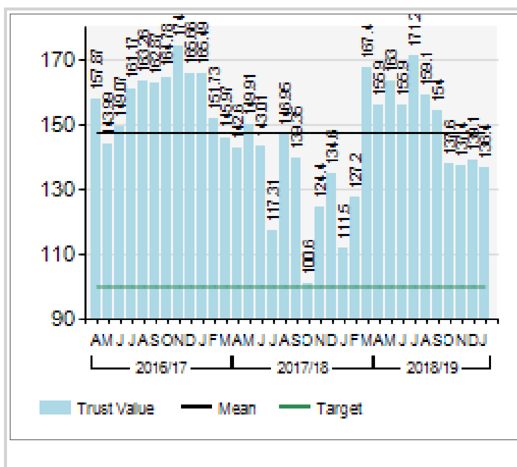
Monthly HSMR is subject to significant month by month variation due to seasonality and case mix (COPD/Asthma in spring for example). However, the trend is for a lower HSMR in general in 2018/2019 than previous years. Of note, January 2019s HSMR of 86.3 has been achieved despite challenging conditions for ED in that month with an increase in waits for admission. This probably reflects the Trusts decision to increase clinical staffing levels in this period, thus allowing the demand and need to be better matched.

Local HSMR Bronchitis



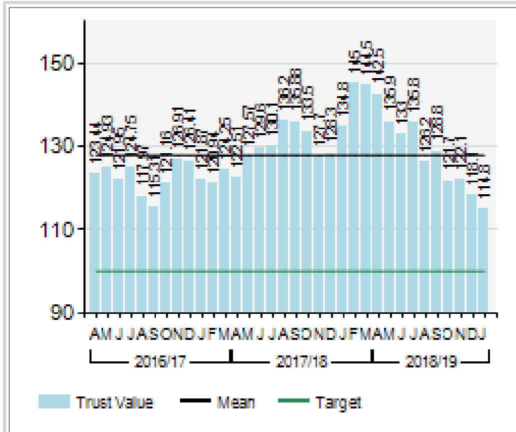
Bronchitis and LRTI remain areas of concern. These diagnoses are frequently used as a reason for deterioration in a patient with chronic complex conditions or frailty when there is no obvious other precipitating factor. The difficulty is that as a standalone condition, it is not expected that patients are admitted to hospital with these diagnoses or that they should die from them. A clinical review of a set of these patients is to be completed, but availability of senior clinicians to perform such a review is limited and thus this is delayed.

Local HSMR Lower Respiratory Tract Infection



See Bronchitis.

Local HSMR Pneumonia

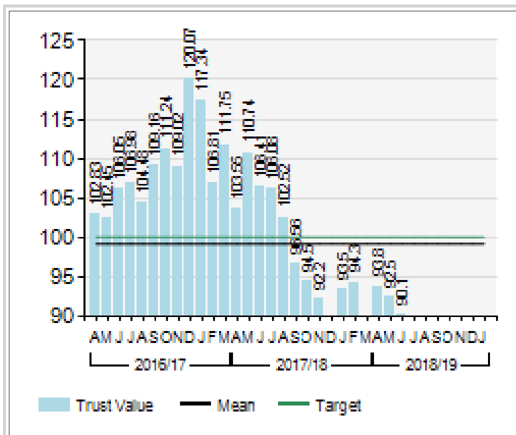


HSMR for pneumonia is on an improving trajectory. Last month's figure of 114.8 is the lowest posted in recent history. This is underpinned by the generic work on the accurate recording of co-morbidity data, but also by awareness and education around the accuracy of the diagnosis and consideration of other conditions such as cardiac failure. The work on providing a consultant review of admitted patients within 14 hours is assisting the accuracy of diagnosis. The trust pneumonia pathway is now in place.

Clinical performance is monitored by AQ; the most recent data, up to March 2019 shows good performance on admission with an improvement in compliance with the CURB-65 risk assessment tool.

Pneumonia			PN-01	PN-02	PN-03	PN-04	PN-05	CPS	ACS
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	Appropriate antibiotic selection	COMPOSITE PROCESS SCORE	APPROPRIATE CARE SCORE
RVY	Southport	90.8%	100.0%	83.3%	86.0%	70.4%	95.8%	86.6%	57.6%

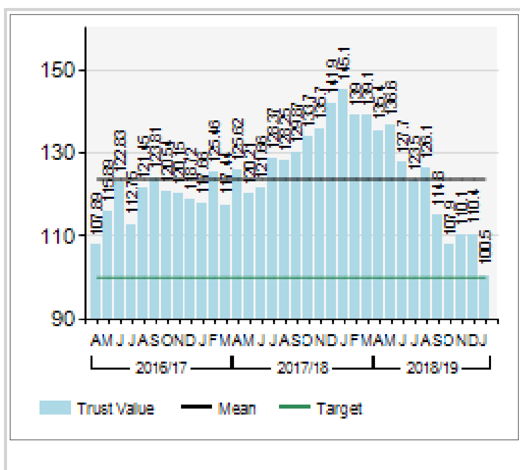
Local HSMR Septicemia



HSMR for sepsis remains in a stable and favourable position. This will continue to be monitored. Sepsis care is a priority for the trust and is monitored by AQ. The areas of improvement focus remain the senior review target of 2 hours and the implementation of the pathway. However, both pathway uptake and blood cultures within the hour are improving.

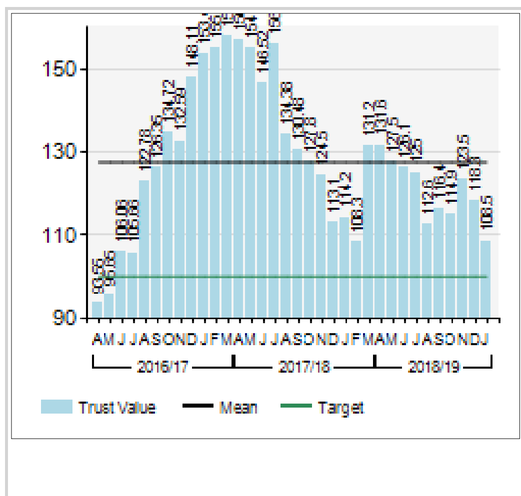
SepsisNEWS			SEPSIS-11	SEPSIS-12	SEPSIS-13	SEPSIS-14	SEPSIS-15	SEPSIS-16	SEPSIS-17	CPS	ACS
Code Provider		Target	National early warning score (NEWS2) recorded within 1 hour of hospital arrival	Blood cultures taken within 1 hour of sepsis diagnosis	Antibiotics administered within 1 hour of sepsis diagnosis	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	APPROPRIATE CARE SCORE
RVY	Southport	75.0%	100.0%	73.0%	82.4%	75.3%	94.4%	31.1%	66.2%	74.7%	22.8%

Local HSMR Stroke



HSMR for stroke has been on an improving trajectory for some time. The value of 100.5 the lowest charted in recent history. Processes of care for acute stroke are robust with clear, defined and supported pathways. Specialist nursing teams, a specialist ward and access to timely imaging. This will all contribute to the position, as will the generic effect of better collection of co-morbidity data improving the accuracy of the underlying health of this population.

Local HSMR Urinary Tract Infection

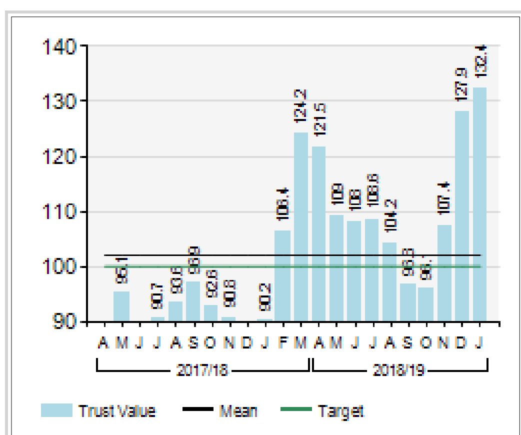


Urinary tract infection is a condition frequently diagnosed as the cause of deterioration in frail patients or those with complex co-morbidity. The accuracy of this diagnosis is not always clear as the presentation in this group is non-specific.

Work in this area is being taken forward jointly with the older persons care project with interventions to reduce catheterization, maintain and improve mobility and maintain continence.

Further work to move away from a reliance on urine 'dipstick' testing for UTI, which is inaccurate, is ongoing.

Local HSMR Acute Renal Failure



Acute Kidney injury is the main focus of improvement work currently. The AKI pathway is produced and available in all wards and departments. Utilisation rates are low, but efforts to improve awareness are ongoing with the development of a standardized education package under development, and a requirement for this to be a part of every department's clinical teaching.

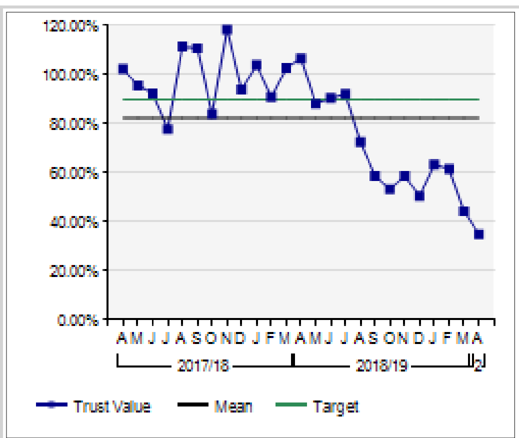
The electronic storage and availability of clinical guidance is under review to ensure that guidance is clearly available.

New processes such as e-mail alerts for AKI twice daily and identifying responsible doctors for AKI during on call shifts have only been introduced from May onwards, so this is not reflected in the current data.

AKI			AKI-01	AKI-02	AKI-03	AKI-04	AKI-05	AKI-06	AKI-07	CPS	ACS	
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	APPROPRIATE CARE SCORE	Number of measures passing out of 6 (excl. data collection measures)
RVY	Southport	57.6%	54.8%	100.0%	59.4%	6.7%	7.7%	61.9%	25.0%	53.1%	18.8%	3

AQ data presented shows our priorities for improvement are ultrasound scanning of appropriate patients, critical care review of AKI 3, pharmacy review and performance of urine dipstick testing. Urinalysis machine establishment for the wards is being reviewed.

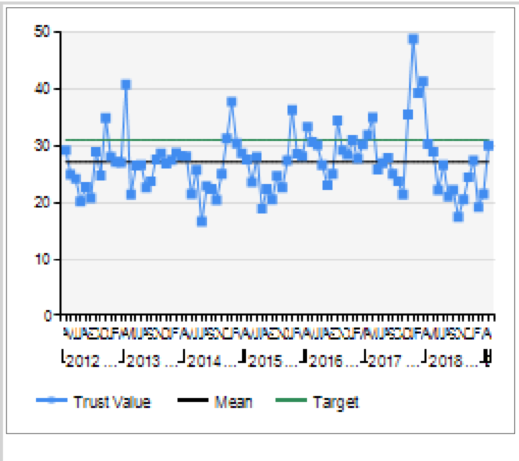
Mortality Screens - % Deaths Screened



Screening rates have declined considerably since the initial launch of the system. Feedback from the bereavement teams is that senior staff are unaware of the process, junior staff are frequently overloaded and have little time, there is not enough IT capacity in the bereavement office to support busy periods and roles and responsibilities are unclear.

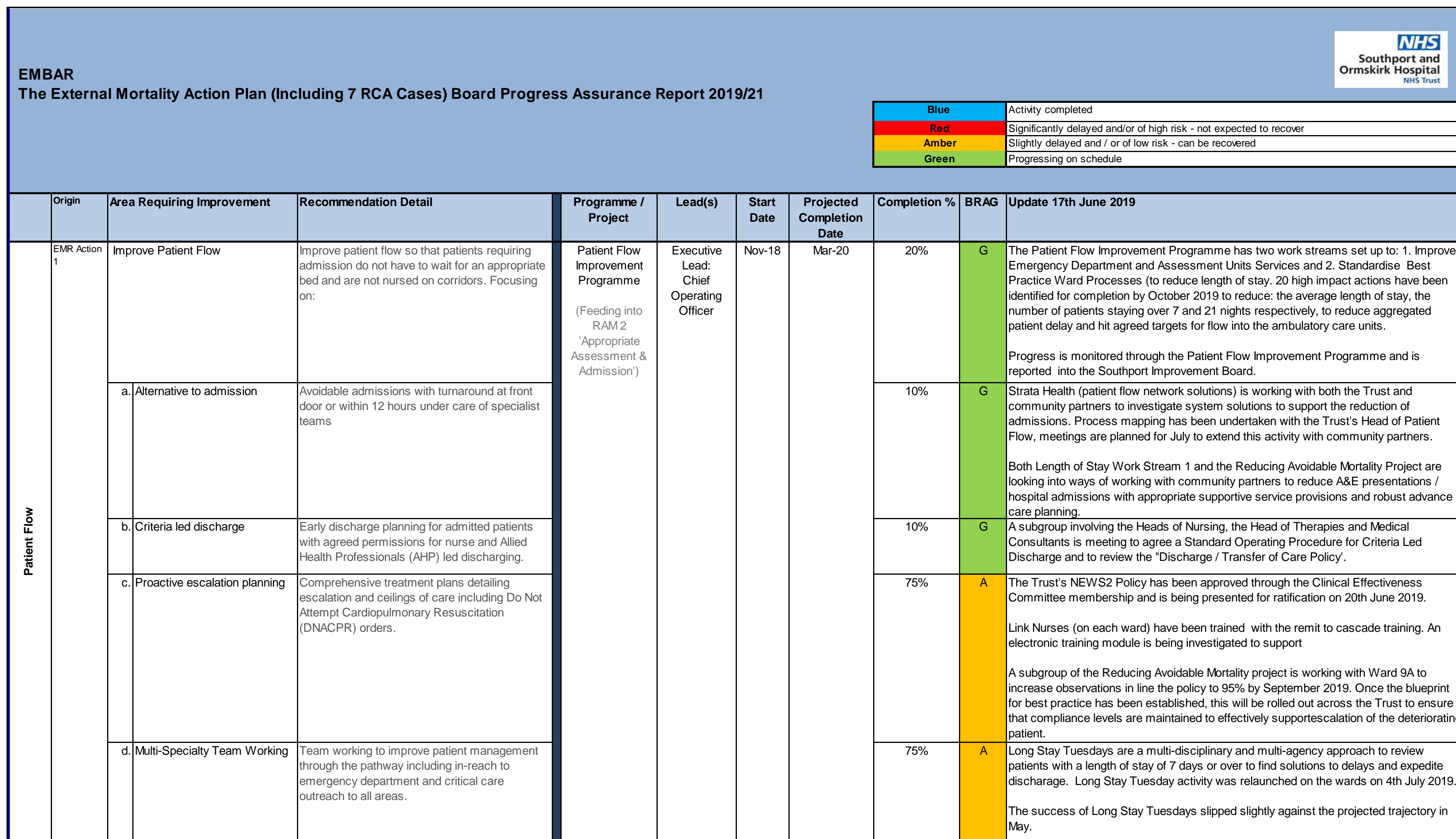
To address this, mobile computing is being considered to reduce login times and allow timely completion without needing more physical desktop computing, A checklist is to be co-designed with the bereavement office to clearly demonstrate roles and responsibilities and the AMD patient safety will attend departmental meetings to explain the process of mortality governance. This already forms part of corporate induction for all medical staff.

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



Crude mortality rate is non-standardised and therefore affected by the case mix of patients attending hospital, seasonal factors and all the factors affecting the standardized indicators. We have seen a rise in this latest report (April 19), this is expected as the standardized rate is frequently highest in April, although this represents a dramatic improvement on the previous 12 months, and remains below the last 12 months average.

2.0 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

NHS Southport and Ormskirk Hospital NHS Trust

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

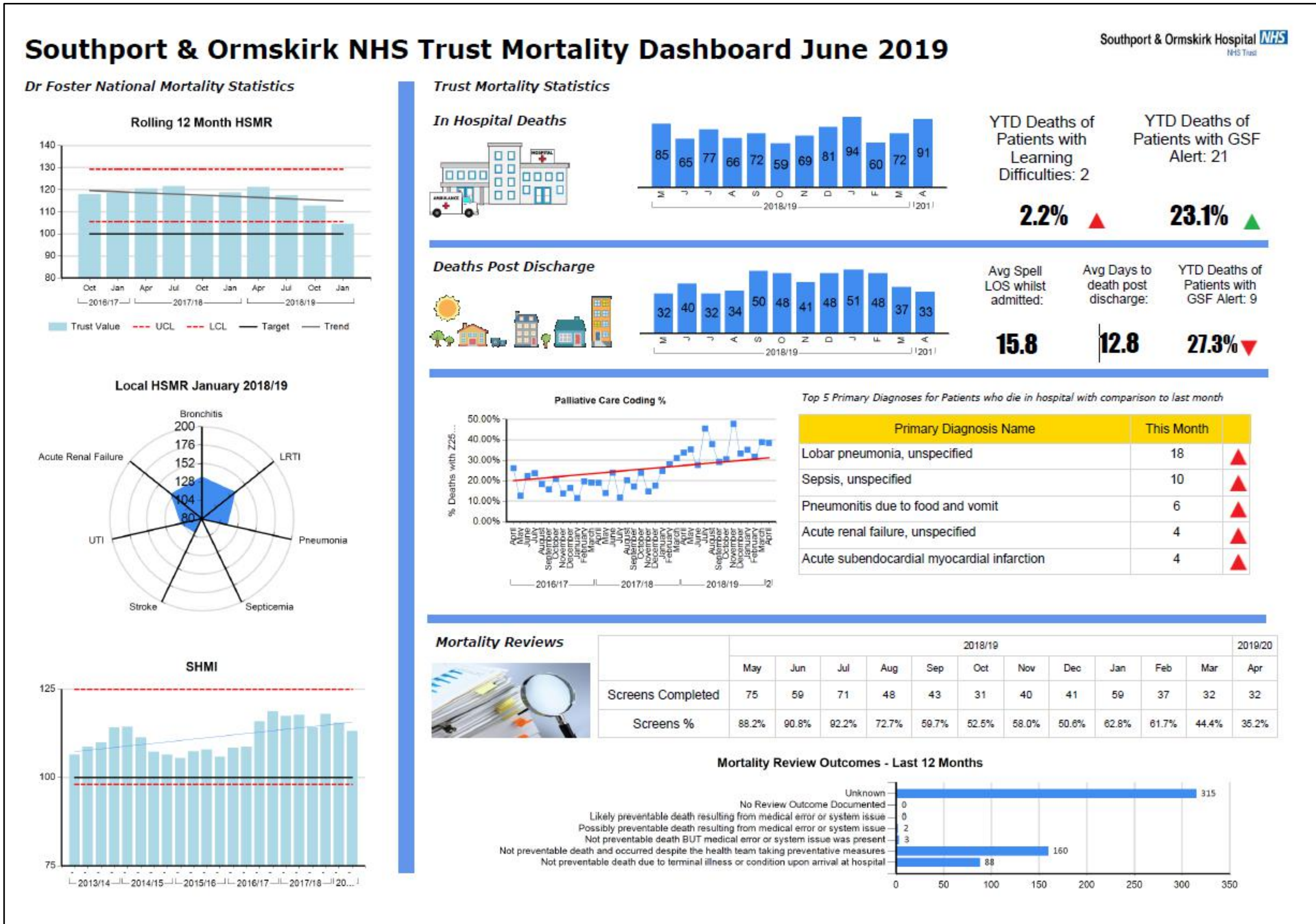
	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 17th June 2019
Patient Flow	EMR Action 1	Improve Patient Flow	Improve patient flow so that patients requiring admission do not have to wait for an appropriate 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	20%	G	The Patient Flow Improvement Programme has two work streams set up to: 1. Improve Emergency Department and Assessment Units Services and 2. Standardise Best Practice Ward Processes (to reduce length of stay. 20 high impact actions have been identified for completion by October 2019 to reduce: the average length of stay, the number of patients staying over 7 and 21 nights respectively, to reduce aggregated patient delay and hit agreed targets for flow into the ambulatory care units. Progress is monitored through the Patient Flow Improvement Programme and is reported into the Southport Improvement Board.
		a. Alternative to admission	Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams					10%	G	Strata Health (patient flow network solutions) is working with both the Trust and community partners to investigate system solutions to support the reduction of admissions. Process mapping has been undertaken with the Trust's Head of Patient Flow, meetings are planned for July to extend this activity with community partners. Both Length of Stay Work Stream 1 and the Reducing Avoidable Mortality Project are looking into ways of working with community partners to reduce A&E presentations / hospital admissions with appropriate supportive service provisions and robust advance care planning.
		b. Criteria led discharge	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.					10%	G	A subgroup involving the Heads of Nursing, the Head of Therapies and Medical Consultants is meeting to agree a Standard Operating Procedure for Criteria Led Discharge and to review the "Discharge / Transfer of Care Policy'.
		c. Proactive escalation planning	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.					75%	A	The Trust's NEWS2 Policy has been approved through the Clinical Effectiveness Committee membership and is being presented for ratification on 20th June 2019. Link Nurses (on each ward) have been trained with the remit to cascade training. An electronic training module is being investigated to support A subgroup of the Reducing Avoidable Mortality project is working with Ward 9A to increase observations in line the policy to 95% by September 2019. Once the blueprint for best practice has been established, this will be rolled out across the Trust to ensure that compliance levels are maintained to effectively supportescalation of the deteriorating patient.
		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.					75%	A	Long Stay Tuesdays are a multi-disciplinary and multi-agency approach to review patients with a length of stay of 7 days or over to find solutions to delays and expedite discharage. Long Stay Tuesday activity was relaunched on the wards on 4th July 2019. The success of Long Stay Tuesdays slipped slightly against the projected trajectory in May.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 17th June 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	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	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. 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	
	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	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	The following progress has been made since the completion of the ward audits with regards to staffing levels. - We have employed 5 SAS doctors and 8 Clinical fellows since the audit and almost all of them have now started in post. - Through job planning, we have changed working patterns for Consultants so that there are now 3 Consultant ward rounds per week instead of 2 on most wards. Job plans are pending exec signoff however as you are aware. - We have modified junior doctor rotas from August 19 so that on calls for Registrars and F2 - CT2 level doctors will be less frequent and this should improve weekday ward presence. A re-audit will be conducted after August, once the impact of these changes can be reassessed.
	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	There was a change of Ward to 10B, (Medical Ward) for the pilot of the Electronic Board Round which commenced on 3rd June. The pilot group is undertaking PDSA cycles in order to identify best practice in conjunction with the Red to Green Board Rounds. Once a blueprint has been agreed, the plan is for a roll out to take place in line with the refurbishment of the wards. Confirmation is required on the status of funds for screens to support the roll out which had been secured in a previous financial year.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 17th June 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%	R	The Project Lead and Project Manager for the Documentation Project have been meeting with Executive Leads to confirm the scope of work required. A meeting is set up with the Chief Clinical Information Officer and Medway Lead on 2nd July while the first scoping session will take places at the monthly Matrons Meeting on 1st July.
	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	The Trust participates in the regional benchmarking execise Advancing Quality. Every month we collect information on care for the following conditions: AKI, ARLD, Pneumonia, Diabetes, Hip and Knee replacement and Sepsis, Hospital acquired pneumonia (pilot). The measures for advancing quality are based on NICE guidelines for best practice.
	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%	R	Update as per 'Review Standards of Documentation' above.
	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	To be incorporated into the scope of the Documentation Project
	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	Ward Catering Assistant Business Case has been approved which will provide resource to the wards to support patient hydration. As the role evolves and with training, it is hoped that they will be able to assist with the completion of fluid balance charts.
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 NEWS2 ('Track and Trigger') Policy has been approved through the Clinical Effectiveness Committee membership and is being presented for ratification on 20th June 2019. Link Nurses (on each ward) have been trained with the remit to cascade training. An electronic training module is being investigated. A subgroup of the Reducing Avoidable Mortality project is working with Ward 9A to increase observations in line the policy to 95% by September 2019. Once the blueprint for best practice has been established, this will be rolled out across the Trust to ensure that compliance levels are maintained to effectively supportescalation of the deteriorating patient.
	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	
Future Care Planning	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.	RAM 1 & RAM 2 ('Future Care Planning')	Medical & Education Director, Queenscourt Hospice	2018	Mar-21	30%	G	Members of the Reducing Avoidable Mortality and the Older People's Care Project Groups are collaborating on Future Care Planning activity; in particular the cultural shift towards proactive Anticipatory Clinical Management Planning and a system wide approach to Care Management Plans. 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.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 17th June 2019
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%	R	It has been recognised that an increased focus is required in order to increase the rate of deaths reviewed (which dropped in May to an all time low of 32.9%). 'Learning from Deaths' is being brought back into the Reducing Avoidable Mortality Project as a stand alone Work Stream to give extra support to the required activity.
	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	The process to diseminate lessons learned through the Mortality and Morbidity Meetings continues to be developed. The Associate Medical Director for Patient Care 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 best practice.
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	The Trust is in the process of recruiting two full time Band 7 Diabetic Nurses (previously there had been one part time 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	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 standard for the administration of analgaesics.

3.0 Appendices Appendix 1: Mortality Dashboard



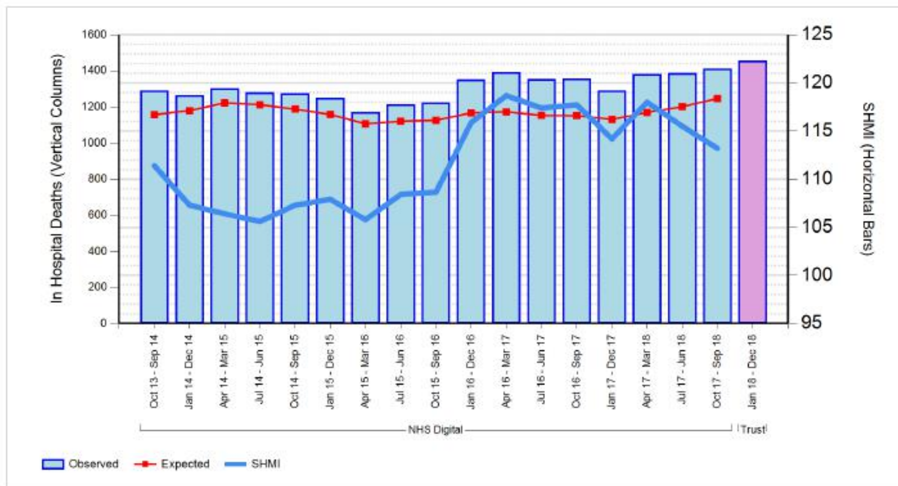
Primary Diagnosis Name	This Month
Lobar pneumonia, unspecified	18
Sepsis, unspecified	10
Pneumonitis due to food and vomit	6
Acute renal failure, unspecified	4
Acute subendocardial myocardial infarction	4

	2018/19											2019/20
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Screens Completed	75	59	71	48	43	31	40	41	59	37	32	32
Screens %	88.2%	90.8%	92.2%	72.7%	59.7%	52.5%	58.0%	50.6%	62.8%	61.7%	44.4%	35.2%

14

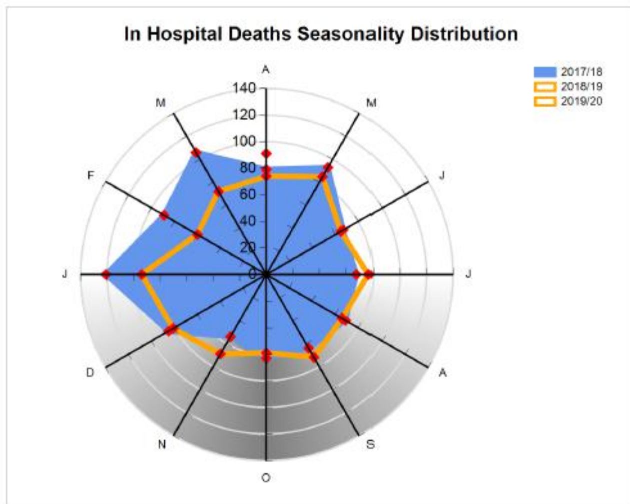
SHMI Breakdown

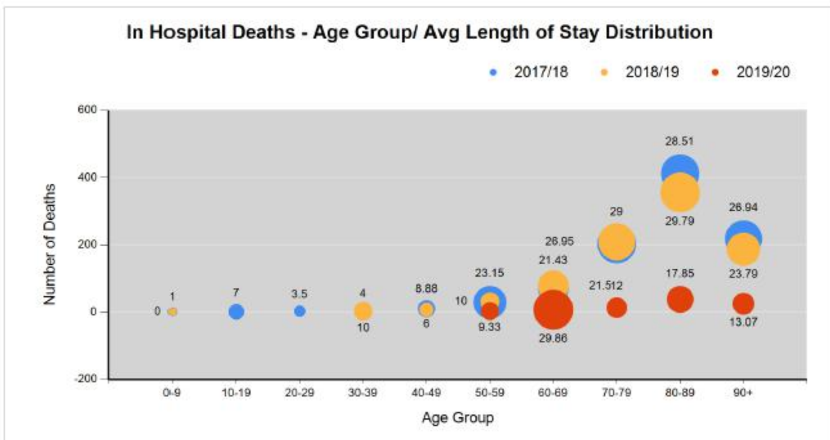
Southport & Ormskirk Hospital NHS Trust



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

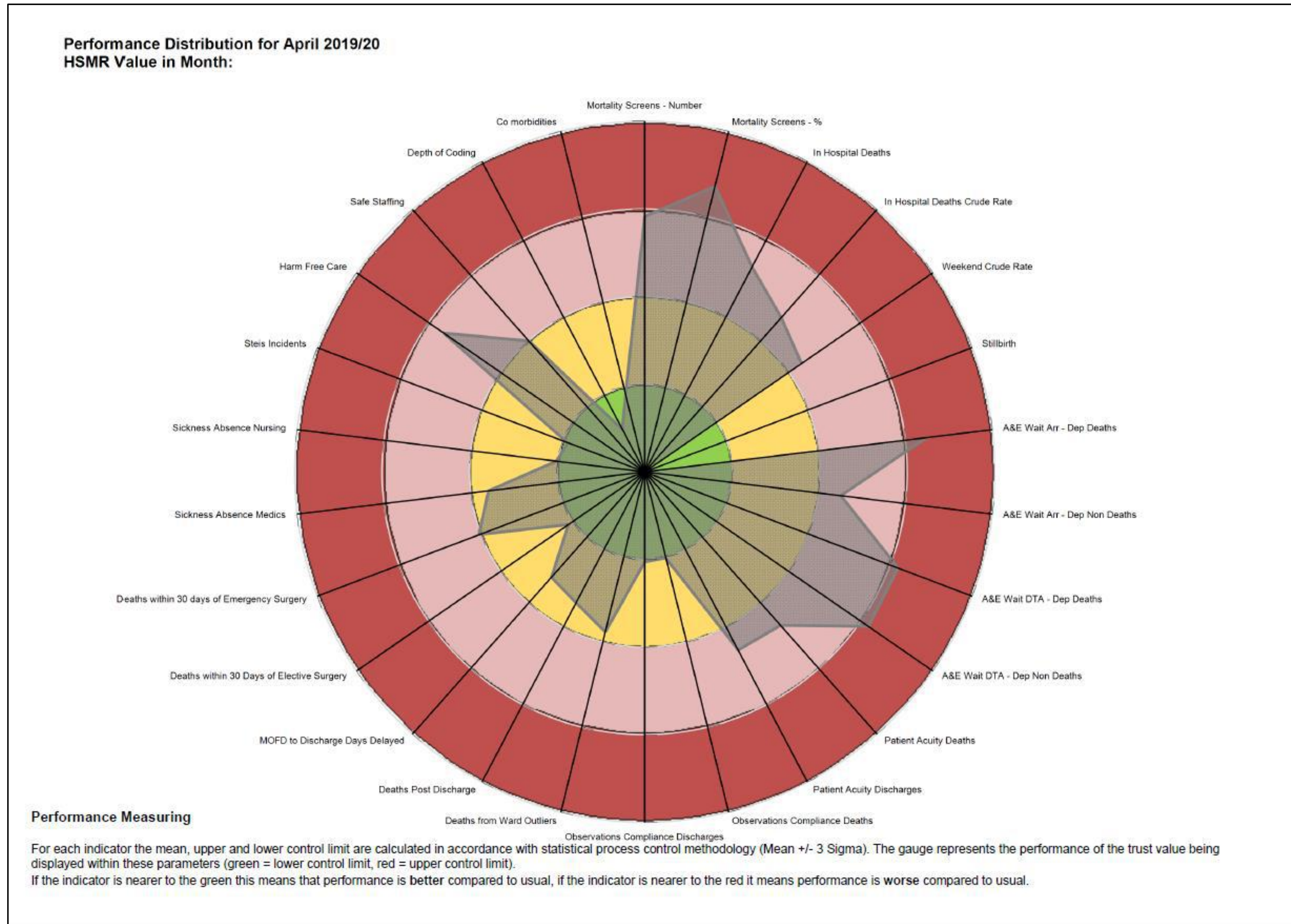
This should give an indication of the SHMI although the number of expected deaths for the recent periods is unknown.





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
3 July 2019

Agenda Item	TB129/19c	Report Title	Quality Improvement Report
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Paul Jebb, Deputy Director of Nursing Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This paper provides the 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

The Board is asked to **receive** progress identified in this report in relation to the Quality Improvement

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

Linked to Regulation & Governance

CQC KLOEs	GOVERNANCE

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

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

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

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

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

This is a live document and will be updated 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

QUALITY IMPROVEMENT PLAN UPDATE JUNE 2019

1. PURPOSE OF REPORT

This paper provides the 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

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 and Safety group operationally monitor delivery of the Quality Priorities:

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

The Trust Quality Improvement Strategy has now been agreed by the Quality & Safety committee and ratified at Board.

The monitoring of the Strategy will be done within the Quality and safety committee via the integrated performance report (IPR).

3. NEXT STEPS

The IPR is currently developing further to include the KPIs included in the Quality Improvement Strategy which were agreed by the Improvement Work stream Leads, this will be incorporated into the Performance and Accountability Framework. Currently the IPR contains a number of Quality Strategy KPIs which will be supplemented by additional indicators relative to the four Quality Priorities that are not currently included. Due to the refresh of Vision 2020 and recent agreement of four Quality Priorities the supplementary report containing progress on KPIs and progress against plan is also being refreshed, an updated version will be available to share at the July 2019 meeting.

The table below provides a high level summary of progress within the month

Care of the Older Patient: Professor Brian Dolan OBE visited the Trust and delivered two 90 minute lectures as well as visiting clinical areas on both sites. The focus of Brian's visit was relating to the last 1000 Days and how we can enhance care for this group of patients he aims to help draw attention to where time is wasted, and what could be done differently for patients who time is limited. End PJ Paralysis focuses on encouraging patients to stop wearing their nightwear during the day in hospital and get them up and moving.
Care of the Deteriorating Patient: 12 Month rolling SHMI up to Dec 18 has been confirmed as 1.1 or 111.1 which brings the Trust mortality index within confidence intervals Trust has been progressing well for pneumonia and sepsis pathways. Issues have been identified with AKI pathway, however electronic alerts are now in place for pharmacists, and the Clinical Audit team are finding more evidence of 'AKI pathway' in patient notes. The Trust is participating in a pilot for Hospital Acquired Pneumonia data collection as there are currently no agreed standards.
Infection Prevention and Control: Operation Sparkle has been launched across both sites, this is a great opportunity to tidy up and improve the environment for our patients, staff and declutter areas. This has been led by the new corporate Matron who is supporting work across estates and facilities. For a Quality Improvement project, the team is looking at why wards and clinical areas are not meeting their HEAT inspection standards, and how to embed improvement. A service review has been planned, this will involve independent experts from Public Health England and the Royal College of Nursing, it is anticipated that this will commence in late June.
Medicines Management: The Medicines Management Team continues to work closely with the requests from the Model Hospital Team as part of the Use of Resources assessment. Work continues on developing Medicines Management Project Initiation Document (PID) with PMO. For a Quality Improvement project, the team are looking at reducing medication administration incidents The Chief Pharmacist and the Deputy Director of Nursing have also plans to meet to discuss the development of a Medicine management lead nurse role

4. QUALITY IMPORVEMENT (QI) TRAINING

Over 40 members of staff attended a two day introductory training to Quality Improvement in early June, this is part of a wider 14 week programme for project leads and team members for the Quality Improvement projects so that methodology is understood and consistent across the Trust. It provided a great opportunity to work with external facilitators developing the 'inch wide mile deep' projects that support our

Improvement Programmes and Quality Priorities using the NHSE / I approach to Quality Improvement.

5. RECOMMENDATION

The Trust Board is asked **receive** progress identified in this report in relation to the Quality Improvement and agree the Quality Improvement Strategy.

NHS Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
3 July 2019

Agenda Item	**TB129/19d**	**Report Title**	**Monthly Safe Nurse & Midwifery Staffing Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Fiona Barnes Deputy Director of Nursing Carol Fowler Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

This report presents the safer staffing position for the month of May 2019.

Alert

- Trust vacancy rate for nurses and midwives has increased in month reflective of commencement to the establishment uplifts.

Advise

- The Nursing Establishment review has been agreed by Trust Board and the increased budgets have been 'uploaded' this month.
- The draft Clinical Indicators Dashboard is shared with the Trust Board in line with national guidance.

Assure

- For the month of April 2019 the Trust reports safe staffing against the national average (90%) at 92.38%.
- No harm events have occurred to our patients due to staffing levels

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

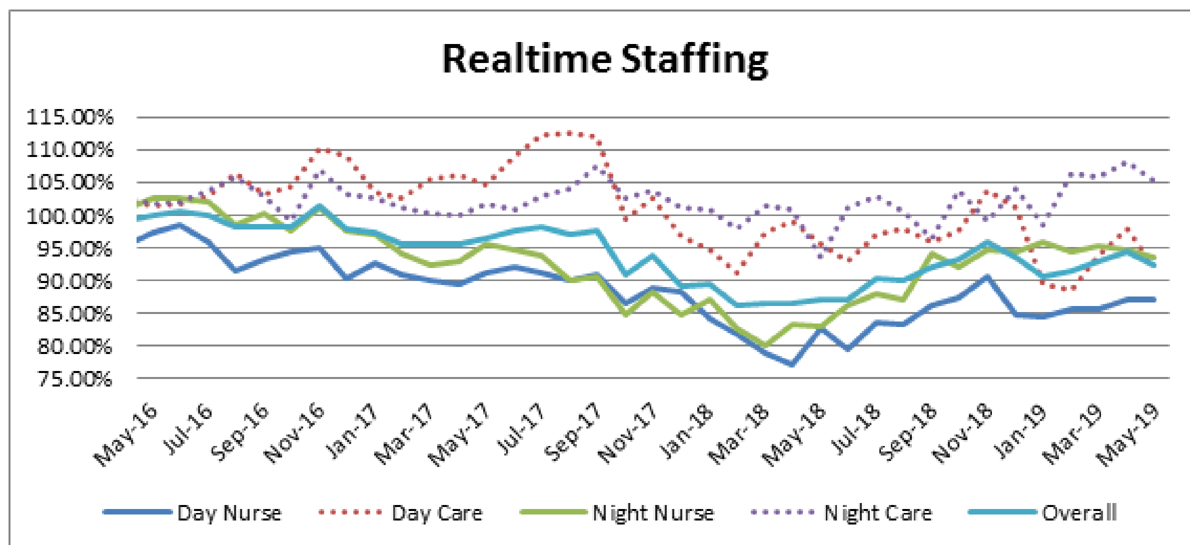
	Strategic Objective	Principal Risk
✓	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
✓	**SO2** Deliver services that meet NHS constitutional 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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*
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

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

Overall fill rate for May 2019 was 92.38% compared with 94.45% in April (appendix 1).

- 87.124% Registered Nurses on days
- 93.42% Registered Nurses on nights
- 92.2% Care staff on days
- 105.12% Care staff on nights



The overall CHPpD for the Trust is 8.3 hours (appendix 1) and slightly above the national average, there are 6 wards that have a low CHpPD, for example 7A, general medicine/cardiology shows 5.0 CHpPD. This means that in a 24hour period a patient would receive 5.0 hours of direct care, which could be registered nurse or HCA, against the national average of 7 hours CHpPD.

2. May Safe Staffing
Trust whole time equivalent (wte) funded establishment versus contracted for May 2019 below:

	Funded WTE	Contracted WTE	Vacancy
Registered	942.03	792.99	149.04
Non-registered	443.63	363.25	80.38
Total	1,385.66	1,156.24	229.42

The Trust vacancy rate for nurses and midwives has increased in month to reflect the uplifts following the nursing establishment review. Recruitment to the revised staffing establishments will be supported by a portfolio of solutions as experience has demonstrated that no one approach will deliver the required outcomes.

Non registered posts will be recruited to through the Trust contract with NHSP Care Support Worker Development (CSWD) programme and local recruitment events.

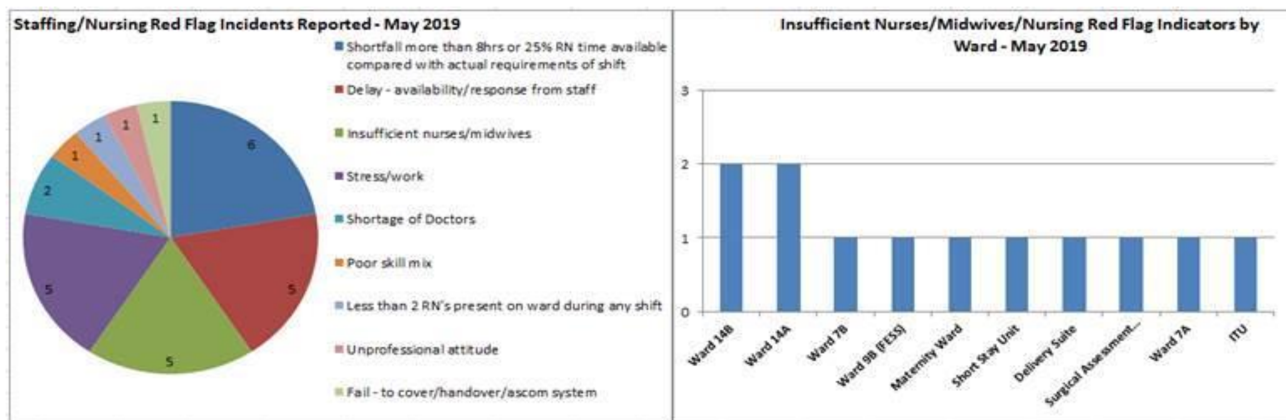
Band 4 posts (trainee Nursing Associates) have recruitment campaigns aligned to the local Academic Educational Institutes (AEI's) in July and October 2019.

It is proposed that several initiatives will be utilised to recruit Registered Nurse posts. Working closely with our recruitment team these will include current opportunities regionally and nationally. Consideration will be given to overseas recruitment campaigns within the Cheshire and Merseyside Nursing and Midwifery Workforce Programme. Further opportunities for multidisciplinary recruitment

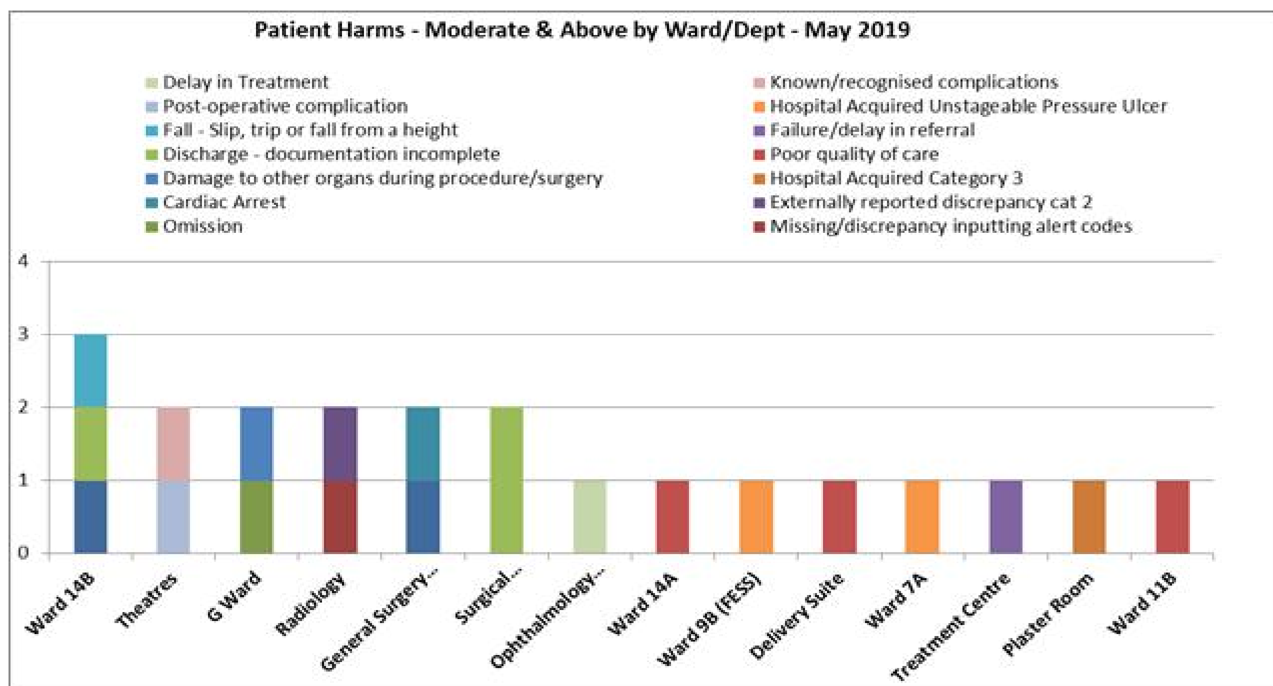
campaigns are within the scope of the Trusts Vision 2020 for example Frail Elderly. There is on-going work to finalise our recruitment 'pipeline' and incorporate the 'profile' of recruitment required to support the new establishments, which will be monitored on a monthly basis.

3. Staffing Related Reported Incidents May 2019

In May 2019, 27 staffing incidents/nursing red flags were reported, 3 more than the previous month. 12 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, the same as the previous month. Both 14A and 14B reported 2 concerns each related to insufficient nurses to meet the acuity of patients.

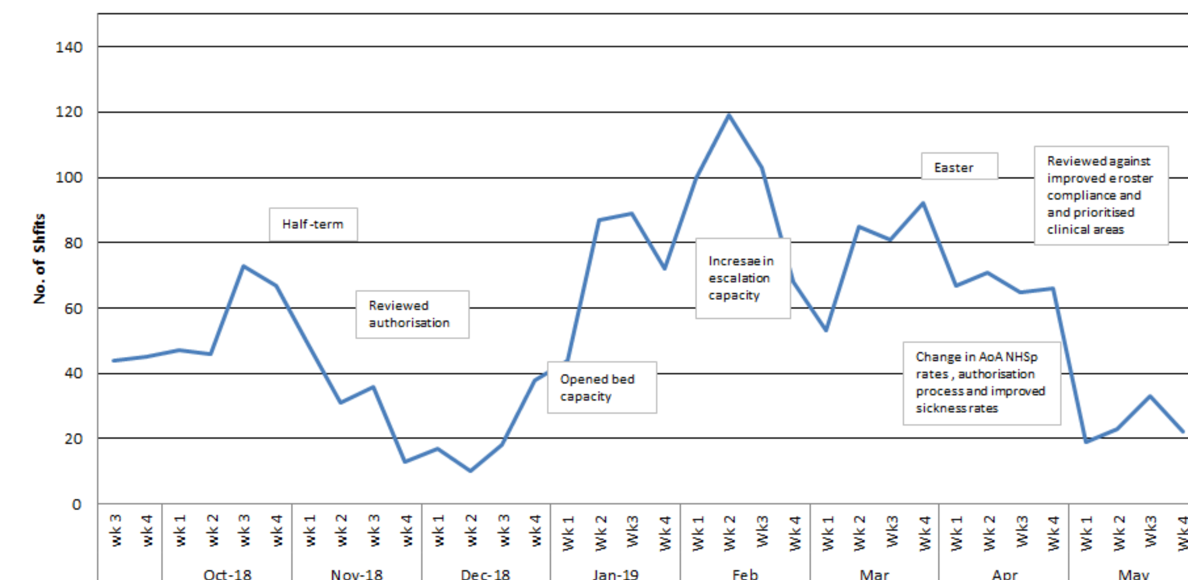


In May 21 patient incidents, moderate or above, were reported, 12 more than the previous month. Ward 14B reported the highest number with 3 in month, with 2 moderate harm falls and an issue with discharge documentation. In accordance with staffing incidents and fed flag events no harm were reported to be related to staffing levels.



4. Non Framework Nurse Agency Usage

Over the past month the Trust has maintained a reduced use of non-framework nurse agency. We have been proactively sourcing nurse agencies that are within the framework to supplement NHSp and replace Thornbury as 'Tier 2' suppliers. It is hoped that this will increase in the next month to allow the Trust to further reduce and stop the use of Thornbury.



5. Clinical Indicators Dashboard

As part of our gap analysis for NICE guidance (Safe staffing for nursing in adult inpatient wards in acute hospitals, 2014) we are currently developing a clinical metrics dashboard that will triangulate staffing with clinical metrics and patient outcomes. Our first draft dashboard is shown in appendix 2. There will be further data on the dashboard in due course, including sickness, vacancies and harm free care (safety thermometer). It is also proposed to incorporate the Matrons monthly Quality Care Indicators in the future. This will allow the senior nursing & midwifery team to consider the implications of, for example vacancies and sickness rates, on patient safety.

6. Recommendations

The Committee 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	1,427.08	965.83	2,548.42	1,209.17	1,088.00	1,087.50	915.00	819.00	819	67.68%	47.45%	99.95%	89.51%	2.5	2.5	5.0		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	770.50	718.00	372.00	589.00	733.00	720.00	365.00	329.00	267	93.19%	158.33%	98.23%	90.14%	5.4	3.4	8.8		
E A U	300 - GENERAL MEDICINE	1,668.00	1,312.50	1,185.25	1,171.50	1,075.00	957.00	732.00	771.50	601	78.69%	98.84%	89.02%	105.40%	3.8	3.2	7.0		
FESS Ward	300 - GENERAL MEDICINE	1,607.92	1,310.92	1,384.50	1,697.40	1,096.50	928.50	749.50	864.75	809	81.53%	122.60%	84.68%	115.38%	2.8	3.2	5.9	Y	
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,391.25	1,182.17	1,197.50	1,366.25	1,090.58	787.00	744.00	915.58	811	84.97%	114.09%	72.16%	123.06%	2.4	2.8	5.2		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,554.08	1,482.92	1,354.25	1,617.00	1,112.00	1,099.50	744.00	836.00	934	95.42%	119.40%	98.88%	112.37%	2.8	2.6	5.4	Y	
Short Stay Unit	300 - GENERAL MEDICINE	1,486.25	1,152.25	1,854.75	1,778.50	1,087.50	1,027.00	1,111.00	1,051.00	880	77.53%	95.89%	94.44%	94.60%	2.5	3.2	5.7	Y	
Ward 15a General Med	300 - GENERAL MEDICINE	1,382.00	1,245.25	852.75	1,594.00	1,099.50	1,086.00	737.75	1,156.50	756	90.10%	186.92%	98.77%	156.76%	3.1	3.6	6.7		
Stroke Ward	300 - GENERAL MEDICINE	1,971.25	1,703.25	1,223.75	1,218.25	1,500.17	1,079.67	781.50	757.50	603	86.40%	99.55%	71.97%	96.93%	4.6	3.3	7.9		
Rehab & Discharge Lounge	314 - REHABILITATION	1,417.82	1,232.82	1,828.33	1,547.08	737.50	737.50	828.00	1,033.50	805	86.95%	84.62%	100.00%	124.82%	2.4	3.2	5.7	Y	
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,269.50	1,426.67	1,662.75	1,851.75	730.83	1,125.33	729.00	1,404.25	881	112.38%	111.37%	153.98%	192.63%	2.9	3.7	6.6	Y	
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,270.00	1,174.25	1,376.75	1,239.75	734.25	753.00	368.50	692.00	485	92.46%	90.05%	102.55%	187.79%	4.0	4.0	8.0		
Ward H	110 - TRAUMA & ORTHOPAEDICS	744.00	477.00	743.00	391.50	744.00	532.50	369.00	157.50	84	64.11%	52.69%	71.57%	42.68%	12.0	6.5	18.6		
Surgical Ward	100 - GENERAL SURGERY	1,342.23	1,141.73	1,235.25	1,215.50	738.00	689.50	730.00	694.00	529	85.06%	98.40%	93.43%	95.07%	3.5	3.6	7.1		
Spinal Injuries Unit	400 - NEUROLOGY	3,849.00	3,314.50	3,687.50	3,399.00	2,880.75	2,733.25	1,498.00	1,419.00	1189	86.11%	92.18%	94.88%	94.73%	5.1	4.1	9.1		
Ward G	101 - UROLOGY	1,919.75	762.92	1,163.75	715.25	1,181.50	739.50	795.50	375.50	301	39.74%	61.46%	62.59%	47.20%	5.0	3.6	8.6		
TOTAL		**25,070.63**	**20,602.98**	**23,670.50**	**22,600.90**	**17,629.08**	**16,082.75**	**12,197.75**	**13,276.58**	**10754**	**82.18%**	**95.48%**	**91.23%**	**108.84%**	**3.41**	**3.34**	**6.75**		

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		4,110.00	3,927.75	1,858.50	1,665.25	3,373.25	3,564.25	736.00	663.00		95.57%	89.60%	105.66%	90.08%					
Ambulatory Care Unit		599.50	382.00	593.98	267.98	184.00	346.00	172.50	0.00	110	63.72%	45.12%	188.04%	0.00%					
TOTAL		**4,709.50**	**4,309.75**	**2,452.48**	**1,933.23**	**3,557.25**	**3,910.25**	**908.50**	**663.00**	**110**	**91.51%**	**56.91%**	**78.83%**	**72.98%**	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	4,907.25	4,643.08	1,182.50	922.00	4,068.00	3,480.50	1,109.50	589.67	381	94.62%	77.97%	85.56%	53.15%	21.3	4.0	25.3		

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	1,634.50	1,615.50	372.00	360.00	1,481.77	1,481.25	372.00	397.00	72	98.84%	96.77%	99.97%	106.72%	43.0	10.5	53.5		
Maternity Ward	501 - OBSTETRICS	1,260.75	1,271.67	721.00	633.00	763.50	763.50	179.00	634.50	351	100.87%	87.79%	100.00%	354.47%	5.8	3.6	9.4		
MAU	501 - OBSTETRICS	1,222.30	1,188.30	369.50	345.50	739.50	728.00	0.00	0.00	74	97.22%	93.50%	98.44%	#DIV/0!	25.9	4.7	30.6		
TOTAL		**4,117.55**	**4,075.47**	**1,462.50**	**1,338.50**	**2,984.77**	**2,972.75**	**551.00**	**1,031.50**	**497**	**98.98%**	**91.52%**	**99.60%**	**187.21%**	**14.18**	**4.77**	**18.95**		

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	1,120.75	1,124.20	192.00	96.00	1,122.25	1,073.00	0.00	0.00	254	100.31%	50.00%	95.61%	#DIV/0!	8.7	0.4	9.0		
Paediatric Unit	420 - PAEDIATRICS	3,825.75	3,413.25	1,623.00	1,307.75	2,226.00	1,990.00	744.00	744.00	395	89.22%	80.58%	89.40%	100.00%	13.7	5.2	18.9		
TOTAL		**4,946.50**	**4,537.45**	**1,815.00**	**1,403.75**	**3,348.25**	**3,063.00**	**744.00**	**744.00**	**649.00**	**91.73%**	**77.34%**	**91.48%**	**100.00%**	**11.71**	**3.31**	**15.02**		

PLANNED		15,301.73	12,940.15	11,051.50	9,734.75	11,077.33	10,053.58	5,599.50	5,331.92	3850	84.57%	88.09%	90.76%	95.22%	6.0	3.9	9.9		
URGENT		15,275.65	12,687.91	14,395.48	14,056.13	10,803.75	9,855.67	7,880.25	8,534.33	7395	85.71%	96.72%	94.66%	106.74%	3.0	3.1	7.4		
W&C		9,064.05	8,612.92	3,277.50	2,742.25	6,333.02	6,035.75	1,295.00	1,775.50	1146	95.02%	83.67%	95.31%	137.10%	12.8	3.9	16.7		
TRUST TOTALS		**39,641.43**	**34,240.98**	**28,724.48**	**26,533.13**	**28,214.10**	**25,945.00**	**14,774.75**	**15,641.75**	**12,391**	**87.24%**	**92.20%**	**93.42%**	**105.12%**	4.9	3.4	**8.3**		

Green- 80% and above
Red- Under 80%

Appendix 2 – Clinical Indicators Dashboard - ***DRAFT***

Clinical Indicators Dashboard

May 19	Care Hours Per Patient Day (CHPPD) - Non Registered	Care Hours Per Patient Day (CHPPD) - Registered	Friends & Family - % That Would Recommend	IC - Cases of C.Diff	IC - MRSA Bacteraemias	Number of Complaints	Number of Complaints relating to Clinical Treatment	Number of Complaints relating to Staff Attitude/Behaviour	Patient Falls - Moderate / Major / Death (Related	Pressure Ulcers	Realtime Staffing - Staffing against Minimum Compliance	Realtime Staffing - Non (Registered (Day	Realtime Staffing - Non (Registered (Night	Realtime Staffing - Registered ((Day	Realtime Staffing - Registered ((Night	RM - Medication Incidents - Omitted Doses for Non-clinical Reasons	Temporary Staffing - Non Registered	Temporary Staffing - Registered
10B SSS/SAU	4	4	100%	0	0	0	0	0	0	0	102.9%	90.1%	187.8%	92.5%	102.6%	0	44.87%	17.57%
11A Gen Surg	3.6	3.5	92.9%	0	0	1	0	1	1	0	92.5%	98.4%	95.1%	85.1%	93.4%	0	54.95%	13.66%
11B	2.8	2.4	62.5%	0	0	3	2	0	0	0	96.1%	114.1%	123.1%	85%	72.2%	1	34.53%	25.86%
14A	3.7	2.9	100%	0	0	0	0	0	0	0	132.2%	111.4%	192.6%	112.4%	154%	0	88.45%	59.94%
14B	2.6	2.8	90%	0	0	0	0	0	2	1	105.7%	119.4%	112.4%	95.4%	98.9%	1	13.92%	16%
15A	3.6	3.1	84.6%	1	0	0	0	0	0	0	124.8%	186.9%	156.8%	90.1%	98.8%	1	42.23%	30.43%
15B Stroke Unit	3.3	4.6	77.8%	0	0	0	0	0	0	0	86.9%	99.6%	96.9%	86.4%	72%	0	17.03%	14.47%
7A	2.5	2.5	88.9%	0	0	1	0	0	0	0	68.3%	47.5%	89.5%	67.7%	100%	0	62.28%	42.11%
7B Rehab	3.2	2.4	84.6%	0	0	1	0	1	0	0	94.6%	84.6%	124.8%	87%	100%	0	91.42%	27.23%
9B	3.2	2.8	100%	0	0	1	1	0	0	2	99.2%	122.6%	115.4%	81.5%	84.7%	0	51.01%	50.5%
ACU	2.4	6.6									64.3%	45.1%	NTR	63.7%	188%		NTR	NTR
Critical Care	4	21.3		1	0	0	0	0	0	0	85.5%	78%	53.2%	94.6%	85.6%	0	20.27%	18.41%
EAU	3.2	3.8	97.1%	0	0	1	1	0	0	1	90.4%	98.8%	105.4%	78.7%	89%	2	44.31%	52.45%
G Urology	3.6	5	100%	0	0	0	0	0	0	0	51.2%	61.5%	47.2%	39.7%	62.6%	1	39.22%	12.22%
H - Ortho	6.5	12	NTR	0	0	0	0	0	0	0	59.9%	52.7%	42.7%	64.1%	71.6%	0	NTR	NTR
Maternity	4.8	14.2	92.5%	0	0	0	0	0	0	0	103.3%	91.5%	187.2%	99%	99.6%	3	11.32%	4.44%
MDU			100%	0	0	0	0	0	0	0	NTR					0		
NNU	0.4	8.7	NTR	0	0	0	0	0	0	0	94.2%	50%	NTR	100.3%	95.6%	1	0%	10.68%
OBS	3.4	5.4	96.3%	0	0	0	0	0	0	1	105.2%	158.3%	90.1%	93.2%	98.2%	0	21.9%	29.41%
Paeds	5.2	13.7	96.4%	0	0	2	1	1	0	1	88.6%	80.6%	100%	89.2%	89.4%	0	0%	6.02%
SIU	4.1	5.1	NTR	0	0	0	0	0	0	2	91.2%	92.2%	94.7%	86.1%	94.9%	0	11.43%	12.46%
SSU	3.2	2.5	100%	0	0	1	0	1	0	3	90.4%	95.9%	94.6%	77.5%	94.4%	3	35.51%	61.95%
Theatres						0	0	0	0							0		
Treatment Centre			100%	0	0	0	0	0	0	0						0		

(NTR=nothing to report)

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	**TB129/19e**	**Report Title**	**CQC Preparation Update**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Paul Jebb, Deputy Director of Nursing Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This paper provides the Trust Board with 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.

Recommendation

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

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of*

and deliver sustainable services for the population of Southport, Formby and West Lancashire	*partner organisations plans resulting in the inability to develop and deliver sustainable services*
Linked to Regulation & Governance *(the report supports …..)*	
CQC KLOEs	**GOVERNANCE**
✓ Caring ✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	✓ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ✓ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
This is a live document and will be updated on a monthly basis.	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

Southport and Ormskirk Hospital NHS Trust

CQC PREPERATION UPDATE

1. PURPOSE OF REPORT

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

In order to support, coach and prepare colleagues across the organisation work is underway to ensure the organisation is in the best position possible to be ready for this and for staff to share the improvements that have been made since the 2017/18 inspections.

3. TRUST PROGRESS AGAINST MUST AND SHOULD DOs

A review in relation to the accountability framework is underway in order to realign responsibility between the operational, nursing and medical management. The framework will enable clear lines of accountability for the CBUs, corporate services, estates and facilities.

Assurance Panels continue to take place, with panels for Emergency Care and Planned Care having been held in June 2019. Documentation was seen as a key area of further work within planned care, and the care of patients who were receiving care on the corridor also needed further attention.

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	10	1	11
Action Completed	41	39	80
On track to deliver	13	10	23
No progress / Not progressing to Plan	0	0	0
TOTAL	64	50	114

4. CQC PREPARATION

The Quality Improvement Delivery Group (QID) continues to meet weekly to understand the progress of the must and should dos in addition to identifying the risks and areas where a shared approach is needed to ensure progress against actions.

The 65 day checklists launched in April 2019 to support key areas in ensuring they had key processes, policies and areas of preparation ready for when the CQC inspect the service are also monitored in the QID.

Board packs have been prepared and distributed to Executive and Non-Executive board members. These contain relevant information including key facts, relevant data, Trust strategies, key patient experience and patient safety information, sustainability plans and relevant regulator information.

Board members will also be receiving coaching from the Regulatory Consultant as part of their preparation for the inspection and interviews.

In order to ensure we are preparing and reviewing the clinical areas a series of KLOE visits are planned, these will be in every area and involve a team of approx. five people (clinical and non-clinical) to review areas against set criteria. This will enable staff to become familiar with the language that inspectors may use as well as also enabling benchmarking against standards.

In June 2019 a service review of theatres was also performed, we are awaiting the final report, but initial feedback was positive, any initial areas for improvement have been shared with the Team.

In relation to Infection Prevention and Control a service review is also currently being planned.

5. AREAS IDENTIFIED AS POTENTIAL KLOE

As the information relating to the PIR was being collated, the Quality team also started to highlight areas that could be potential key lines of enquiry (KLOE) for the inspection team when the visit the Trust, as we get further requests from the CQC this will be added too, as well as any areas of good practice that CQC highlight. These areas all have identified Executive and operational leads, and also highlight weather these areas fall into an existing improvement work stream or are a new improvement project, these are also monitored through QID.

6. RECCOMENDATIONS

The Trust Board are asked to **receive** 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

3 July 2019

Agenda Item	TB130/19	Report Title	Our Staff Engagement Strategy
Executive Lead	Jane Royds, Director of Human Resources and Organisational Development		
Lead Officer	Tracy Gunn, Head of Education, Training & OD		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper is to inform the Board of the Trust's new Staff Engagement Strategy – 'Happy Healthy Here'. The strategy sets out what engagement is, why it is important, key roles and how we propose to enhance engagement across the organisation.

The strategy was approved at Workforce Committee on 20th June 2019 following minor amendments included in the attached document.

Recommendation

The Board is asked to **approve** 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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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)*

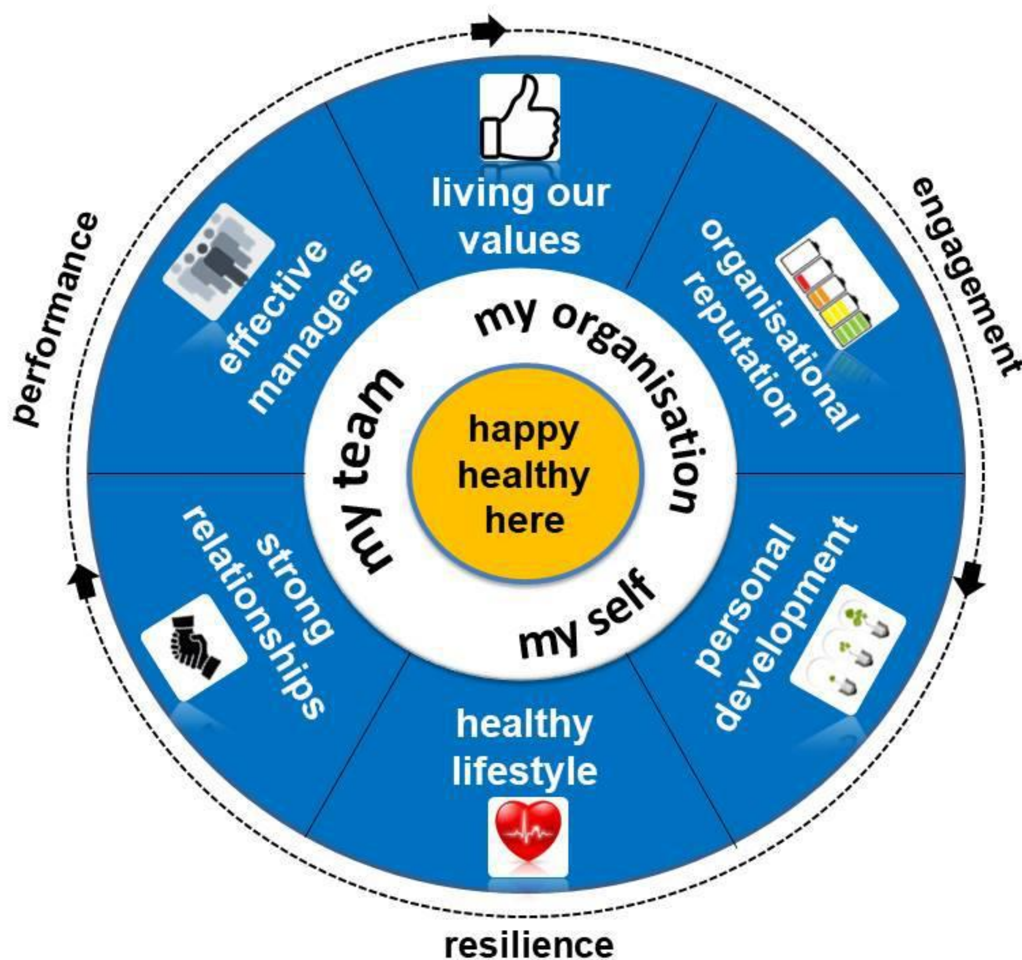
Add actions with milestones and Leads here

Previously Presented at:

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Our Staff Engagement Strategy
"Happy, healthy, here"
2019-2021



Our Values

Supportive, Caring, Open and Honest, Professional, Efficient

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1. Introduction

The Engagement Strategy has staff at the heart of its aim to ensure that as an organisation we are engaging with staff and developing Southport & Ormskirk Hospitals NHS Trust (SOHT) as a 'great place to work'.

The strategy sets out what engagement is, why it is important, key roles, reflecting on what we have already implemented and how we propose to enhance engagement across the organisation.

It also describes how we will measure engagement on an ongoing basis in addition to the NHS Staff Survey. Staff engagement must be made a priority and embedded into everything we do.

A key priority is to increase the staff survey response rate and engagement score and to support the development of a more engaged workforce who can deliver the Trust's Vision 2020 strategy (Appendix 1).

The Engagement Strategy will also support the Workforce & OD Strategy and supporting activities for this strategy will be monitored by the Workforce Committee through the Workforce & OD action plan.

Silas Nicholls
Chief Executive Officer

Jane Royds
Director of HR & OD

2. Staff engagement in context

Staff engagement is a measure of individual staff member's emotional attachment to their job, colleagues and organisation which profoundly influences their experiences at work and their willingness to learn and perform.

High levels of engagement result from a combination of experiences at work which includes involvement in decision making, personal development and training, great management and leadership and a healthy, safe, work environment, where every role counts.

Employee engagement is a workplace approach designed to ensure that staff are committed to their organisation's goals and values, motivated to contribute to organisational success and are able, at the same time, to enhance their own sense of well-being. Engagement is therefore a tool for organisational success.

David McLeod, Engaging for Success Report said that staff engagement ***"is about how we create the conditions in which employees offer more of their capability and potential".***

There are many definitions of staff engagement but in reality, it doesn't matter how employee engagement is defined, as long as strategies can be implemented that deliver an engaged workforce.

3. Our vision for our workforce

Our workforce has been commended for its care of our patients. We value and are proud of the commitment and contribution of every member of staff. We want our staff to be equally proud to work for us as a provider of 'safe, high quality services' (Vision 2020) and as a desirable employer. We want our staff to:

- ✓ feel SOProud about working for us and enthusiastic about their role
- ✓ say time passes quickly at work
- ✓ be prepared to give discretionary effort when required
- ✓ believe that they make a difference
- ✓ identify with the task & describe themselves to others in the context of the task (e.g. a nurse)
- ✓ invite others into the activity or organisation (their enthusiasm is contagious)
- ✓ report higher levels of life satisfaction and lower levels of ill health, depression and mental health problems
- ✓ be less likely to experience symptoms of stress or burnout, such as emotional exhaustion and cynicism
- ✓ report higher levels of self-efficacy (the extent or strength of one's belief in one's own ability to complete tasks and reach goals)
- ✓ find it easy to stay focussed
- ✓ have higher levels of commitment to the organisation are less likely to say they intend to leave.

4. Impact of engagement on staff health & wellbeing

Ultimately increased staff engagement will lead to better staff health and well-being, with reduction in sickness absence and presenteeism. This in turn, results in less pressure on services, improved performance, improved patient satisfaction, less strain on relationships and more time to engage in learning opportunities and continuing professional development.

There are a number of ways in which senior leaders can develop a culture of engagement by

- living our values day to day
- making a commitment to staff development
- encouraging staff to challenge assumptions and voice their opinions
- showing that staff are valued
- acting in an honest and consistent manner
- being visible and available to staff at all levels

5. Our ambitions & plans

This is an ambitious strategy. There is a lot to do and from where we are now it will take considerable time to fully achieve consistent, sustainable engagement across our organisation.

Our approach is to set a realistic framework and pace. Whilst this is a three year strategy, it sets the time frame within which we will expect to see the start of transformational change during this period and beyond. This strategy delivers predominantly on the first strategic pillar within the Workforce & OD Strategy but will ultimately impact on the delivery of all three strategic pillars.

6. Our engagement framework

Staff engagement is measurable; there is a direct correlation between engaged employees and high quality patient care; individual performance; team performance; organisation success. It varies from poor to great. The four enablers of engagement below have proved to be useful lenses which can help organisations assess the effectiveness of their approaches.

- Visible, empowering leadership providing a **strong strategic narrative** about the organisation, where it's come from and where it's going;
- **Engaging managers** who focus their people and give them scope, treat their people as individuals and coach and stretch their people;
- There is **employee voice** throughout the organisations, for reinforcing and challenging views, between functions and externally, employees are seen as central to the solution;
- There is organisational **integrity** – the values on the wall are reflected in day to day behaviours. There is no 'say –do' gap.

Our overarching Staff Engagement Framework (Appendix 2) will focus on the following three strategic pillars with the aim of deploying a strong narrative not only to our staff through our Vision 2020 but placing the organisational reputation at the heart of our community to attract and retain talented people to deliver the best care for our patients. This strategy also recognises the power of team working and the individual skills and experience that make up those teams, collectively empowered to drive quality improvement at a ward/departmental level.

7. How is employee engagement measured?

The NHS staff survey is a tool to allow us to find out how engaged our staff are, to address particular issues and to analyse the feedback.

Southport & Ormskirk NHS Trust uses the following surveys:

- Annual NHS Staff Survey
- Friends & Family Test (quarterly)
- Local Pulse Surveys (quarterly)

The staff survey is an important part of the process, but only part of it. Further ways to measure engagement on an ongoing basis include using So Proud Conversations, pulse surveys, employee forums etc.

It's also important that we use our other workforce key performance indicators, which in themselves tell a story, these include:

- Overall Staff Engagement (Trust target in line with or exceeding National Average)
- Nursing Turnover (Trust target 10% or below)
- Appraisal compliance (Trust Target 85%, stretch target to 95%)
- Statutory & core mandatory training compliance (Trust Target 85%, stretch target 95%)
- Attendance (Trust target attendance at >95%)

8. Responsibility for delivery

Creating a culture of engagement takes intention, planning, time and adjustments; it will not be achieved overnight.

The Director of HR & OD and Deputy CEO will have overall accountability for the strategy monitored via the Workforce Committee.

However, every member of staff from the floor to Board has an essential role to play; as we can only achieve this strategy and make our Trust a great place to work and learn by working collaboratively. This means:

For individuals

- Make it personal - we all have a role to play
- Make sure you have your appraisal and prepare for it
- Take part in organisational wide issues outside your area
- Contact the senior team with ideas and comments
- Have open and honest relationships with all colleagues

- Take your part in holding meaningful conversations with your line manager
- Role model the values and behaviours of the Trust

For line managers

- Bring the right people in
- Be clear about the behaviours you expect
- Give your team a voice
- Encourage your team to care for themselves
- Work with staff to develop them
- Recognise and amplify all opportunities to engage
- Make sure all of your staff have at least an annual, meaningful appraisal
- Role model the values and behaviours of the Trust

For senior leaders

- Seek opportunities for the Senior Leadership Community to be visible and accessible
- Increase the profile of the employee engagement agenda
- Empowering line managers to make decisions and are equipped to deal with concerns
- Create the forums for staff to provide feedback in your area of the Trust
- Demonstrate a compassionate and inclusive leadership style
- Role model the values and behaviours of the Trust
- Overall accountability for delivering improved staff engagement in your area of the Trust

9. Bringing the strategy to life

An "Everyone's Responsibility" staff engagement action plan for this strategy has been developed (Appendix 3) showing everyone's responsibilities for staff engagement. This will be shared through our SOProud conversations, online, via e-communications, Trust social media channels, podcasts etc.

Activities delivered centrally by the Valuing our People Group members will be monitored via the overarching Workforce & OD action plan monitored monthly at the Workforce Committee.

There are more detailed action plans in place with specific focus as follows:

- Equality & diversity action plan
- Nurse recruitment & retention action plan
- Health & wellbeing action plan
- Core mandatory training action plan
- Staff survey action plan
- FTSU action plan

10. Strategy Review

This strategy is a live document that will flex to opportunities that may arise during its lifespan. It will be reviewed on a regular basis to ensure it remains relevant to our aims and objectives and is reflective of our staff feedback about what will engage them.

11. Monitoring and Review

This strategy and the Workforce & OD action plan will be monitored by:

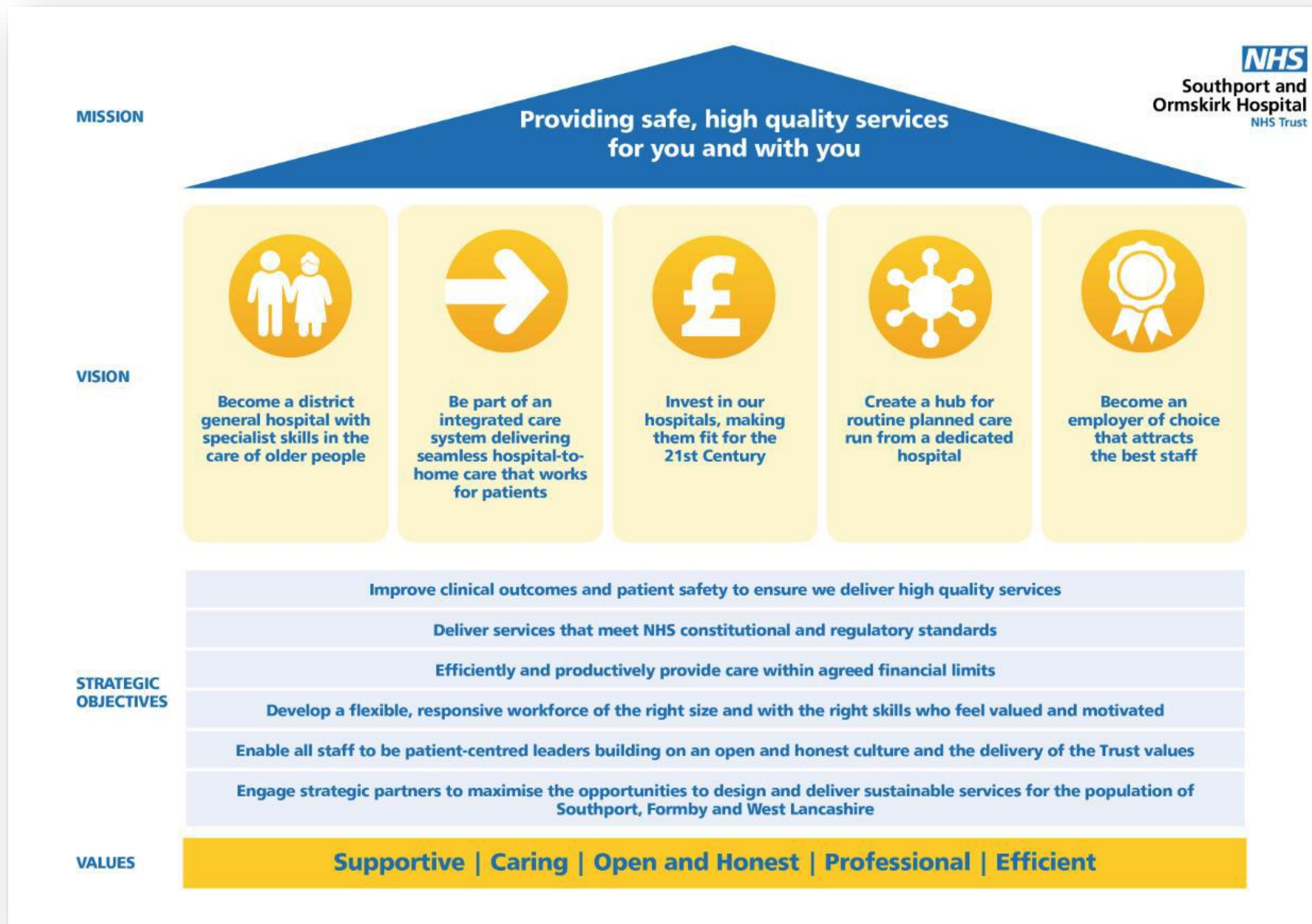
- Workforce Committee
- Workforce Improvement Board
- Valuing our People Group

12. What will success look like?

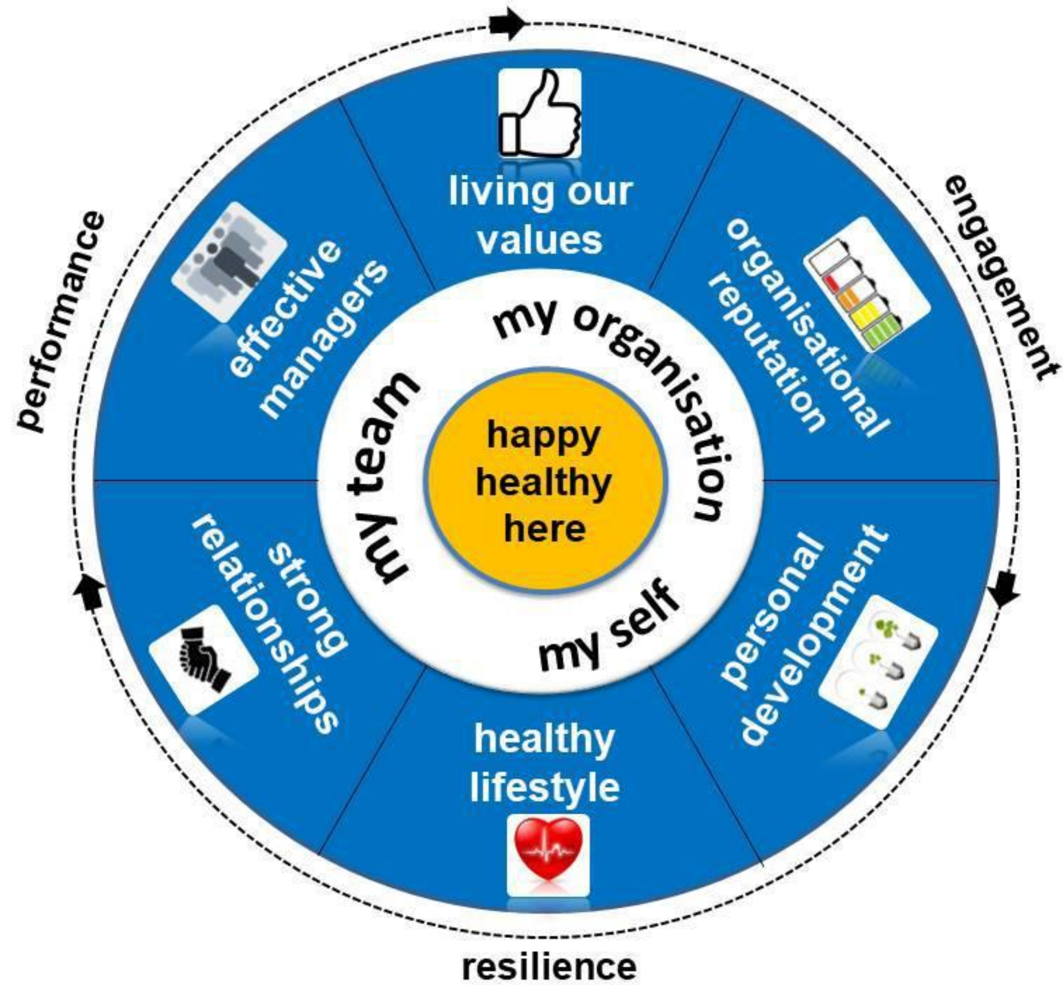
Potential outcomes of this strategy could include a more engaged workforce highlighted by improvements in our engagement score which in turn should create tangible benefits including:

- Greater productivity
- Improved financial performance
- Improved patient care
- Increased innovation
- Healthy turnover
- Improved morale and wellbeing
- Improved Health & Safety performance
- Quality improvement as a continuum

APPENDIX 1 - VISION 2020



APPENDIX 2 – OUR STAFF ENGAGEMENT FRAMEWORK ON A PAGE



Our Values

Supportive, Caring, Open and Honest, Professional, Efficient

APPENDIX 3 – Staff Engagement is "everyone's responsibility"

KEY ENABLER	OUTCOME	ACTIONS
Strong set of organisational values & behaviours	SOHT will ensure that it has a strong set of **organisational values** that are explicitly set and consistently communicated. These values will be mainstreamed throughout SOHT and embedded in practices. Values will be reflected in the behaviour and actions of senior leaders, managers and all staff	• Actively contribute to making SOHT a great place to work through our organisational values & behaviours • Embed values in to 1-1 conversations, coaching and appraisal conversations • Role model organisational values & behaviours every day
Compassionate & inclusive senior leaders	**Senior Leaders** must see increasing employee engagement as one of their top strategic priorities. They need to set the tone at the top of the organisation by being visible, approachable and accountable. They need to ensure there is regular effective two way communication from frontline staff. They need to actively promote diversity & inclusivity across their staff groups and services	• Act as a role model. • Prioritise staff engagement. • Bring the right people in via effective recruitment & selection strategies. • Provide good quality inductions. • To attend induction sessions within the departments to show commitment to new staff • Embed values – be clear about expected behaviours. • Give all staff a voice via surveys, staff engagement forums, team briefings with feedback to senior managers • Ensure that the impact of engagement interventions locally are monitored and evaluated. • Work with HR/OD to really understand staff survey results, identifying areas with low and high engagement. • Provide training/resources to boost resilience, copying mechanisms and awareness or self and others. • Ensure that all people-related policies and processes are clear and accessible. • Have a presence in departments/directorates/teams. • Be visible throughout the CBU. • Attend team meetings on a regular basis, not just when there are problems • Support team working and team development **Support for Line Managers** • Support training for first-time supervisors and managers, e.g. people management, budget, etc.

KEY ENABLER	OUTCOME	ACTIONS
		• Use buddying arrangement for new line managers • Support training in coaching (engaging managers typically adopt a coaching style with their teams) • Encourage managers to self-assess and gather feedback, e.g. 360 feedback, self-assessment tools • Ensure line managers know how to manage poor performance and poor behaviour
Excellent line managers	**Line Managers** need to be empowered, supported and trained to better engage their teams. They should adopt coaching and supportive approaches. Managers should focus on team working, performance management and training and development. Both senior leaders and managers need to devolve power and responsibility wherever possible, within safe limits, giving frontline employees and teams more of a say over how they deliver their service.	**Individuals and Teams** • Bring the right people in, effective recruitment strategies. • Give good quality inductions. • Be clear about expected behaviours in the team. • Give your team a voice, e.g. regular team meetings, team briefings, etc. • Encourage your staff to participate in resilience and mindfulness training and take part yourself. • Undertake annual PDRs **Your own behaviour** • Ask for training in people management, especially if you are a first-time manager or have never had any training before. • Be clear about people management behaviours the organisation expects of you • Ask for training in coaching • Self-assess and gather feedback about your performance as a people manager • Ensure you know what to do when tackling poor performance and poor behaviour • Be generous with praise and recognition.
A strong employee voice	A strong and robust employee voice should be encouraged and supported throughout the organisation so that all staff are able to raise concerns, suggest improvements and contribute to organisational decision making. This needs to be supported by both effective channels for communication, and a culture that welcomes and values employee	**Improve communication** • Monthly SO Proud conversations • Develop a Quality Improvement culture • Regular staff / team meetings • Regular 1-1 conversations • Further develop Facebook closed group • Develop internet & intranet pages • Promote effective two way communications • Use PDR's as means of engagement • Further develop the quarterly Grapevine newsletter • Promote and raise awareness of Freedom to Speak Up Guardian and Champions

KEY ENABLER	OUTCOME	ACTIONS
	voice.	• Develop suggestion schemes for improvements • Involvement & empowerment • Staff Survey • Pulse Surveys • Involve staff in Working Groups • Joint Negotiating Committee • Partnership working with Trade Union Representatives
Great partnership working	The **organisation** should continue to invest in partnership working with the trade unions and professional organisations. This should be based on culture of openness, honesty, early engagement and a real involvement in decision making.	• Encourage effective partnership working. • Emphasise the importance of close working relationships • Commitment from Trade unions • Joint Negotiating Committee

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	**TB131/19**	**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 IPR now contains an additional summary report and update to alert, advise and assure the Board of actual performance against targets and trajectories and month on month improvements to the integrated performance management and reporting process set out within the performance and accountability framework.

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

Strategic Objective(s) and Principal Risks(s)

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

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

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*. If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

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

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

To apprise the Board that controls and assurances are in place

Previously Presented at:

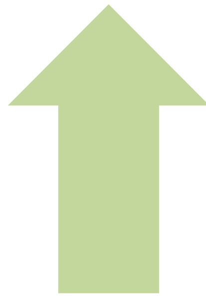
☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

Trust Board
Integrated Performance Report

Steve Christian
Chief Operating Officer

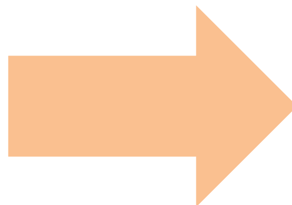
July 2019

IPR Performance Summary – May 2019



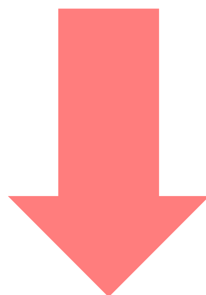
23 indicators have improved

Safe	3
Effective	4
Caring	1
Responsive	5
Well-Led	2
Efficient	8



7 indicators have remained the same

Safe	1
Effective	2
Caring	0
Responsive	3
Well-Led	1
Efficient	0



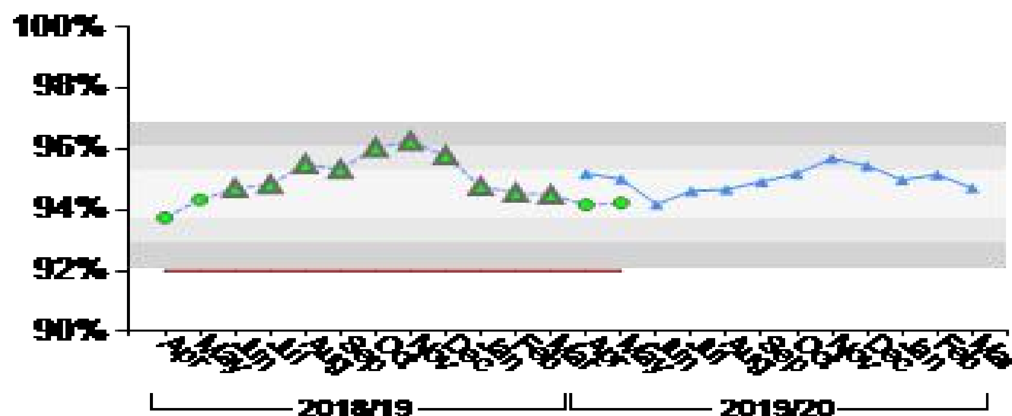
29 indicators have deteriorated

Safe	5
Effective	0
Caring	2
Responsive	5
Well-Led	14
Efficient	3

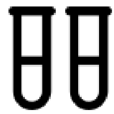
Trajectory Update

A trajectory is a path, a series of positions over time. When aiming to accelerate performance you should pay attention to the trajectory—considering where you start, the rate of progress, and the direction you want to go—and not get too excited or discouraged by performance at any given moment.

- The “target” is shown as a red line on the graphs (not changed and influenced by national standard and / or local contractual agreements
- The month on month “trajectory” is shown as a blue line on the graphs
- The “actual” performance is shown as a green line on the graphs, where we are achieving performance, and red where we are not
- The trajectory has been set within the context of SMART however the “Ambition” element to the algorithm has been a key focus
- All trajectories that are set are subject to final validation and approval in July . The panel will consist of the Hospital Improvement Board (HIB).
- 30 Key Performance Indicators (KPIs) have been set within the Trust Board IPR for July. The remaining KPIs were applicable , of which there are 10 KPIs, will be developed and signed off by the end of July.
- Accountability is through the Performance Review Boards (PRB) for Clinical Business Units (CBU) and the Hospital Improvement Board (HIB)



Top 5 Improving Indicators



C-Diff
Domain: safe
Exec Lead DoN

C.Diff has returned to achieving the standard.

Conversion rate
Domain: efficiency
Exec lead: COO

The overall conversion rate, which includes patients admitted directly to a ward or via an assessment ward, is 19% in May, down from 20% in April which was down from 21% in March.

Mandatory Training
Domain: well-led
Exec lead: DofHR

Mandatory training is continuing to achieve the standard and demonstrates a stable programme of staff undertaking their training.

HSMR
Domain: Safe
Exec lead: MD

HSMR continues to show month on month improvement. The latest score (January) is 104.5.

Theatre Utilisation
Domain: efficiency
Exec lead: COO

Performance has continued to increase for the third month in a row.

Top 5 Deteriorating Indicators

Vacancy Rate (Medical)
Domain: Well-led
Exec Lead: MD

The medical vacancy rate has risen again in month and is now significantly higher than previous months. This is adversely impacting on agency spend.

Fractured Neck Of Femur
Domain: Safe
Exec Lead: MD

May saw a further deterioration of fractured neck of femur repairs within 36 hours, this is somewhat due to Orthogeriatrician capacity.

A&E 4 hour
Domain: Responsive
Exec Lead: COO

Whilst performance is not at its desired level we have to put this into context. The Trust is holding performance (4th best in the North West for May) whilst many others have seen a worsened position for May which is a concerning national trend which started at the beginning of October 2018.

Diagnostic Waits
Domain: Responsive
Exec Lead: COO

May saw a further deterioration away from meeting the standard. Reasons include capacity (Radiology and Endoscopy) and patient choice of appointments.

Staff Turnover
Domain: well-led
Exec Lead: DofHR

Staff turnover has been increasing since January. This is materially affecting several other areas of performance, including the agency spend, as recruitment is not keeping pace with the number of leavers.

Activity Summary – May 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Indicator Name	May 2018	April 2019	May 2019	Trend
Overall Trust Attendances	10,648	10,248	10,469	▲
SDGH A&E Attendances	4,523	4,795	4,918	▲
ODGH A&E Attendances	2,535	2,280	2,420	▲
SDGH Full Admissions Actual	1,080	981	997	▲
Stranded Patients AVG	160	189	191	▲
Super Stranded Patients AVG	62	70	79	▲
MOFD Avg Patients Per Day	45	51	67	▲
Elective Admissions	232	170	200	▲
Daycase Admissions	1,845	1,824	1,837	▲
Outpatient Seen	20,647	21,818	22,625	▲
In Hospital Deaths	85	90	81	▼

Southport and Ormskirk Hospital
NHS Trust

Performance Dashboard

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - May 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	0	0	0			
C-Diff	3	2	5	2			
Never Events	0	1	1	1			
VTE Prophylaxis Assessments	95%	95.9%	96.3%	180			
Harm Free (Safety Thermometer)	94.99%	96.3%	96.3%	14			
Falls - Moderate/Severe/Death	1	3	4	3			
Patient Safety Incidents - Low, Near Miss or No Harm		775	1595	775			
Safe Staffing	90%	92.4%	93.4%	N/A			
Fractured Neck of Femur	90%	63.6%	72.3%	14			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
SHMI (Summary Hospital-level Mortality Indicator)	100.1	111.1		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	104.5	104.5	N/A			
WHO Checklist	99.9%	100%	100%	608			
Stroke - 90% Stay on Stroke Ward	80%	64.9%	62.7%	13			
Sepsis - Timely Identification	90%	100%	98.4%	N/A			
Sepsis - Timely Treatment	90%	78.3%	78.8%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	37	69	37			
Written Complaints	35	26	48	26			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	95.3%	94.2%	30			

REGULATORY	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
CQC Registration	-						
Monitor Governance Rating	Green	-	-			-	-

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Accident & Emergency - 4 Hour compliance	94.99%	85.7%	88.6%	1497			
Accident & Emergency - 12+ Hour trolley waits	1	12	22	12			
Ambulance Handovers <=15 Mins	99%	53.8%	50.6%	710			
Diagnostic waits	1.01%	4.1%	4.1%	147			
14 day GP referral to Outpatients	93%	94.5%	94.5%	46			
31 day treatment	96%	100%	100%	0			
31 day treatment (Surgery)	94%	100%	100%	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%	69.6%	69.6%	12			
Referral to treatment: on-going	92%	94.2%	94.2%	650			
Bed Occupancy - SDGH	93%	95.2%	94.2%	N/A			
Bed Occupancy - ODGH	60%	47.9%	45.6%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	93.3%	94.7%	1			
Duty of Candour - Evidence of Letter	100%	93.3%	94.7%	1			
I&E surplus or deficit/total revenue	-1%	-10.9%	-19%	N/A			
Liquidity	-23	-103	-103	N/A			
Distance from Control Total	0%	-3.2%	-7.9%	N/A			
Capital Service Capacity	-2.423	-1.258	-3.559	N/A			
% Agency Staff (cost)	5.6%	8.4%	8.2%	N/A			
Use of Resources (Finance) Score	3	4	3	N/A			
Distance from Agency Spend Cap	0%	125%	-5.6%	N/A			
Staff Turnover	0.76%	1.1%	6.8%	N/A			
Staff Turnover (Rolling)	10%	11.3%		N/A			
Vacancy Rate - Medical	5%	11.2%	11.2%	N/A			
Vacancy Rate - Nursing	8%	16.6%	16.6%	N/A			
Sickness Rate	3.9%	4.9%	4.9%	N/A			
Personal Development Review	85%	72%	72%	N/A			
Mandatory Training	85%	86.7%	86.7%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.3	8.5	N/A			

Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	67	59	67			
DTOC - Number of Beds lost per month		183		183			
Length Of Stay	6.06	7.5	6.9	N/A			
New:Follow Up	2.64	2.4	2.5	N/A			
DNA (Did Not Attend) rate	8%	7%	7%	1680			
Cancelled Ops	0.61%	0.3%	0.3%	7			
Theatre Utilisation - SDGH	80%	51.2%	50.6%	N/A			
Theatre Utilisation - ODGH	90%	64.7%	63.7%	N/A			
Stranded Patients (>6 Days LOS)	170	193	387	193			
Super Stranded Patients (>20 Days LOS)	58	80	152	80			
Southport A&E Conversion Rate	20%	19.4%	19.4%	982			

Reporting Frequency is monthly except for SHMI which is quarterly.

Southport and Ormskirk Hospital
NHS Trust

Executive Assurance

Executive's Assessment Of Overall Position	Executive: Director of Nursing, Midwifery & Therapies	AMBER

Overview

There is continued focus on improving patient safety. Datix remains our incident reporting system, and there is an improvement programme to ensure the process is streamlined.

Safe Staffing is compliant with national average in May 2019 (92.4%).
Performance in Harm Free Care (Safety Thermometer) - 96.3%
VTE – 95.9%

Assured/Most Improved

Safeguarding Prevent training at level 3 to 5 is up to 96.9% which is on target

Board packs relating to CQC inspection have been distributed and coaching sessions being booked in relevant senior leaders diaries.

Numbers of complaints has reduced. Complaint responses sent within the 40 day target for May 2019 is 100%

Not Assured/Most Deteriorated

Duty of Candour was reported at 93.33% in May 2019 for both documentation of the discussion and letter, 1 incident breached the 10 day standard in within Urgent Care who are reviewing their process, this is a complex case reported to the Trust via local authority

Delivering single sex accommodation breaches have increased to 37 breaches for May 2019, this was due to waits for beds from critical care environments

There has been two C. Diff. infections reported in May 2019 against a trajectory of two per month.

Safeguarding training and compliance with the training remains a concern, the team continue to work hard to increase compliance across all levels as well as across MCA training

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 3 pt falls in May being graded as moderate or above harm.

Friends & Family Test (FFT) response rate continues to be low, however the likely to recommend in May 2019 was 95.3%, the Matron for patient experience is reviewing this with the DDON

Continued expenditure in nurse Bank & Agency due to vacancies, sickness and additional capacity across the Trust, however there has been a reduction in the use of non-framework agency usage.

1 never event was reported in May, this was related to use of an anaesthetic block, currently being investigated.

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

Overview

SHMI & HSMR: Trust is actively working to reduce both HSMR and SHMI which has brought them within acceptable parameters but an ongoing improvement is still the aim for 2020.
The rolling HSMR shows a successive fall, down to 104.5 in January
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 in response to mortality screening reports that are filled in at the time of death certification.
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 now running 24 hours, 7 days a week. Significant increase in number of referrals in first 2 months

Assured/Most Improved

High SHMI and HSMR continue to improve and the mortality rate is now within the expected range however we expect to see continued improvement.
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 however has increased in acute renal failure
In hospital deaths fell in April increased to 91 above trust target of 77 however post discharge deaths decreased to 33
Interventions to improve performance in AKI have been implemented in April
Sickness absence improved and was below the trust target of 7% for nursing (5.7%)

Not Assured/Most Deteriorated

Mortality screening continues to require improvement. Work done with this month with bereavement office and addition of extra IPads as time spent by junior doctors and lack of computer access identified as issues. The MD meets regularly with junior doctors and by allowing easier access to the screening tool this will improve screening rates.
LRTI and Bronchitis HSMR remains unacceptably high although significantly improved in the month of April. Further evaluation continues
NOF SHMI 1.6, revised NOF action plan and impact of improved performance awaited. Lack of Ortho-geraitric input remains a risk
Fractured neck of femur performance improved significantly in March with implementation of consultant of the week has now returned to 63% in May. CD for Orthopedics doing an audit to explain issues around the fact that this has deteriorated

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

Overview

A&E 4 Hour Performance

- The Trusts reported 4 hour A&E performance in May was 85.5%, May 2018 was 88.8% so a 3.3% decrease from last year.
- The Trust failed to achieve its performance trajectory by 2.8% in May and was 3.3% down on May last year. Whilst performance is not at its desired level we have to put into context the Trust performance against the national backdrop as country-wide 4 hour performance has significantly deteriorated. The Trust is holding performance (4th best in the North West for May) whilst many others have seen a worsened position for May which is a concerning national trend which started at the beginning of October 2018. There are no current signs of the pressures easing on the urgent and emergency care system for the NHS.
- Southport attendances in May were nearly 9% higher than May last year. The overall conversion rate, which includes patients admitted directly to a ward or via an assessment ward, is 19% in May, down from 20% in April which was down from 21% in March.
- The Trust has had issues in Mid-May with the norovirus closing large numbers of beds which has inhibited the Trusts ability to deliver good and timely patient flows. This has severely impacted on 4 hour performance due to ED experiencing crowding for prolonged periods of time across May. Despite the collective pressures, care given on the corridor remains significantly lower than last year with 405 patients nursed on the corridor compared to over 1622 in May 2018.
- The Ambulatory Care Unit has continued to be used as an escalation area on a continued basis to try and support the deficit of discharges compared to admissions. This has resulted in pressures on available capacity to stream patients from ED to ambulatory pathways.
- The ED workforce strategy continues to be pursued. 4 new Physicians Associates have been recruited and are undergoing pre-employment checks, and another substantive consultant has been appointed to start summer 2019 and a further interview scheduled with an expected date of October 2019. Whilst positive developments in ED are being delivered, the recruitment across acute Medicine for general physicians remains challenging and Trust is working on a revised workforce strategy for acute medicine.

18 Week RTT Performance

- May 18-week RTT performance was 94.2% which maintains the April position and is still well above the 92% target.
- The ongoing waiting list increased slightly to 11,243 however this is not impacting on the ongoing performance.
- There are currently 13 patients waiting over 40 weeks, the number of 30+ week waiters has also grown and is currently 113 , both of these figures are largely due to the continuing challenges in Community Paediatrics which at present is performing at less than 50%.
- Despite the performance level being maintained there are still challenges in Community Paediatrics, Oral Surgery, Diabetic Medicine, Gastroenterology & General Surgery.

Is assured

Cancelled Operations only had 7 out of 2035 operations cancelled in May and Theatre Utilization has continued to increase for the third month in a row. Both are being driven by the Theatre efficiency improvement programme. 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 Endoscopy lists due to staff availability has reduced from 25 (per month) to 6 (per month) attributed to improved oversight of scheduling and rostering. An organisational change is underway to ensure sustainability of the performance.

Not Assured/Most Deteriorated

<u>Length of Stay</u>

- Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 7.56 days in April, with patients on assessment wards staying an average of 9 hours. This is slightly increased on previous months. The 3 main concerns being:

Beds closed for Infection, Prevention & Control Issues

- May 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.

Medical Workforce instability

- The challenges in stabilising the medical workforce continue which directly impact on the ability to deliver a consistent offer in early and daily senior review in line with Royal College standards. 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 and once delivered sustain.

Continued poor performance of patients waiting in hospital that now no longer require acute care

- The Medically Optimised for Discharge (MOfD) rate continues to operate at 60 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 May the community services, like the Trust, were operating at occupancy levels greater than 90% and flows across the system was challenging.

<u>Diagnostics</u>

- Performance for May against the 6 week wait target was 4.14% a deterioration of 1.32% over the April position.
- Non-obstetric Ultrasound is the area of most concern with 54 waiters over 6 weeks, MRI and Urodynamics also have over 20 patients waiting over 6 weeks.

<u>Overdue Follow Ups Backlog</u>

- The numbers of overdue follow up patients has increased again throughout May with the current position at 2841
- This is an increase of over 100 since April and is mainly driven by increases in Ophthalmology

Cancer 62 Day

- Performance for April 2019 was 69 6% a drop of 11.6% from the March position

The key tumour group challenges and reasons for each:

- Colorectal: Capacity issues within wider team for clinics, diagnostics, endoscopy and theatre.
- Head & Neck: Capacity issues within clinics here at S&O (S&O provide diagnostic service only with the Consultant provided by UHA)
- Gynae: Capacity challenges (Business plan approved)
- Haematology: Consultant vacancy remains issue. Short term cover from locum consultant, but no longer term plan yet in place.
- Lung: Delays to CT biopsy causing delays in pathway. Increase in number of upgrades which has impacted on capacity within Rapid Access Clinics.
- Upper GI: Diagnostic service only at S&O. Project work within endoscopy should have positive impact on the front of pathway resulting in quicker referrals to tertiary centres. Nurse led service
- Skin: Anticipated problems include lack of capacity in derma and plastics meaning 14 day standards have potential to slip. Service is only currently open to 2 week wait, and not routine.

-

Executive's Assessment of overall position	Executive: Director of Human Resources and Organisational Development	AMBER

Overview

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 slightly increased in May to 4.93% although this is a minor deterioration compared to last month 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 to 6.39% which was felt nationally however February, March and April saw a reduction in sickness absence to 4.85% the lowest levels since September 2017.

Core Mandatory Training

Mandatory training rates have now consistently exceeded the Trust target of 85% Trust compliance is now 86.66%. Work is ongoing to support managers to ensure rates are monitored and staff encouraged and given the opportunity to undertake mandatory training. In order to ensure there is a continuous focus, especially in terms of content and delivery, Mandatory training will now be discussed on a regular basis at the Risk and Compliance Committee.

Reducing Agency Spend

The 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 20th June 2019 a 27% reduction for off framework work shifts is expected for June 2019. Key areas of improvement to note month to date has been a 71% drop in usage in 14A and a 24% drop in usage in 7A. The Trust has engaged with the CPC procurement framework and has implemented tier 2 cascade. 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 is therefore be delayed in its delivery with medical agency delivery now expected in December 2019.

Recruitment Service

The recruitment service and time to hire has been identified as a priority project for the QI programme commencing in June. The Recruitment team have worked with the NHSI model hospital team in June to complete an initial process mapping of the recruitment process. Focused support to recruiting managers in high time lapse recruitment stages has delivered an early reduction in time in stage

- Time to shortlist 8.9 days average May 19 delivering an improvement of 17.2 days (26.1 Q4 average)
- Time from advert start to 'employment checks OK' 70 days average May 19 delivering an improvement of 3.8 days compared to April 19
- Time to complete OH check 15.8 days average May 19 delivering an improvement of 0.6 days compared to Q4.

It should be noted that the corporate services benchmarking return has been completed in June. This reviews the performance in recruitment during Q3 & Q4 in 2018/19 and enables benchmarking against other providers. The benchmarking return indicates a deterioration of time to hire (advert close to start date) from 57 days in the previous benchmark period to 65 working days in the most recent period. This supports the feedback received from Trust employees during the period of the service being outsourced. This data is expected to be published in Q3. Recruitment volumes have increased significantly during June and a further increase in time to hire is predicted where further capacity to complete recruitment processes is not available.

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

The Trust launched the Big Conversations & Big Brews on the 18th June. This programme of engagement activities will run until December 2019 followed by a 3month period of focus groups where staff will be asked to review the behaviours that make Southport & Ormskirk a great place to work to inform the new Values & Behaviours Framework (April 2020). 'Quick wins' and longer term engagement activities will be actioned following staff feedback via these forums and communicated to ensure staff know the employee

voice is being heard and actions taken. Staff engagement is everyone's responsibility and as such the conversations will also incorporate what staff will do to be part of making this Trust a great place to work.

A Trust Staff Engagement Strategy has been drafted and presented to the Workforce Committee (20-06-2019). This engagement strategy focuses on MacLeod's four enablers for success – a strong strategic narrative, great senior leaders, effective managers and the employee voice. This will be presented to Board in July.

NHSi commenced a programme of QI training in June to over 40 project leads, team leaders and executive sponsors. There are 15 focussed projects which will be supported and coached by NHSi and the internal PMO team. A celebration event will be held in September.

Over the next 3-4 months, the training department will finalise the process map and implement the outcomes of the NW Streamlining Project to remove the repetition of mandatory training at induction. This will allow the OD team to fully review the Corporate Induction programme for launch Jan 2020. The Coaching & Mentoring Strategy is currently under development and will describe the Trust's approach to the full implementation of a coaching style in our communications, behaviours and interactions. It will be due to Workforce Committee July 2019.

Leadership and Talent Management (TM)
The Shadow Board programme has been rescheduled for September 2019, 9 delegates have been identified to date. Executives have been asked to recruit senior talent to the programme.

The Trust is part of the pilot group to test the new NHS Leadership Academy's Talent Management Online Self-Diagnostic Tool (July 2019). It is anticipated that in many areas the Trust will assess at 'not yet' or developing' This tool will show the current position of the Trust in relation to Talent Management and the work that will need to happen to put the Trust in a position where TM & Succession Planning can become part of how we do things around here.

Not Assured/Most Deteriorated

Personal Development Reviews
PDR compliance is now at 72.02% for May 2019 which is a slight decrease from last month. 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 Finance	RED

Overview

Month 2 (May 2019)

Month 2 Year to Date (YTD) financial performance is a deficit of £3.4 million against a plan of £2.5 million resulting in an adverse variance of £0.9 million against the plan.

The overall finance and use of resources risk rating is now a “4”.
The change from a “3” to a “4” is a result of the “distance from financial plan” metric now being graded a “4” (this was “2” in month 1). This is a result of the YTD deficit being a more significant variance from the plan (in percentage terms).
All ratings are now graded 4:- Capital service cover, Liquidity, I&E margin, distance from financial plan, agency.
Although liquidity is an issue the Trust is liaising with its commissioners to ensure timely contract payments.

Assured/Most Improved

- Model hospital workstreams progressing with NHSI input and will assist with CIP programme.
- Positive discussions with CCG’s regarding timing of contract payments in order to assist with cashflow
- Tier 2 nurse agency arrangement in place although fill rate from this source needs to improve in order to reduce use of non framework agencies

Not Assured/Most Deteriorated

- Underlying expenditure levels have not reduced from Quarter 4 (2018/19) levels which are not funded in the financial plan. Month 2 expenditure is similar to month 1
- May’s agency spend (£995,000) slightly higher than April’s spend (£970,000); at this rate of agency spend the agency cap will be breached in Month 5. Medical and nursing staff is the significant areas of agency spend.
- 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 (£2 million risk).
- Elective activity 9% under plan.
- 2019/20 CIP plan now dependent on £5.7 million expenditure reduction following contract discussions.
- CIP schemes not yet fully developed/approved through the CIP governance framework and there is currently a significant gap. Month 2 YTD achievement of £140,000 (current Year effect of £879,000) which is £509,000 behind plan.
- Based on current expenditure levels, and the status of expenditure reduction schemes in the CIP plan, there is no assurance that expenditure levels can be reduced back to the plan.

Southport and Ormskirk Hospital
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KPI Graphs and Update

Board Report - May 2019

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.	There were 2 C diff cases in May - One case on ward 15A which was a relapse and therefore could have been treated based on symptoms, but a specimen was sent, and so hence is counted again in May's figures as well as April's - this case should be appealable. Another patient was in Critical Care who had just returned from Liverpool Heart and Chest where they were treated for sepsis, hence essentially this is a LHC case. However due to the new criteria set by NHSI it has become a Southport case because within the 28 days of being C diff positive they were a patient at Southport prior to going over to LHC - this is another case where there are no lapses in care - in fact the care and the identification of infection were excellent, therefore will be appealed.	
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death.	There have been 2 never events in the last 12 months - The incident in May relates to Theatres - A block was done on the wrong side for an Orthopaedic patient. This is being reviewed through SIRG. Immediate actions were put in place and 'stop before you block' training undertaken. There is ongoing further investigation	

Board Report - May 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 98.25% for April continues to be above required compliance level - The compliance rate can improve as the month progresses as further patient discharges in month occur. Work is underway to improve the reporting cycle for VTE, and this indicator is in the 19/20 data quality improvement programme to validate and assure on the accuracy of the data	100% 98% 96% 94% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May 2018/19 201...
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance remained stable in month, and also remains slightly above national trajectory - Trust Performance for May 2019 fell slightly in relation to the previous month but continues to exceed the national benchmark of 95%. On the day of census (n=377 patients) there were 12 new harms attributed to the hospital which included 2 grade 2 hospital acquired pressure ulcers (Ward 9b x 1 and Ward 11b x 1 which originally occurred on critical care) and 1 grade 3 on Ward 7b , 2 falls with moderate harm (Ward 14b x 1 incurring a #NoF and Ward 14a reported 1 x #NoF that had occurred in a N/Home immediately before admission) and 3 x VTE (Ward 9b x 1 PE, Ward 9a x 1 DVT and Ward 10a x 1 DVT). The remaining harm events related to 4 patients receiving treatment for Catheter Associated UTI since being admitted to hospital (14a x 1, 14b x 1 and NWRSIC x 2). The continued increase in reportable harms was previously 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. It is recommended that a review of process is undertaken and the Quality Team will support the CBUs in the development of reintroducing this process if considered appropriate.	100% 98% 96% 94% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May 2018/19 201...
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	Falls with harm has demonstrated a slight increase. - The falls leadership has been handed over to the Head of Older Peoples Care. The new falls risk assessment, care bundle and daily checklist have been further revised and rolled out in 6 areas to test with an accompanying educational module for staff on ESR. The training and documentation provide best practice considerations and therefore encourage staff to take appropriate action when managing falls risk. In addition, this has been rolled out in conjunction with a new cognitive assessment/care plan and bed rails assessment/care plan / daily check- both of which are hugely prevalent in the incidence of falls and therefore interdependent in generating the improvement required in reducing falls with harm. The reporting/KPIs are also to be reviewed and the CQUIN incorporated with planned development for a specific dashboard, and an action tracker created to manage the roll-out. The post-falls pathway and practice is also under review alongside an audit, this will involve new documentation, education for Doctors and then a re-audit to ensure compliance with best practice. The falls policy is to be re-written and a strategy developed.	5 4 3 2 1 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May 2018/19 2019...

Board Report - May 2019

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 higher number is good.	Reported incidents remain higher than the previous year, suggesting a positive reporting culture - Low harm - 114 incidents Near miss - 34 incidents The main themes are: accidents, clinical care, infection control, pressure ulcers and safeguarding incidents (Not pressure ulcers)	900 800 700 600 500 400 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May 2018/19 2019...
Safe Staffing	The ratio between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts. Threshold: 95%, Fail 90%.	Safe staffing continues to be above 90% national target. - May performance is slightly lower than April 2019 but remains within the normal range	102% 100% 98% 96% 94% 92% 90% 88% 86% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May 2018/19 201...
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	May saw a further deterioration of fractured neck of femur repairs within 36 hours - This is somewhat due to Orthogeriatrician capacity. Performance is expected to rapidly improve following the approval of the business case and subsequent appointment. In the meantime, tactical improvements remain a focus.	90% 70% 50% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May 2018/19 201...

Board Report - May 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.	Continued 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. Action plans are as for HSMR.	
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.	The steady improvement towards target continues, with a significant reduction to 104.5 in January - This is the lowest recorded in recent history. This figure is expected to improve in line with the monthly HSMR as the figures average out over time. This is being driven by improved flow (as HSMR includes in-hospital death only) and improved recognition of co-morbidity. Timeliness of data is reliant on the Dr Foster system. This is the latest available data	
WHO Checklist	WHO Checklist.	Compliance against target -	

Board Report - May 2019

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Effective

Indicator Name	Description	Narrative	Month Trend
Stroke - 90% Stay on Stroke Ward	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Please note: Indicator may change as a result of delayed validation.	Performance remains below target at 64.86% - but continues to show month on improvement towards target. The clinical and operational teams have enhanced focus in ensuring a Stroke bed is protected at all times to support timely transfer and admission from suspected strokes in ED. This is being monitored at the bed / site meetings which take place 3 times per day. In addition, the service has experienced challenges in medical workforce availability which remains a challenge with an over reliance of temporary staff being a risk. The Trust is in the process of recruiting an Early Supported Discharge Team (ESDT) to support the reduction of delayed discharges. The substantive consultant is also now on a phased return to work.	
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.	Consistently achieving 100% target - The A&E team are consistently ensuring that patients presenting with suspected sepsis are having a NEWS recorded within 1 hour of arrival. No action required as achieving 100% target	
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.	In March, 18 out of 23 patients received their antibiotics within one hour of diagnosis - The North West current average for antibiotics within 1 hour of diagnosis is 66.9% and the Trust average above this level, however it does not mean we should not continue to improve. We have had a poster submission accepted at the national patient safety congress explaining our Sepsis improvement journey which we are still on. March is the latest available data The RCEM red flag sepsis audit showed we were consistently better than benchmark in this measure in the most sick patients. Sepsis management and treatment continues to be stressed at induction and throughout teaching programmes	

Board Report - May 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.	Although breaches have again increased - all remain in relation to step down from critical care - all delays are datixed by critical care; There is a review of all patients for stepdown from critical care at all bed meetings and the plan is dependant on the overall Trust position; The Critical Care Manager now attends the 12:30 bed meeting daily	
Written Complaints	The total number of complaints received. A lower number is good.	There were 26 complaints in May. This is higher than April (4) 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. Complaints improvement work is a key workstream in the Quality Improvement Plan	
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 improved on the previous month's data and achieved target - However the total Trust response rate remains low but has increased slightly from 6.11% to 6.52%. Planned Overall response rate has increased to 18.55% from 15.9% Those that would recommend has increased to 98.78% from 89.19% Urgent Overall response rate has increased to 5.26% from 3.6% Those that would recommend has increased to 91.88% from 89.47% Maternity Overall response rate- has decreased to 8% from 9.82% Those that would recommend has decreased to 92.54% from 95.18% Paediatrics Overall response rate- has increased to 3.45% from 2.72% (Children's Ward 12.44% and A&E 2.53%) Those that would recommend has increased slightly to 92% from 91.67% A&E Southport response rate has increased slightly to 0.68% from 0.53% The 'would recommend' has increased to 80.95% from 66.67% A&E Ormskirk response rate has increased to 2.53% from 1.52% The 'would recommend' has increased to 96.43% from 82.35% Response rates are reviewed monthly and shared with relevant CBU's, qualitative comments are also shared with relevant areas on a monthly basis in a poster format for staff to access easily. Use of an I-PAD to collect results are currently being piloted on the childrens' ward. Interviews are planned to recruit patient experience volunteers.	

Board Report - May 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.	The Trust reported performance in May was 85.5% which was the 5th best performing Trust in the North West region - Whilst performance is not at its desired level we have to put into context the Trust performance against the national backdrop as country-wide 4 hour performance has significantly deteriorated. The Trust is holding performance whilst many others have seen a worsened position for May. This is a concerning national trend which started at the beginning of October 2018. There are no current signs of the pressures easing on the urgent and emergency care system for the NHS. Southport attendances in May were nearly 9% higher than May last year (increased demand experienced across SFCCG and for WLCCG there was nearly 15% less demand from the previous year) . The overall conversion rate, which includes patients admitted directly to a ward or via an assessment ward, is 19% in May, down from 20% in April which was down from 21% in March. The Trust has had issues in Mid-May with the norovirus closing large numbers of beds, inhibiting the Trusts ability to deliver good and timely patient flows. This has severely impacted on 4 hour performance due to ED experiencing crowding for prolonged periods of time across May. Despite the collective pressures, care given on the corridor remains significantly lower than last year with 405 patients nursed on the corridor compared to over 1622 in May 2018.	
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0.	There was 1 x 12 hour breach as a result of a delay in accessing a mental health bed. The remaining 11 were due to delays in acute bed availability. - All acute bed breaches occurred as a result of accumulated pressures from the weekend, with patients bedded in ED overnight with a DTA awaiting admission to a bed. May saw a 7.6% increase in attendances, a number of wards with beds closed due to norovirus, continued reliance on escalation beds to bridge gap between admissions and discharges, and an increase in the number of stranded patients. Workstream 2 reporting into the Patient Flow Improvement Programme (PFIP) is critical in creating sustainable bed flow, reducing the need for use of escalation areas, and ensuring patients are seen and treated in the most appropriate clinical area .	
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.	Completion of ambulance handovers within 15 minutes remains a challenge, largely due to high occupancy levels in ED as a result of increased demand and bed pressures, and the impact that this has on patient flow - May 2019 saw a total increase of 7.6% attendances (372 additional patients), whilst the number of patients classed as stranded and super stranded increased. Workstream 1, reporting into PFIP, has a high impact action focused on handover times with a 'Fit to Sit' drive as well as a planned NWAS pilot using autoclear to support reducing handover times. ECIST will also be undertaking a clinical walk through in July 2019 reviewing A&E attendances and alternative clinical settings to A&E.	

Board Report - May 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.	May saw a further deterioration in meeting the standard and achieved 4.14% - The breaches were as follows: Audiology - 0.6% 1 patient - staff sickness Cardiology - Echo - 0.5% 2 pts -unreported reason Colonoscopy - 9.3% - 14 pts - 9 DNAs, 5 reduced activity (WLIs) Computed Tomography - 1.6% - 6 pts Cystoscopy (not Gynaecology) - 7.6% 9pts - patient choice Dexa Scan- 6.1% - 10pts - Capacity - all patients will have had their scan by the end of June Gastroscopy - 2.9% - 4 pts - patient choice MRI - 4% - 25pts - all bar one patient are booked in June on or before 13/06/19, the remaining patient is booked for 03/07/19 Non obs ultrasound - 4.1% - 54 pts - patient choice, unable to contact patient - locum Radiologist engaged and additional Radiology and Sonography sessions. Recruitment for a Sonographer underway. Urodynamics (treatment centre) - 71% - 20pts - capacity - issue now resolved Video Urodynamics (Urol) - 20% - 1 pts - reduced consultant capacity - escalated for resolution	6%, 5%, 4%, 3%, 2%, 1%, 0% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20
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.	Compliance against standard maintained - As more patients are seen in the first seven days of their pathway, the numbers of referrals that fail this standard should reduce.	100%, 98%, 96%, 94%, 92% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20
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.	100% compliance against target - Target met for all patients.	99%, 97%, 95% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20

Board Report - May 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').	100% of patients compliant against standard - All patients treated within time	
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').	100% of patients compliant. - Small numbers are reported against this audit, but all are compliant	
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Compliance improving against standard - The initiation of the Cancer Improvement Board has resulted in several work streams across the hospital concentrating on improving performance against the 62 day standard.	

Board Report - May 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.	The Trust continues to experience difficulties meeting 62 day target - 10 patients breached their 62 day referral to treatment target in all tumour sites except gynae and skin. In-month achievements include the completion of exception meetings held with COO, MD and Cancer services with all tumour sites teams. The Tumour sites all have completed action/improvement plans and plans are regularly reviewed at the weekly Cancer Performance meeting. The key challenges at service level (i.e. Radiology and IT) Radiology: Challenges are still within the recruitment of workforce to enable moving towards 7 day pathway in all modalities. IT: Still no link between Medway and SCR which means we are unable to effectively track all cancer referrals from day 0. Therefore we are unable to compile a true picture of issues within the 14 day pathway in order to reduce first appointments down to day 7. The critical improvement actions required that need to be progressed over the next 30, 60 and 90 days 30 Days: • Secure SCR and Medway link is imperative to moving forward, in order to give clearer picture of issues within performance • Cancer Project manager to be in post • Communication to CCH and GPs to ensure all referrals are complete with appropriate testing completed before 2ww referral made. 60 Days: • Capacity and demand review for all tumours site that identified capacity as an issue to moving forward. (Gynae, Colorectal, Head & Neck) 90 Days: • All tumour groups explored and developed the possibility to support RAS in ERS to assist with front end pathway. • To reduce first appointments to within 7 days of referral	100%, 95%, 90%, 85%, 80%, 75%, 70%, 65% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20
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 remains consistently above the target and trajectory - The slight reduction is as a result of a number of small issues across a number of specialities. Urology, Oral Surgery, Community Paediatrics, vascular are all impacted by clinician shortages. General Surgery is impacted by long waiters as a result of bed capacity at SDGH. Each of these areas have action plans in place.	100%, 98%, 96%, 94%, 92%, 90% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20

Board Report - May 2019

Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Bed Occupancy increased in May although the level remains within the normal range for the Trust - Daily management continues	110%, 105%, 100%, 95%, 90%, 85%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site, based on open beds. A lower percentage is good. Threshold is 93%.	Occupancy at ODGH continues to improve with ongoing plans to relocate activity. - Occupancy at ODGH is at its highest level since Dec 2017	60%, 55%, 50%, 45%, 40%, 35%, 30%, 25%, 20%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20

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Board Report - May 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.	The Trust was not able to meet the Duty of Candour compliance in May - Out of 15 cases, 14 of which complied, one case was a complex incident reported to the Trust by the Local Authority requiring an initial 72 hour review prior to going to the Serious Incident Review Group (SIRG)	
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.	The Trust was not able to meet the Duty of Candour compliance in May - Out of 15 cases, 14 of which complied, one case was a complex incident reported to the Trust by the Local Authority requiring an initial 72 hour review prior to going to the Serious Incident Review Group (SIRG)	
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Performance appears to be improving as percentage has reduced - The deficit is benefitting from non recurrent income in respect of Financial Recovery Fund and Provider Sustainability Fund. The planned underlying position (circa £26.5 million) is not being achieved.	

Board Report - May 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.	Downward trend continues - The downward trend will only increase as loans due within 12 months are being reclassified as current. This significantly affects the calculation of the metric and this can be seen in the monthly step changes.	
Distance from Control Total	Distance from Control Total.	Material deterioration this month - The first two months financial performance has seen underperformance against the income plan and overspending against expenditure.	
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.	Performance is improving - The improvement is related to a lower deficit in 19/20 which in turn is related to additional funding of PSF (Provider Sustainability Fund) and FRF (Financial Recovery Fund). Note that despite the improvement this metric remains at a 4 as it is less than -1.25.	

Board Report - May 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.	Agency costs remain high as a percentage of staff costs. - The reduction in April's figure was skewed due to April's total pay bill including the 2019/20 pay award. The reliance on agency staff to provide safe care is instrumental in both medical and nursing costs. The 19-20 improvement programme focuses on the following priorities: 1. CIP 2. Time to recruit 3. Agency costs (regional protocol)	12% 10% 8% 6% 4%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May; 2018/19 201…
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Moved from 3 to 4 for first time. - For May 2019 in all 5 of the metrics that make up the Use of resources - capital service capacity, liquidity, I&E margin, distance from control total and agency are all 4.	4 3; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May; 2018/19 2019…
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Material overspend against the cap - Quarter 4 agency spend has continued into April and May. Recruitment isn't keeping pace with the number of leavers, particularly in medical and nursing staff.	120% 100% 80% 60% 40% 20% 0% -20%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May; 2018/19 201…

Board Report - May 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 by 5. There were 33 in leavers in May compared to 28 in April. Numbers have steadily risen since January - The Trust has established a Nursing Recruitment and Retention group which has recently established and agreed its terms of reference. The group is now up and running and focusing with key stakeholders on improving the Nursing Workforce retention rate.	1.6%, 1.4%, 1.2%, 1%, 0.8%, 0.6%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May; 2018/19, 201…
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.	Rolling staff turnover shows a steady increase over the last year - Performance sits within the normal range, although the rising numbers demonstrates a cumulative deterioration in turnover. The Trust has established a Nursing Recruitment and Retention group which has recently established and agreed its terms of reference. The group is now up and running and focusing with key stakeholders on improving the Nursing Workforce retention rate.	13.5%, 13%, 12.5%, 12%, 11.5%, 11%, 10.5%, 10%, 9.5%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May; 2018/19, 201…
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The medical vacancy rate has risen again in month and is now significantly higher than the previous eight months. - A medical workforce strategy is being developed as part of the Workforce Improvement Group, chaired by the Director of HR	14%, 12%, 10%, 8%, 6%, 4%, 2%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May; 2018/19, 201…

Board Report - May 2019

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.	Nurse vacancy has increased considerably in month due to the financial increase in nursing budget from the Nurse Establishment Review - This increase in vacancy was expected and there is a recruitment plan, retention plan and close working with the Universities who train our student nurses to support the implementation of the staffing review.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence has slightly increased in month to 4.93% although this is a minor deterioration compared to last month - The Trust continues to 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 slightly in month to 72.02%. - PDR compliance is now at 72.02% for May 2019 which is a slight decrease from last month. 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 - May 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.	Mandatory training remains above 85% target but with a minor downward trend in month - This is due to an increase in staff numbers in month - there was an increase in actual numbers trained.The training department remains focussed on the administrative management of core mandatory training records. Without the appointment to the current substantive posts, the department is unable to deliver key projects which will deliver improvements in quality & compliance. Posts are currently being reviewed by PAG.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Care Hours per Patient Day remains compliant and above target -	

Board Report - May 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.	May saw an increase to an average of 67 daily beds lost which sits outside of the normal range for the Trust - Ongoing management - #longstaytuesday currently being completed by Acute team, daily discharge huddle expanded to include both Sefton and WL patients to support cross system working; trusted assessment document continued for ICRAS referrals to D2A and ICB;red2green on all in-patient wards across the Trust; implementation of real-time data collection from discharge facilitators. ward closures and restricted movements continued throughout March due to infection led to delays in discharge of MOFD patients to alternative care facilities; closure of ward 1; MADE with senior system partners	
DTOC - Number of Beds lost per month	The number of beds lost per month from patients who have experienced a Delayed Transfer of Care (DTOC).	Delayed transfers of care reduced in May to 183 days, compared to 206 in April - Numbers remain within the normal range for the Trust	
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.	ALOS for Full Emergency Admissions in April was 7.47 days, the highest it has been since July 2018. Elective ALOS saw a spike in April and was up to 7.17 days. - Model Hospital data, which is subject to a delay of several months, demonstrates that through August to October the Trust was performing better than its peers for emergency and elective length of stay for elderly patients (aged 75+). The performance in April was influenced through a number of operational challenges which are detailed in the report. The key issues being 1) beds closed for Infection, Prevention & Control Issues; 2) Medical Workforce instability; 3) Continued poor performance of patients waiting in hospital that now no longer require acute care; and 4) Configuration of hospital sites. The COO has re-set the Patient Flow Improvement Programme (PFIP) and has established a "reducing LoS project group" and set this group a goal to reduce all Emergency ALOS by 0.5 days.	

Board Report - May 2019

NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	Performance remains within target -	
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	The DNA rate for the trust has seen a slight increase on last month. - Due to sickness in the Access dept and reception areas there has been a reduction in the capacity to deliver on telephoning patients. A review of workforce in this area has commenced	
Cancelled Ops	Percentage of Operations Cancelled.	The Trust has achieved beyond target at 0.34%. In total, 7 out of 2035 operations were cancelled in May - Data from a 6 week review of on the day cancellations is currently being analysed for trends as part of the Theatre Utilisation Improvement Programme	

Board Report - May 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Improvement is seen on April Performance. - There is implementation of the Golden Patient SOP pilot by the T&O Team, to ensure lists are commencing on time. Delays due to start times due to bed pressures are to be addressed as part of this process.	
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Performance has seen an improvement for the 3rd consecutive month. - Analysis of impact of on the cancellations is underway. Planned activity is reviewed as part of 6-4-2 process.	
Stranded Patients (>6 Days LOS)	Patients who spend 7 days or more as an inpatient.	New KPI - 'balancing' metric to support overall LOS reductions - Refer to ALOS for update	

Board Report - May 2019

NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Super Stranded Patients (>20 Days LOS)	Patients who spend 21 days or more as an inpatient.	New KPI - 'balancing' metric to support overall LOS reductions - Refer to ALOS for update	
Southport A&E Conversion Rate	Proportion of Southport A&E Attendances that are moved to a base ward. Patients who only stay on an Assessment Ward are not included.	The Trust returned to compliance - for the second month in succession	

NHS Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	PB131/19.2	**Report Title**	**Vision 2020 and the Single Improvement Plan**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Donna Lynch, Head of PMO		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

Vision 2020 describes a number of strategic objectives which have been refined and agreed by the Trust Board during winter 2019. The objectives support our mission of 'providing safe, high quality services for you and with you' and are:

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

The Trust Single Improvement Plan (SIP) is the consolidated plan for all the improvement activities that are being conducted during the year. The SIP sets out the priorities, actions and timescales that the Trust needs to deliver to achieve its Vision. The priorities for 2019/20 are:

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

The documents attached papers detail progress against the above priorities. Current progress for the programme is an overall rating of Amber.

Recommendation
The Trust 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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY IMPROVEMENT PLAN

Quality Improvement : Following CQC visits in 2017 and 2018 the Trust Quality Improvement Plan contains 114 'must' & 'should do' recommendations. Assurance Panels have established to test the improvement evidence, subject to approval by assurance panels there are 0 Reds (Not progressing to plan), 20 Ambers (On track to deliver), 84Greens (Action Completed and 10 Blues (Delivered and Sustained).

Concerns raised from QID (05.06.19)

- Slow progress against Estates and Facilities preparation plan, particularly in relation to 'regulatory compliance'. Meeting to be arranged asap between Deputy CEO and Julie King
- Storage / location of personnel files – to be raised with Director of HR / OD
- Role specific mandatory training for Sepsis to be rolled out – discuss with Out Reach Team and Training Department
- Review of SOP for theatre 'deep cleaning' following patients with infections – to be actioned by Andrew Chalmers
- Review Security Contract to check arrangements for mandatory training – Simon Williams & Steve Shanaghan
- Discussion needed regarding Security cover at Ormskirk site
- EBME Training records – discuss with Cath Carter and Training Department

The four Quality Improvement Priorities all have identified support from PMO, project plans are being developed for all including metrics, outcomes and timescales for delivery

The Clinical Quality Strategy has been approved by Quality & Safety Committee in May 2019

Quality Risk Profile updated with CCG, CQC , NHSI, NHS England, the most recent version was discussed at Southport & Ormskirk Improvement Board in May 2019, this demonstrated a clear improvement trajectory for the Trust since 2016.

QI METHODOLOGY

Programme to deliver QI training agreed and dates booked

SAFE STAFFING

Nursing Establishment Review recommendations presented to Executive Team & Hospital Management Board for final ratification at Trust Board in May 2019.
Nurse Retention Task & Finish Group will be reengaging with NHS Improvement Workforce Team

MEDICAL WORKFORCE ENGAGEMENT

Medical Director and Director of Nursing - weekly walk around to engage clinical staff. Medical Director reviewing timescales for Medical Engagement follow up visit, now expected December 2019.
The domains within the MES from May 2018 survey will be mapped to the outcome of the 'cultural review paper 'as presented to June 2019 Board by HR outlining progress on equality and diversity, and circulated to the Medical Workforce.

QUALITY & SAFETY GOVERNANCE

Plans to review risk registers in place and Risk and Compliance Group ongoing.
New BAF and risk appetite developed (through facilitated Board Development sessions), this was approved at May 2019 Board meeting
Policy Review underway, extraordinary Policy Panels in Place - expected completion date June 2019
Complaints process mapping review and incident process mapping exercise completed with subsequent actions developed, external review of complaints process underway

Operational Performance

RAG Rating

Key Achievements/Progress

Winter Planning for 2018/19 (STATUS, GREEN)
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. The COO and DoN attended AUH to review ward 35 to gain a greater understanding of the model with a view to replicate at ODGH.

Actions that require competing by next HIB. Every scheme:
- A proposal will be presented to CE by the end of June to ensure appropriate time is set to plan & implement for 1st October 2019. The two options that will be worked up and proposed are 1) Development of a post operative rehab pathway for Orthopaedics at ODGH and; 2) Introduction of a intermediate care unit at ODGH for patients no longer requiring acute care

Achieving Constitutional Standards - whilst delivery of the constitutional standards performance remains challenging for the Trust in context (i.e. national ranking position) the month of April has been satisfactory – ****the figures have not yet been issued for May*****
- 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.

Improving Operational Efficiency (STATUS, AMBER) – *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) and status therefore is **Green.**
- **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.
- **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 Endoscopy lists due to staff availability has reduced from 25 (per month) to 6 (per 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 months performance of 2018/19. Each tumour group has an improvement plan and meetings are in the process if being completed whereby tumour 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 team have identified a 14 point plan. The aim of the programme is to ensure the DNA rate is no greater than 8%.

WORKFORCE

AMBER

Key Achievements/Progress

WORKFORCE EFFICIENCY

Establish a Trust wide People and Activity Group
Reduce Agency Spend to comply with NHS cap of £5.6 Million (£4.9 Million 19/20)
Extend utilisation of TempRE bank resourcing system to include AHPs, A&C, Estates/Facility staff
Improve Productivity through robust Job Planning
Supporting Attendance Policy (sickness absence) launched from 28th January 2018 with guidance, training and support to ensure a sustained reduction in sickness absence rates. So far 81% of managers have been trained on the new policy with further training planned for April 2019. Sickness absence rates have decreased again in month to 5.15% in March (the lowest rate since September 2017) whilst this is a positive trend a continued improvement is required to achieve assurance.

CLINICAL WORKFORCE PLAN

Deliver a comprehensive 5 year plan – initial scoping undertaken. For Review by Executive team.

RECRUITMENT AND RETENTION

Action Plan developed in connection with NHSI Retention pilot
Exit Interview process, reviewed and relaunched to ensure meaningful data is captured, analysed and utilised going forward
Reduction in time to hire programme

LEARNING AND DEVELOPMENT

HR working with CBU's to set trajectories to increase mandatory training rates to stretch target of 95%
HR working with CBU's to set trajectories to increase appraisal rates to 85%
Work in partnership with AQuA and NHSi on Leadership Development and Quality Improvement
Deliver Essential Management Skills training to Trust managers on an ongoing basis
Over 100 apprenticeship registrations on a variety of level 2-7 programmes including free maths and English courses for all staff

HEALTH AND WELLBEING

Review the Health and Wellbeing Strategy for the Trust. Representatives attended the National Health and Wellbeing event in March, which was informative enough to help to shape and develop the Strategy.
Deliver a robust Flu campaign in 2018/2019 – 81%.
Develop the Mindful Employer initiative by offering Mental Health First Aid Training

OD AND STAFF ENGAGEMENT STRATEGY

Workforce and OD Strategy (including associated plan) agreed and circulated to wider organisation.
Develop an Action Plan to improve Board Visibility
Ensure the Trust meets its statutory Equality and Diversity obligations
OD Manager commenced May 2019, OD Facilitator to commence in July 2019
Staff engagement strategy to include the "big conversations" approach with a focus on values & behaviours to develop the Southport & Ormskirk Way – launch June 2019
Working with NHS Elect to develop Leadership & Talent Management Strategy

HR IMPROVEMENT PRIORITIES

Workforce efficiencies programme model delivery

WORKFORCE (1)

AMBER

Key Achievements/Progress in Month

- Initial Workforce Improvement Board held May
- Review held with C&M cluster trusts to establish shared position on renewal/ extension/ review of contract position of NHS Professionals – further review planned June.
- Cheshire & Merseyside collaboration on nursing and midwifery agency call off contract and rate card – plan in place to implement for 1 June 2019 delayed due to C&M project support withdrawal.
- Tier 2 agency engagement completed – Procurement contracting underway.
- Model Hospital HR directorate reviews commenced.
- Initial Clinical Workforce Strategy meeting held May 2019
- The new Supporting Attendance Policy has been implemented with training now being delivered across the Trust. So far 81% of managers have been trained on the new policy with further training planned for April 2019.
- 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.
- 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. In examining the significant drop in performance it was established that the calculation of the figure had been changed to the ESR calculation which has impacted on the performance, however it is anticipated that compliance will increase again next month.
- Core mandatory training action plan in place and agreed at the Risk & Compliance Group
- Board Visibility initiatives ongoing
- AQuA provided feedback about the outcomes of the Well Led report to the Board.
- Monthly Valuing our People Group meetings to deliver Workforce & OD Plan
- Plans being developed to work with NHS Elect on Trust wide Culture Change Programme with particular focus on anti-bullying - roll out in June 2019.
- Relocation of HR consultation has concluded with a review of feedback now underway. There have been some delays to finalisation of relocation due to IT infrastructure and resources available. Further cabling and networking is needed to be undertaken in order to support the additional workstations, contractors will need to be sourced in order to undertake this piece of work.
- Workforce Efficiencies Improvement programme scoped and governance arrangements proposed via PMO.
- Agreement obtained to implement revisions to salary sacrifice vehicles schemes to address issues and gain improvements and efficiencies

WORKFORCE (2)

AMBER

Key Achievements/Progress in Month

- Rostering policy development – presentation to JNC and Workforce Committee completed.
- 2nd Cohort of CMI Level 5 Award Management of Coaching & Mentoring – to form part of Coaching Strategy
- Application for Trust to be part of NHS Leadership Academy pilot of the Talent Management Diagnostic Assessment Tool
- Scoping meeting held with Deputy CEO – to plan for Board Talent Management Masterclass and Executive Team TM Workshop
- Logistical planning for Shadow Board Development programme for senior leaders, re-scheduled for September 2019 – next recruitment phase post Board/Exec TM masterclass
- NHSi funding bid submitted for 1) Triumvirate, 2) new Consultant and 3) Senior Clinical Leaders development programmes (£110,000) – as part of TM approach
- NHS Elect support secured to co-design Trust Leadership & Talent Management Strategy
- Staff Engagement Strategy under development for review at June Workforce Committee – action plan entitled "Everyone's Responsibility"
- "Big Conversations" – staff engagement final approach being developed for launch in mid June 2019
- Scoping exercise held with Valuing our People group members for big conversations approach, bespoke session held with HR team (May 2019)
- OD Manager commenced 13th May 2019
- "Introduction to QI" - 1st cohort delivered by NHSi scheduled for 12th and 13th June 2019
- Review of format and behavioural contract of the Workforce Committee
- Q4 Staff Friends and Family Test and Pulse check results provided to the Trust
- Appointment of Assistant Director of Health and Wellbeing due to commence in post July 2019
- Staff turnover has decreased slightly in month and remains on target. A review was undertaken of the exit questionnaire process which identified that the HR Transact provider was not sending out the questionnaire as per the service catalogue. This has since been rectified and the provider will be providing monthly KPI's against performance.
- Assessment centers set up and undertaken for the Head of Estates and Facilities and Deputy Director of Nursing roles
- Time to hire reduced in April
- Recruitment underway for permanent Recruitment Team staff

WORKFORCE (3)

AMBER

Key Risks/Issues	Mitigating Actions	RAG
Sickness Absence rate reduction	New policy, Health and Wellbeing initiatives, early support to "Hot Spot" areas, Training for all managers on role and responsibility of dealing with sickness absence.	A
Delay in A&C & Estates and Facilities being included on the TempRE bank resourcing system.	Review of current resources available to support this work	A
CBU's failing to meet trajectories of improvement for mandatory training and/or appraisals	HR to continue to support CBU's and performance review meetings will ensure evidence of ongoing improvement. Revised Appraisal process and paperwork launched (Dec 2018) focussing on person centred conversations. Training on meaningful, quality conversations offered to managers on an ongoing basis. Consultant mandatory training days scheduled throughout 2019 to provide easier access. Junior Doctors mandatory training under review by Medical Education Team to improve recording/reporting processes. and compliance. Core mandatory training action plan in place to provide further scrutiny of the training data	A
Lack of recruiting manager ownership in key responsibilities to improve time to hire	Recruitment website to be developed. Escalation process and deep diver to in breaches of KPI targets required.	R

2018/19 FINANCIAL PLAN

RAG Rating

Key Achievements/Progress

IMPROVE THE SHORT TERM FINANCIAL POSITION – CONTROL & USE OF RESOURCES

Current performance

Month 1 year to date (YTD) deficit (£2.025 million); £123,000 worse than plan (£1.902 million).

At month 1 the contract was not agreed. The income position was based on PbR.

An agreement with Sefton CCG's has now been reached. West Lancashire CCG have been informed they will remain on a PbR contract as agreement could not be reached alongside the same terms as Sefton CCG's. The latest contract positions will result in less income being received than reported in the month 1 position. Therefore, a more realistic assessment of the financial position will be available for month 2.

Elective activity is under plan but both outpatients and non electives are over plan. In addition to this the initial contract plan included circa £1.5 million for Best Practice Tariffs (BPT -above 2018/19 levels) to be earned for the whole year. No additional income for BPT was received in April.

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.

Agency levels remain high (£970,000).

Month 1 CIP performance was under plan.

Progress re plan

1. Although the 2018/19 plan was achieved the expenditure levels incurred in Quarter 4 represented an underlying deterioration in the monthly run rate. This level of expenditure has continued month 1 and is not sustainable if continued into 2019/20 due to the system financial position.

Key actions

Finalise contract with Sefton and West Lancashire CCG's.
Action the agreements reached with Sefton in order to achieve contract sign off. This involves reducing reserves.
Reassess financial plan and requirement to achieve Quarter 1 and secure non recurrent funding.

COST IMPROVEMENT PROGRAMME

Current performance

Trust has set a CIP plan of £6.3 million. This was to be achieved by £4.5 million expenditure reductions and additional income of £1.8 million from BPT.

At month 1 only £53,000 was achieved (non pay) against a target of £277,000; a shortfall of £224,000.

Progress re plan

This is now reported through the COO's Operational Performance Assurance report.

Key actions

See COO's report. In addition, to accommodate the changes agreed in finalising the contract, the CIP plan will be amended upwards to £6 million expenditure reductions. Any income from the £1.8 million BPT target will not be part of CIP.

2018/19 FINANCIAL PLAN(2)

RAG Rating

Key Achievements/Progress

FINANCIAL GOVERNANCE

Progress re plan
All the measures to improve financial governance have now been completed and embedded by the Turnaround Director who left post on 31 March 2019.
Key action
Continue to ensure all areas of governance are embedded.
Assess the number of relevant staff who have received training to date and establish a programme/timetable to deliver training to the remainder.

FINANCIAL STRATEGY

Current performance
A "reset" of the acute sustainability programme commenced on 26th February 2019. No further financial modelling work has taken place.

Progress re plan

In the absence of any significant capital funding during 2019/20 the Trust will review options and look to begin the development of the elective care centre at Ormskirk DGH.

Financial modelling work will recommence in line with the emergence of the preferred clinical model.

Trust required to complete 5 year financial plan (Long Term Financial Model) in summer 2019. Finance staff attended the training in May.

FINANCIAL PLANNING CYCLE

Current performance

The Trust's 2019/20 financial plan was submitted on 4th April 2019 to NHSI.

There has been no request for the Trust to resubmit although the financial plan has changed significantly following contract discussions.

Progress re plan

Plan submitted.

Key action
2019/20 CIP requires further work on schemes to deliver the £6.0 million expenditure reduction plan.

2018/19 FINANCIAL PLAN(2)

RAG Rating

Key Achievements/Progress

Key Risks/Issues	Mitigating Actions	RAG
Underlying expenditure levels in month 1 will not reduce back down to pre January 2019 levels.	*Nurse establishment business case funding has been allocated in month 1 and will enable a more meaningful analysis can take place of nurse overspends and mitigating actions to bring back into balance.* *Analysis of other overspending areas (mainly medical staff) that are contributing and reconciliation to determine where current business cases will resolve the issue or there is a need for recurrent investment. Business cases will be required where this is the case.*	R
Although income plan has been revised down following contract discussions there is a risk that this lower level will not be achieved through both BPT and repatriation.	*Best Practice Tariff opportunities of £1.1 million have been shared with CBU's. Repatriation target of £1 million requires a plan. £0.5 million of this should be available from T&O.*	A
New CIP target for expenditure reduction (£6.0 million) is not backed up by schemes	*See COO's report*	R

ACUTE SUSTAINABILITY

RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

Over the past month work has focused on finalising a draft terms of reference for a Pre Consultation Business case which has been reviewed and agreed in principle with the Cheshire and Merseyside Health and Care Partnership system board. A draft programme implementation plan has been developed to show the key areas of work planned to be completed by October 2019. Work is underway on defining all fragile services with a desktop exercise completed in analysing demand/capacity issues, workforce challenges and any other relevant performance or quality challenges. Interviews with clinical and managerial teams across all3 CBUs are near completion to enable a full picture of fragile services to be developed and fed into the acute sustainability programme plan.

CLINICAL SCENARIOS

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 undergoing a series of check and challenge events across Southport and Formby and West Lancashire with a piece of modelling work commissioned to baseline capacity and demand for 18/19 . Feedback from the check and challenge process alongside the baseline data will inform the development of the next iteration of the care models and their emerging care pathways. This work will all feed into the development of the pre consultation business case.

ESTATES SOLUTIONS

The Strategic Estates Group continues to develop a one system estates strategy for Sefton (inclusive of West Lancashire)

FINANCE SOLUTIONS

Work continues to explore system Financial models with priority work focusing on the Frailty model

OPERATING MODEL

Target operating models to emerge from the clinical scenarios

Key Achievements/Progress in Month

Funding has been secured, in principle, for £497k to mobilise the development of a pre consultation business case from Cheshire and Merseyside Health and Care Partnership. This funding is subject to resource support from Southport and Formby CCG and West Lancashire CCG.

Key Risks/Issues	Mitigating Actions	RAG
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 finalisiation of clinical models which will impact on the PCBC timescales	PCBC inititian plan in development with clear scope, impact, timescales for development, resource requirements and options appraisal process. To be agreed with NHSI/NHSE and CMHCP be end of May	R
Ensuring alignment of service change proposal with existing system planning processes (5 year plan and Health & Wellbeing Plan)	System partnership (STB) to enable direction and ownership Alignment of planning priorities within options evaluation criteria	A

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 24 June 2019
Lead:	Jo Morgan, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- We are still waiting on the agreement of the 2019/20 contract with West Lancashire CCG which is likely to become the subject of Arbitration.
- The financial position was discussed in detail and remains challenging. The current forecast control total could be missed by £5m, which includes the assumption of a £4m saving from the CIP programme. The current forecast for the CIP programme is currently £2m.
- We need to demonstrate that the trust complies with the criteria for receiving the conditional income elements.
- Staff turnover is continuing to show an increase month on month, whilst the use of agency staff continues to be of huge concern. The use of non-framework agency nurses will reduce as we look to develop Tier 2 supply which went live at the beginning of June

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)

- Several of the financial performance indicators are starting to show deterioration.
- The Capital Programme needs to be monitored, whilst it is too early to forecast an out-turn the projects which are to be delivered or are in the process are forecast to overspend.
- Length of stay has gone up in the month, a more detailed look at specific areas of concern will be discussed at the next meeting.
- IG training hit 92% for 2018/19, whilst this performance is good it is below the 95% target.
- The PIR report was discussed, whilst the data received is improving there are gaps within it which is a cause for concern regarding assurance.

ASSURE

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

- A comprehensive report on the expenditure of medicines for quarter 4 was well received with efficiency improvements to be realised.
- Due to the level of debt more than 90 days being very high, assurances have been made that an exercise is currently underway. The total being £3.1m of which £2.7m is NHS related.
- A&E performance - whilst the trust failed to achieve its performance by 2.8% in May and was 3.3% down on May last year the performance against the national backdrop as a country-wide (4 hour performance) has also significantly deteriorated. However the trust is holding performance 4th best in the North West for May. The hard work was recognised and acknowledged by the committee.

New Risks identified at the meeting

Review of the Risk Register

Alert, Advise, Assure (AAAs) Highlight Report

Committee/Group:	Hospital Management Board
Meeting date:	20 June 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 contract with West Lancashire CCGs had not been agreed and there is a risk that income could fall below the levels declared in the Director of Finance report to the HMB.
- Monthly pay expenditure levels incurred in Quarter 4 of 2018/19 had not been budgeted for in the 2019/20 financial plan. The 2019/20 deficit control total will not be achieved unless this can be addressed.
- The HMB was asked to note the following:
  - The Trust is significantly adverse from plan
  - Contract discussions had not been finalised with West Lancashire CCG
  - Income is lower than initial plan as due to elements of the income plan now only being paid once certain conditions have been reached.
- Urgent Care CBU noted the current budget does not match the current establishment and does not support future recruitment.

ADVISE

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

The Business Investment Development Sub-Committee (BIDSC) advised the HMB of the outcomes of the following Business Cases and actions taken by the HMB:

- **Ward Catering Assistant**

  HMB considered the recommendation from BDISC and was happy to approve the recommendation for the Business Case; however the final model of care had not yet been agreed.
- **Windows 10 adoption**
  HMB considered the recommendation from BDISC and was happy to approve the recommendation for the Business Case.
- **A revised Business Case for the establishment of the post of Clinical Engagement Manager with additional coding resource**
  For noting - this case is not included in the 2019/20 business case list
  The decision was deferred until next month (July) as further clarification regarding the figures were required.
- **Cardiology Specialist Nurse**
  HMB considered the recommendation from BDISC and was happy to approve the Statement of Case

ASSURE
(Detail here any areas of assurance that the Committee/Group has received)
• The updated Board Assurance Framework (BAF) was discussed at the meeting so that senior managers were aware of the changes and the Risk Appetite Statement. It was also agreed that the Company Secretary to attend the Senior Operational Leadership Team meeting to discuss in details the changes. • Following a discussion at Executive Team Meeting on Thursday 20 June regarding the CBUs' budgets it was agreed that Kim McNaught would support Urgent Care in reviewing their budget. • The Corporate Governance Manual was discussed and noted as a useful reference tool for senior managers especially in relation to Well Led.
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:	QUALITY & SAFETY COMMITTEE
MEETING DATE:	24th JUNE
LEAD:	MR DAVID BRICKNELL

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Mortality – Despite good progress on the overall HMSI figure there are areas of concern at the level of kidney related mortality and the low level of screening of death; both of which are being investigated.
- We are still failing to meet targets on Same Sex Breaches and the time spent on the Stroke Unit.
- We are also failing on 62-day Cancer target and we will be sharing Chief Operating Officer's report with FP&I.
- Despite a close review of the extreme risks it was determined that the CQC inspection, quality of older people's care, nurse staffing and anaesthetics should remain 'red', although significant work is taking place in all areas.
- The National In-patient Survey was very disappointing in that we were worse than most Trusts in a number of areas and had deteriorated from the previous year. This reflected the position in July 2018, much work has been done and there are plans to address significant issues in the short-term.

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)

- Consultant Job Plans need a further iteration of scrutiny and feedback before they can be finalised.
- Fracture Neck of Femur performance can be improved by refinements to the pathway but the absence of recruitment is still a key issue.
- Pressure Ulcers – There will be a review of the target and reporting process.

ASSURE

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

- CQC Preparation is in accordance with plan.
- Southport & Ormskirk Nursing Assessment & Accreditation Scheme (SONAAS) – (nursing quality survey) is being rolled out with support from specialist Matrons, in particular recognising the potential for extra workload for pressured wards.
- Maternity CNST – Assurance was received in relation to the specific requirements of the 10 safety indicators which the Board has to report on to NHS Resolution.
- Safeguarding – Significant assurance was received in relation to the quality of adult and children safeguarding delivered by the Trust reflected in its unique representation at regional level.
- Research, Innovation & Development – The annual report reflected significant level of high quality research carried out in the Trust, a key indicator being that this Trust had kept its level of research funding despite the fact that many of our neighbours had had their funding cut.
- Freedom to Speak Up Annual Report reflected good progress and evidence that the workforce is more trusting of raising issues formally.
- Clinical Audit Annual Report – Evidence of significant areas of good practice despite the pressures within the organisation.
- Quality Account – The annual report considerable improvement from previous years, largely because there were far more good stories to tell.

New Risk identified at the meeting	• No new risks were identified at the meeting.
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)	

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 20th June 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)

Risk Register
'1368 - Safe Staffing Levels - Impact on Quality and Finance' risk remains as Extreme. There is disparity between the risk's narrative in the Assurance column of the HR Register and the Integrated Performance Report. It was suggested at the Committee to change the risk as the position has moved, as well as splitting the risk into nursing and medical staff.

'1881 - Appraisal Compliance' remains as a high risk. It was noted that the Trust doesn't have a developed campaign which looks into undertaking PDR's differently.

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)

Staff Engagement Strategy
A draft version of the Staff Engagement Strategy was brought to the Committee for comments and discussion. The membership were generally impressed by the work undertaken to produce the document and acknowledged that it is a starting point. They agreed that ownership of the document belongs to everyone and the next steps in communicating out are critical.

Safe Staffing
For the month of May 2019 the Trust reports safe staffing against the national average (90%) at 92.38% compared with 94.45% in April. Vacancies have increased.

Health and Wellbeing (HWB) Project
The Head of Human Resources and the Assistant Director of Health and Wellbeing have been invited to share their progress on the HWB Project with NHSI in London.

Time to Hire
The HR and OD directorate are focussed on Time to Hire and working closely with Model Hospital to improve their processes. A dashboard was reviewed at Committee which is focussed on the key metrics.

Sickness Absence
Sickness absence has slightly increased in month to 4.93% from 4.85% in April. The Trust must monitor levels closely and continue the focused work around improving and support staff's attendance to work.

ASSURE

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

Health and Wellbeing (HWB) Project
The Ward Manager on FESS, Brenda Lovett, attended the meeting and shared good

<table>
<tr><td colspan="2">practice on how she effectively manages sickness absence on her ward. The Committee commended her on their leadership skills and thanked her for her contribution to the Trust. The membership were focussed on how to share best practice and suggested some ideas including: inviting managers in high performing areas to present at Supporting Attendance policy training sessions.

Staff Survey
HR and OD have commenced their focus groups with staff to receive feedback on how the Trust can improve response rate in the Staff Survey. 66 staff provided feedback which will be included in the 2019 campaign.

E-rostering Workstream
NHSI have published the E-Rostering workstream undertaken in the organisation.</td></tr>
<tr><td>New Risk identified at the meeting</td><td>None.</td></tr>
<tr><td colspan="2">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)</td></tr>
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Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	TB132/19	**Report Title**	**Financial Positon at Month 2 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

This report contains the month 2 (May) performance against the plan submitted to NHSI on 4th April 2019.

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 for Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF).

In May a deficit of £1.4 million has been delivered against a plan of £0.6 million resulting in £0.8 million adverse against plan.

Year to date (YTD) a deficit of £3.4 million has been incurred against a plan of £2.5 million; an adverse variance of £0.9 million.

The £0.9 million adverse position is a combination of expenditure overspends and loss of income resulting from a compromise positions with commissioners.

The main commissioner contract with Southport & Formby CCG has been agreed. The contract with West Lancashire CCG's has not been agreed and there is a risk that income could fall below the levels declared in this report. Monthly pay expenditure levels incurred in Quarter 4 of 2018/19 were not budgeted for in the 2019/20 financial plan as they were mainly associated with non recurrent winter pressures. These higher expenditure levels have continued into both April and May and are not sustainable. The 2019/20 deficit control total will not be achieved unless this can be addressed.

The CIP programme delivered £88,000 in month, £140,000 YTD; this represents £879,000 of the £6.3 million target but is already £509,000 behind the month 2 YTD plan.

The Board is asked to note:-

- The Trust is significantly adverse from plan.
- Expenditure has not reduced from 2018/19 Quarter 4 levels.
- Contract discussions have not been finalised with West Lancashire CCG.
- Income is lower than initial plan due to elements of the income plan now only being paid once certain conditions have been reached.

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

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

Previously Presented at:

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

Director of Finance Report – May 2019

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 2 (the financial period ending 31st May 2019).

1.2. The report also includes an update on the 2019/20 contract discussions.

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 2 performance against the plan submitted to NHSI on 4th April 2019.

2.4. At month 2 a deficit of £1.419 million has been delivered against a plan of £0.601 million resulting in £818,000 worse than plan.

2.5. The year to date position is a deficit of £3.442 million against a plan of £2.502 million resulting in £941,000 worse than plan.

2.6. The contract with Sefton CCG's (Southport & Formby CCG and South Sefton CCG) has been agreed. The contract with West Lancashire CCG remains outstanding. Therefore, there is a risk that the month 2 position could deteriorate following contract agreement as income could be lower than plan.

2.7. The Southport & Formby CCG contract has £3.5 million "conditional income" attached. A material element of this has not been achieved in Month 2 YTD. This is a key component of the income underperformance.

2.8. Expenditure levels incurred in May were consistent with April and are not sustainable. The 2019/20 control total will not be achieved unless this can be addressed.

2.9. The 2019/20 CIP programme delivered £88,000 in month which was £284,000 lower than the £372,000 target.

2.10. The table below is the I&E statement for May:

I&E	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	164,965	28,271	27,726	(544)	14,461	13,997	(464)
PP, Overseas & RTA	1,090	182	138	(44)	91	77	(14)
Other Income	11,781	1,910	2,023	113	945	996	51
PSF/FSF	18,271	1,826	1,826	0	913	913	0
Total Income	**196,107**	**32,188**	**31,713**	**(475)**	**16,410**	**15,983**	**(426)**
Operating Expenditure							
Pay	(139,997)	(23,698)	(24,095)	(397)	(11,832)	(11,857)	(25)
Non-Pay	(52,290)	(8,963)	(9,029)	(66)	(4,163)	(4,538)	(375)
Total Expenditure	**(192,287)**	**(32,661)**	**(33,124)**	**(463)**	**(15,995)**	**(16,395)**	**(400)**
EBITDA	**3,820**	**(473)**	**(1,411)**	**(938)**	**415**	**(412)**	**(826)**
Non-Operating Expenditure	(12,149)	(2,052)	(2,048)	4	(1,028)	(1,020)	8
Retained Surplus/(Deficit)	**(8,329)**	**(2,525)**	**(3,458)**	**(934)**	**(613)**	**(1,432)**	**(818)**
Technical Adjustments	33	23	16	(7)	12	13	1
Break Even Surplus/(Deficit)	**(8,296)**	**(2,502)**	**(3,442)**	**(941)**	**(601)**	**(1,419)**	**(817)**

3. Business Cases

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

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

3.3. As described previously the SOC investment has been reduced to £2.3 million to account for in year slippage.

3.4. In month 2 the nurse establishment business case was funded into budgets at a cost of £1.769 million (note the funding for April and May has been funded in May's budget); £1.1 million of this was funded from the £2.3 million business case reserve.

3.5. Any further proposed investment of the £2.3 million will only be sanctioned providing the financial performance (including CIP) allows.

4. Income Performance

4.1. The income plan is £32.2 million YTD. Actual income is £31.7 million which delivers an adverse performance of £0.5M.

4.2. The contract settlement with Southport & Formby CCG has resulted in £3.5 million of "conditional income". This means that income cannot be counted until expenditure has been incurred and signed off by the System Board. The contract pays for additional activity above the baseline plan under a "blended tariff" arrangement

4.3. The current offer from West Lancashire CCG is circa £2 million below the Trust's view. As the Trust has not yet agreed a contract with the CCG then month 2 income is based on a PbR contract.

4.4. The main reason for being behind the income plan YTD is:

4.4..1. Elective activity is below plan

4.4..2. Not achieving any of the following conditional income elements of the contract:

- Best Practice Tariffs above 2018/19 levels
- Repatriation of elective activity
- No contingency incurred to date
- No contingency (other conditional) incurred to date

4.4..3. A&E, Non elective and Outpatients are all above plan

4.5. It is assumed that CQUIN (now 1.25%) will be received in full.

4.6. Sanctions for non-performance against operational performance standards are not applicable as the Trust has signed up to its control total.

4.7. As explained in section 3 it is likely that the Trust's income plan (and actual) will reduce as part of the contract discussions with West Lancashire CCG. Therefore, this income underperformance will worsen following contract sign off.

Commissioning for Quality and Innovation payments (CQUINS)

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

4.9. 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.

4.10. In month 2 the Trust has assumed full payment for the 1.25% CQUIN in the plan. CCG's have not yet notified the Trust of the schemes which will support the 1.25% so this has been accrued in month 2.

4.11. **Sanctions**

4.12. 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 May is £17,250. No sanctions have been brought into the month 2 income position as contract negotiations have not been finalised.

4.13. Had the Trust not accepted the control total CCG's could have applied sanctions totalling £262,370 in May (YTD £555,550).

5. Expenditure

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

5.2. Expenditure is overspent by £0.5 million.

5.3. As highlighted above nursing budgets in month 2 have been increased to reflect the nurse establishment business case (£1.8 million for the full year).

5.4. Despite this nurse budgets remain overspent (YTD £466,000) which is partially due to the additional escalation beds and A&E activity; high levels of agency spend are also contributing with non framework agencies still being used when necessary.

5.5. Medical budgets are £364,000 overspent at month 2 YTD, mainly within non consultant staff. The vast majority of this relates to decisions made in Quarter 4 which appear recurrent and are being incurred with significant bank/agency costs (£1.6 million YTD) at premium rates.

5.6. An analysis of the medical pay variance is being undertaken to understand the various constituent elements eg unfunded posts and posts that are vacant but filled with premium costs.

5.7. Total Agency spend is £995,000 in month 2 (Month 1 £970,000).

5.8. Total Bank spend £898,000 in month 2 (Month 1 £918,000).

5.9. 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 (£112,000).

6. Agency spend

6.1. The Trust spent £995,000 on agency staff in May (8.4% of the total pay bill) and is mainly across medical and nursing staff although spend on Admin & Clerical posts continues.

6.2. 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 and May.

6.3. 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 non framework agencies. There is evidence of continued non framework usage in June at the time of writing this report.

6.4. Nurse agencies spend for May was £397,000 with the main area being A&E (£150,000), medical wards (£86,000) and Ward 14A (£72,000).

6.5. Consultant agency spend in May (£279,000) was consistent with April. The key areas are General Medicine (£191,000) and anaesthetics (£75,000)

6.6. Other medical staff agency spend in May is £257,000. The key areas are General Surgery £57,000, General Medicine £77,000, A&E £31,000 and T&O £53,000.

6.7. 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.

7. Cost Improvement Plan (CIP)

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

7.2. The 2018/19 balance to FYE is in respect of schemes such as pathology that are spread across the financial year.

7.3. The CIP plan has now been changed following contract discussions. Following a £1.5 million loss of income from the contract discussions the plan will now mainly be dependent on expenditure reduction.

7.4. The table below illustrates the new targets with performance to date.

	Annual Plan £000	Annual Budget £000	Month 2 Budget £000	Month 2 Actual £000	Month 2 Var £000	YTD Budget £000	YTD Actual £000	YTD Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	249	6	(243)	413	6	(407)	47	49
19/20 Plan - Expenditure (non pay)	1,724	1,724	105	79	(26)	205	129	(76)	814	820
19/20 Plan - Income (other op income)	325	325	0	3	3	0	5	5	18	0
19/20 Plan - Income (BPT)	1,800	300	18	0	(18)	31	0	(31)	0	0
18/19 Balance to FYE	372	372	31	31	0	62	62	0	0	372
Total	6,686	6,686	403	119	(284)	711	202	(509)	879	1,241

8. Cash

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

8.2. 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. May's cash flow was originally sent on 8th April with a final version on 17th April.

8.3. The reason for the revision was to reduce the value of the required loan based on up to date cash flows.

8.4. The loan request for May was reduced from £2.324 million to £1.458 million.

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

8.6. Performance against the cash target in May was as follows:

Description	Target £000	Actual £000	Comments
Opening balance	2,500	4,389	Brought forward balance. April's balance higher than forecast due to paying March's national insurance bill in March (rather than April) and supplier payments being up to date.
Cash inflows	16,858	16,415	April's VAT return not submitted until end of May so monies not received in month. Slight reduction in CCG cash received in month.
Cash outflows	-18,358	-19,133	Some of the brought forward balance utilised to start making some progress against a backlog of high value Veolia invoices.
Closing balance	**1,000**	**1,671**	

8.7. The Board should note that although the Trust is accruing for PSF and FRF the first tranche of cash associated with this is not due until September 2019 and will only be in relation to the first quarter (£2,741,000)

8.8. As such the Trust will be seeking cash support from our local commissioners to minimise the impact of PSF and FRF timing issues.

9. Capital

9.1. Capital Resource Limit (CRL) for the financial year 2019/20 is £6.417m. Actual spend year to date (YTD) is £321,000 with a further £769,000 committed expenditure.

9.2. Actual spend in month 2 was low, although there was quite a lot of activity on the ongoing capital schemes in preparation for schemes starting in June and July.

9.3. Work has now started on the SDGH Ward Upgrades, with regular weekly technical meetings. A project board is planned and the first meeting will take place shortly.

9.4. The Spinal Isolation Part 1 Scheme was further delayed by the requirement for an asbestos survey. This has now been completed and contractor work onsite commenced June 18th.

9.5. The tender for the 6 Facet survey closed 10th June. Procurement evaluation of the tenders is not yet complete.

9.6. Windows 10 project has also commenced, with new PCs on order at the end of May, and Resus trolleys also on order at the end of Month 2, further progressing the investment in medical equipment.

9.7. The Capital Plan for the year was prepared and submitted in February 2019, since when a number of probable changes have become apparent:

9.7..1. Spinal Isolation tender was finally agreed at £232,000. With £150,000 budgeted for this year, there is a shortfall of £82,000.The additional funds required to complete this phase of the Spinal works will need to be found elsewhere within the capital plan for this year.

9.7..2. Pharmacy Robots replacement was included in the 2020/21 plan but may need to be brought forward to 2019/20.

9.7..3. A replacement car parking scheme was not included in the 2019/20 plan but has become increasingly urgent due to lost revenue when ticket machines and barriers are not operational. This is becoming more of a problem as time passes and so a scheme has been put out to tender which will close towards the end of June.

10. **Recommendations**

10.1. The Board is asked to receive the month 2 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	Month 2
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	7,176	7,230
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	1,707	1,705
Elective	199	227	194	178	221	179	212	189	138	180	175	179	144	187
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	2,368	2,504
Non Elective Non Emergency	211	226	237	255	261	273	239	233	285	241	254	262	75	78
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	15,075	15,501

NHS 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	164,965	28,271	27,726	(544)	14,461	13,997	(464)
PP, Overseas & RTA	1,090	182	138	(44)	91	77	(14)
Other Income	30,052	3,736	3,849	113	1,858	1,909	51
Total Income	**196,107**	**32,188**	**31,713**	**(475)**	**16,410**	**15,983**	**(426)**

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	14	14	0	7	8	1
Overseas Patients	90	15	6	(9)	7	4	(3)
RTA Income	916	153	118	(35)	77	65	(12)
Total Income	**1,090**	**182**	**138**	**(44)**	**91**	**77**	**(14)**

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	915	915	0	457	457	0
Income Generation	2,704	430	457	27	214	233	19
Services to Other Bodies	222	37	46	9	18	22	4
R&D	244	35	45	10	20	22	2
Other Income & Charges	3,118	492	559	67	236	262	26
PSF/FRF	18,271	1,826	1,826	0	913	913	0
Total Income	**30,052**	**3,736**	**3,849**	**113**	**1,858**	**1,909**	**51**

Operating income

Commissioning income - Income plan reduced to reflect 'Memorandum of Agreement' with Sefton; West Lancs contract based on PbR with no growth so could potentially reduce depending on the finalisation of the contract.

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 £1.48m and the provider sustanability fund of £346k at month 2 . Total £1.826m.

NHS
Southport and Ormskirk Hospital
NHS Trust

Staff Group	Staff Type	2018/9											2019/20	
		Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2
		Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000
Consultants	Substantive	1,275	1,302	1,346	1,258	1,346	1,319	1,299	1,319	1,395	1,324	1,118	1,238	1,239
	Bank	85	80	106	63	70	50	40	70	101	78	104	98	70
	Agency	131	86	69	96	109	110	154	187	179	206	272	279	279
	Total	1,491	1,468	1,521	1,417	1,525	1,479	1,493	1,576	1,675	1,608	1,494	1,615	1,588
Other Medical staff	Substantive	1,129	1,147	1,114	1,220	1,165	1,243	1,202	1,263	1,319	1,307	1,245	1,320	1,285
	Bank	97	155	136	157	129	129	163	142	137	115	167	165	167
	Agency	222	246	318	279	240	226	217	208	244	273	316	256	257
	Total	1,448	1,548	1,568	1,656	1,534	1,598	1,582	1,613	1,700	1,695	1,728	1,741	1,709
Nurses & Midwives	Substantive	3,529	3,567	3,588	3,879	3,600	3,628	3,604	3,570	3,703	3,672	3,388	3,955	3,816
	Bank	522	496	494	660	544	529	565	543	595	588	684	609	637
	Agency	181	156	191	250	291	367	294	262	427	415	436	372	397
	Total	4,232	4,219	4,273	4,789	4,435	4,524	4,463	4,375	4,725	4,675	4,508	4,936	4,850
Scientific, Technical &Theraputic	Substantive	1,268	1,252	1,272	1,375	1,320	1,331	1,330	1,307	1,320	1,319	1,271	1,453	1,370
	Bank	3	4	13	16	12	11	13	12	9	12	12	7	7
	Agency	18	13	22	17	17	16	20	15	12	8	14	4	8
	Total	1,289	1,269	1,307	1,408	1,349	1,358	1,363	1,334	1,341	1,339	1,297	1,464	1,385
Other Staff	Substantive	1,847	1,859	1,962	2,183	1,989	2,010	2,040	1,981	1,965	2,008	1,731	2,284	2,156
	Bank	27	30	34	37	24	31	7	28	27	19	34	38	17
	Agency	58	50	16	46	48	63	51	58	59	50	54	59	54
	Total	1,932	1,939	2,012	2,266	2,061	2,104	2,098	2,067	2,051	2,077	1,819	2,381	2,227
Reserves	Substantive	394	357	125	(199)	0	0	(35)	(184)	(232)	(798)	176	57	56
Apprenticeship Levy	Substantive	43	38	38	40	38	39	44	39	41	40	47	44	42
	Total	437	395	163	(159)	38	39	9	-145	-191	-758	223	101	98
Total Pay	Substantive	9,485	9,522	9,445	9,756	9,458	9,570	9,484	9,295	9,512	8,872	8,976	10,351	9,964
	Bank	734	765	783	933	779	750	788	795	869	812	1,001	917	898
	Agency	610	551	616	688	705	782	736	730	921	952	1,092	970	995
	Total	**10,829**	**10,838**	**10,844**	**11,377**	**10,942**	**11,102**	**11,008**	**10,820**	**11,301**	**10,636**	**11,069**	**12,238**	**11,857**

Non-Pay	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2
Supplies & Services Clinical	2,287	2,174	2,140	2,290	2,260	2,317	2,291	2,228	2,249	2,227	2,413	2,264	2,325
Supplies & Services General	186	222	183	182	222	204	214	200	203	199	212	186	172
Establishment Expenses	257	250	230	273	291	288	352	295	298	292	268	213	260
Premises & Fixed Plant	1,002	929	1,002	830	936	990	943	993	953	917	790	1,018	1,035
Miscellaneous	652	662	656	637	625	616	632	659	638	654	595	707	685
Services From Other NHS Bodies	268	239	280	251	269	279	293	209	287	253	328	103	61
Non Operating Expenditure	935	935	935	938	954	920	939	942	939	940	411	1,031	1,031
Total	**5,587**	**5,411**	**5,426**	**5,401**	**5,557**	**5,614**	**5,664**	**5,526**	**5,567**	**5,482**	**5,017**	**5,522**	**5,569**
Total Expenditure	**16,416**	**16,249**	**16,270**	**16,778**	**16,499**	**16,716**	**16,672**	**16,346**	**16,868**	**16,118**	**16,086**	**17,760**	**17,426**

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)

Staff Group	Staff Type	2018/19											2019/20	
		Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Consultants	Substantive	94	101	99	93	98	100	103	102	94	99	97	96	95
	Bank	5	5	6	3	2	2	2	4	4	5	5	5	5
	Agency	6	6	4	4	4	5	8	9	8	10	12	12	12
	Total	105	112	109	100	104	107	114	115	107	114	115	114	112
Other Medical staff	Substantive	195	186	193	198	203	207	207	215	218	224	222	221	221
	Bank	9	11	15	10	10	10	11	10	9	10	11	13	23
	Agency	18	21	26	21	19	18	19	18	21	24	28	20	10
	Total	223	219	235	229	231	235	236	242	249	258	261	254	254
Nurses & Midwives	Substantive	1,092	1,088	1,087	1,080	1,076	1,097	1,101	1,098	1,094	1,101	1,110	1,106	1,122
	Bank	167	160	185	206	158	161	171	161	172	176	208	178	185
	Agency	35	27	30	34	39	48	44	42	62	59	69	63	60
	Total	1,294	1,275	1,302	1,320	1,273	1,305	1,315	1,302	1,329	1,336	1,387	1,347	1,367
Scientific, Technical &Theraputic	Substantive	405	395	394	391	406	410	403	402	402	407	405	409	405
	Bank	1	2	3	4	4	3	2	2	2	3	2	2	2
	Agency	4	3	4	4	3	3	4	3	3	2	2	1	1
	Total	410	401	401	399	413	417	410	407	407	411	410	412	408
Other Staff	Substantive	756	764	764	764	772	775	774	771	760	772	773	810	802
	Bank	15	15	15	15	15	12	15	12	9	11	14	15	13
	Agency	8	7	7	8	7	9	14	11	7	10	8	8	10
	Total	779	786	787	787	794	797	803	793	777	793	795	833	825
Total Pay	Substantive	2,542	2,534	2,538	2,527	2,555	2,589	2,589	2,588	2,569	2,603	2,608	2,642	2,645
	Bank	197	193	225	237	189	187	200	190	198	205	240	213	228
	Agency	71	65	71	71	72	84	89	82	102	104	119	103	93
	Total	**2,811**	**2,792**	**2,834**	**2,835**	**2,816**	**2,860**	**2,878**	**2,860**	**2,868**	**2,912**	**2,967**	**2,959**	**2,966**

2019/20 notes

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital
NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	31/05/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	122,200	(867)	(559)
Other assets	966	1,148	182	96
TOTAL NON CURRENT ASSETS	**124,033**	**123,348**	**(685)**	**(463)**
CURRENT ASSETS				
Inventories	2,382	2,355	(27)	32
Trade and other receivables	11,678	14,542	2,864	2,172
Cash and cash equivalents	1,042	1,671	629	(2,718)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**18,568**	**3,466**	**(514)**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(26,108)	(3,337)	1,092
Provisions	(199)	(203)	(4)	6
PFI/Finance lease liabilities	(1,153)	(1,153)	0	0
DH revenue loans	(20,487)	(43,244)	(22,757)	(1,800)
DH Capital loan	(411)	(400)	11	0
Other liabilities	(1,025)	(950)	75	43
TOTAL CURRENT LIABILITIES	**(46,046)**	**(72,058)**	**(26,012)**	**(659)**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(53,490)	(22,546)	**(1,173)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**69,858**	**(23,231)**	**(1,636)**
NON CURRENT LIABILITIES				
Provisions	(207)	(196)	11	2
DH revenue loans	(82,953)	(63,505)	19,448	342
PFI/Finance lease liabilities	(13,831)	(13,716)	115	58
DH Capital loan	(1,000)	(800)	200	0
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(78,217)**	**19,774**	**402**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(8,359)**	**(3,457)**	**(1,234)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,214	0	0
Retained earnings	(112,432)	(115,889)	(3,457)	(1,234)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(8,359)**	**(3,457)**	**(1,234)**

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.

Although invoiced debt is reducing we are accruing income for PSF and FRF which is actually increasing the receivables figure.

There was a planned reduction in cash in the month as it was utilised to pay suppliers.

The movement in loans looks high but this is because two things are happening. First of all the Trust took out a loan of £1.458m and then one of our loans for £1.8m that was classified as non-current has been reclassified as current as it is due within 12 months.

The adverse movement on the balance sheet is consistent with the in-month deficit.

Source of information from Financial se\controlxxYY\balance sheets

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	2019/20 £'000	M2 YTD £'000			Ordered not yet received	Verbally agreed / letter of intent	Remaining Budget to Yr end £'000		
		Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	1,000	25	30	(5)	61		1,000	91	909
	Pharmacy Robots									
	Sub total MEDICAL DEVICES	**1,000**	**25**	**30**	**(5)**	**61**		**1,000**	**91**	**909**
IM&T	Electronic Patient Record Bluespier	111	55		55			111		111
	Electronic Patient Record PDS	69	12		12			69		69
	Electronic Patient Record Careflow	149				277		149	277	(128)
	Vitalpac	10						10		10
	Patient Service Signposting	184	46	184	(138)			184	184	
	eDMS Evolve	80		43	(43)			80	43	37
	Windows 10 Project	318				413		318	413	(95)
	Telephony System Replacement	50						50		50
	Baby Tagging	50						50		50
	Cyber Security	80	20	(3)	23			80	(3)	83
	Fixed Network Infrastructure	120	20		20			120		120
	PAS Replacement			6	(6)				6	(6)
	Data Storage Infrastructure	25						25		25
	Wireless Network Upgrade			1	(1)				1	(1)
	IM&T Contingency	450						450		450
	Sub total IM&T	**1,696**	**153**	**231**	**(78)**	**690**		**1,696**	**921**	**775**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	350						350		350
	6 Facet Survey	90	90		90			90		90
	Nurse Call System	100						100		100
	Upgrade Ventilation Plants	100						100		100
	Fire compartmentation	100						100		100
	Fire Precautions - Fire Doors	100						100		100
	Legionella Prevention	50						50		50
	Spinal Lift & Ramp	85						85		85
	Spinal isolation works	150	100		100	12	1	150	13	137
	SDGH Ward Upgrades	600						600		600
	Library Extension	145	80		80			145		145
	Capital Team	160	26	27	(1)			160	27	133
	CCTV	50						50		50
	UPS Theatre			1	(1)				1	(1)
	Southport A&E			1	(1)				1	(1)
	Sexual Health Accomodation			3	(3)				3	(3)
	Car Parking Scheme									
	Waste Management									
	EBME Lift									
	Endoscopy both sites									
	HR Move - Further Alterations to LRC									
	Sub total ESTATE IMPROVEMENT SCHEM	**2,080**	**296**	**32**	**264**	**12**	**1**	**2,080**	**45**	**2,035**
FACILITIES	Catering equipment	75	25	18	7			75	18	57
	Vehicle Replacement	50						50		50
	Sub total FACILITIES	**125**	**25**	**18**	**7**			**125**	**18**	**107**
	CONTINGENCY	**202**	**20**	**2**	**18**	**7**		**202**	**9**	**193**
	Capital plan excluding donations and IFRIC 12	**5,103**	**519**	**313**	**206**	**769**	**1**	**5,103**	**1,083**	**4,020**
OTHER	Donated assets	100		8	(8)			100	8	92
	GE Radiology equipment replacement programme (IFRIC 12)	1,214						1,214		1,214
	Sub total Donations and IFRIC 12	**1,314**		**8**	**(8)**			**1,314**	**8**	**1,306**
	TOTAL CAPITAL SPEND	**6,417**	**519**	**321**	**198**	**769**	**1**	**6,417**	**1,091**	**5,326**

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	**TB133/19**	**Report Title**	**Board Assurance Framework, Risk Appetite Statement & Risk Management Strategy**
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 (BAF) has been the focus of discussion at the last three Trust Board. At the June Board it was presented in conjunction with the Trust's Risk Appetite Statement and each risk owner assigned an overall Appetite to their risk as well as specific areas of risk within their overall strategic risk.

The last report of the BAF to the Board highlighted some areas of improvement; they were:

- Risk owners needed to be clear as to the difference between Controls and Assurances and ensure that they were appropriately populated
- Action plans to mitigate gaps in both controls and assurances needed to be made **SMART**: Specific/Measureable/Appropriate/Realistic and Time-bound.
- The gap which should show the number of linked risks from the Corporate Extreme Risk Register to be populated
- The number of linked incidents (Serious Untoward Incidents and Never Events) to be shown where applicable. (This would normally apply to Risk 1: *If quality is not maintained in line with regulatory standards, this will impede clinical outcomes and patient safety.*

These have been addressed. In addition, areas outlined in the BAF have been given definitions for clarity and avoidance of doubt. There has not been any change to the risk scores since the BAF was last presented at the Board and are summarised below. The Risk Appetite for each overall risk is also shown:

Risk No	Risk Title	Current Risk Score	Overall Risk Appetite	Risk Appetite Definition
1	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*	**12** **3x4** **(LxC)**	**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.
2	*If the Trust cannot achieve its key*	**16**	**OPEN**	Prepared to consider all

	performance targets it may lead to loss of services.	**4x4 (LxC)**		delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks
3	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*	**16 4x4 (LxC)**	**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
4	*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*	**12 3x4 (LxC)**	**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
5	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*	**12 3x4 (LxC)**	**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
6	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*	**15 3x5 (LxC)**	**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

The BAF risks areas are attached at **Appendix1.**

A lot of work has gone into refining the BAF but it is recommended that during July, August and September some further work be done by the Improvement Manager and the Senior Datix Analyst working with Executives to put the finishing touches to it including ensuring that this new BAF format is updated and monitored on Datix and extreme risks from the corporate risk register and SUIs are also linked via Datix. The BAF is next due at the Audit Committee in July and at the Board in October 2019.

As a result of the refresh of the strategic objectives, the principal risks for 2019/20,the adoption of a Risk Appetite Statement and the establishment of the Risk and Compliance Group, the **Risk Management Strategy** has had to be reviewed. The areas updated in the Risk Management Strategy are listed below:

- Replaced *Board to Ward Escalation* Diagram with the *Risk Management, Escalation and Assurance schematic* as shown in the Terms of Reference of the Risk and Compliance Group
- Removed *objectives* from Section 3 heading
- Inserted Integrated Governance Structure after Section 5 with introductory statement
- Added the Hospital Management Board's role in risk management/monitoring

- Inserted Risk Appetite Statement and moved section from the end of the document relating to Risk Appetite, to link with this.
- Inserted current risk scoring matrix and update the Consequence scoring matrix to correspond with the scoring matrix

The updated Risk Management Strategy is attached at **Appendix 2**.

Recommendation

The Board is asked to **review** the BAF scores and assigned risk appetite, make recommendations for change/improvement if applicable and **approve** the updated Risk Management 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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

Assessment **must** accompany the report)	☐ Strategy
Next Steps	
The Risk Management Strategy will be uploaded to the Trust's Intranet if approved.	
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

Risk Management Strategy 2018-2021

VERSION CONTROL	DATE	BY
Policy Author	**TBC**	Assistant Director, Integrated Governance
Version 6.0		
Reviewed by	**28th March 2018**	Interim Company Secretary
Date Approved	**11th April 2018**	Board of Directors
Version 6.1		
Reviewed by	**14 June 2019**	Company Secretary
Date Approved	**TBC**	Board of Directors
Mandatory Review date	**March 2021**	

VERSION 6.1 Amendments	
	• Replaced *Board to Ward Escalation* Diagram with the Risk Management, *Escalation and Assurance schematic* as shown in the Terms of Reference of the Risk and Compliance Group • Removed *objectives* from Section 3 heading • Inserted Integrated Governance Structure after Section 5 with introductory statement • Added the role of the Hospital Management Board's role in risk management/monitoring • Inserted Risk Appetite Statement and moved section from the end of the document relating to Risk Appetite, to link with this. • Insert current risk scoring matrix and update the Consequence scoring matrix to correspond with the scoring matrix

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1. Introduction

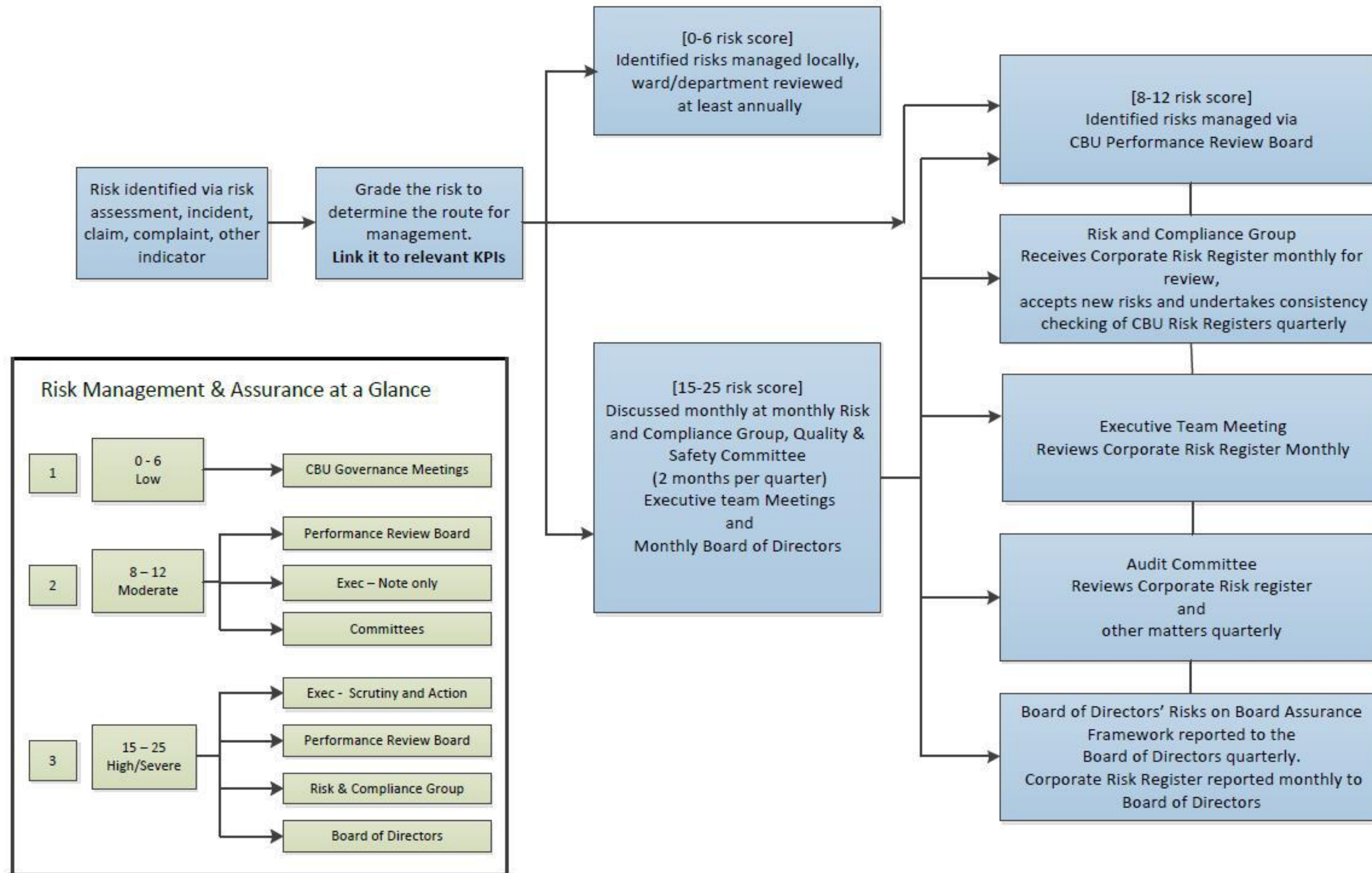
Risk Management is an integral part of Southport and Ormskirk Hospital NHS Trust management activity and is a fundamental pillar in delivering the Trust vision of ***providing safe, high quality services*** for the people of Southport and Ormskirk. As a complex organisation delivering a range of services in a challenging financial environment we accept that risks are an inherent part of the everyday life of the Trust. Effective risk management processes are central to providing Southport and Ormskirk Hospital NHS Trust Board with assurance on the framework for clinical quality and corporate governance.

Southport and Ormskirk Hospital NHS Trust is committed to a Risk Management Strategy which minimises risk to all of its stakeholders through a comprehensive system of internal controls, whilst maintaining the potential for flexibility, innovation and best practice in delivery of its strategic objectives around delivering high quality care. The *Risk Management Strategy* provides a framework for taking this forward through internal controls and procedures which encompass strategic, financial, quality, reputational, compliance and health & safety risks. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient-centred services that achieve excellent results and promote the best possible use of public resources, through an integrated approach to managing risks from all sources.

The strategy also seeks to support consistency and standardisation through the gathering and dissemination of intelligence on risks and mitigation control measures amongst all staff.

The Risk Management Strategy should be read in conjunction with the Risk and Compliance Group's Terms of Reference which includes the process to identify and manage local risks and the systematic means by which these local risks are escalated to Board level attention through the Trust Risk Register and how risks are controlled and monitored as shown at **Figure 1** below:

Figure 1



Risk is an inherent part of the delivery of healthcare. This Risk Management Strategy outlines the Trust's approach to risk management throughout the organisation

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them.

Southport and Ormskirk Hospital NHS Trust is committed to developing and implementing a Risk Management Strategy that will *identify, analyse, evaluate and control* the risks that threaten the delivery of its strategic and other objectives.

The Board Assurance Framework (BAF) will be used by the Board and its committees to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as integrated performance reports, quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

The Trust's strategic objectives 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 are 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**

The Trust believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, it is also significant in the financial and business planning process where a successful and competitive edge and public accountability in delivering health services is required. This illustrates that risk management is the responsibility of all staff.

The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks. This risk assessment process is described in more detail in the Trust *RM026 Risk Assessment and Risk Register Process Policy.*

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust values which are:

Supportive ***Caring*** ***Open and Honest***

Professional ***Efficient***

The Risk Management Strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding on risk appetite..

The Trust Risk Management Strategy is built around the following statement:

"Southport and Ormskirk Hospital NHS Trust is committed to the control of risks in a structured and organised manner to ensure that risks can be eliminated, reduced and /or controlled to an acceptable level thereby improving the experience and safety of patients, visitors and staff. This commitment is commensurate with the Trust's objective to "deliver high quality, well-performing services."

2. Definitions

Risk is defined as '*the chance of something happening, or a hazard being realised that will have an impact upon objectives'* (NPSA). It is measured in terms of consequence and likelihood.

Risk management therefore encompasses:

The process of minimizing risk to an organisation by developing systems to identify and analyse potential hazards to prevent accidents, injuries and other adverse occurrences, and by attempting to handle events and incidents which do occur in such a manner that their effect and cost are minimised. (MeSH 2009 cited in Dückers 2009, p.1)

Effective risk management can therefore be described as a systematic process for pro-actively identifying risks and opportunities, by assessing and removing the uncertainty they pose whilst minimising their potential consequences, likelihood and impact on the achievement of strategic objectives.

Effective management of operational risks is very important here as this refers to the robust mitigation of risks associated with the delivery of key business processes and high quality patient-centred care within a safe environment. Operational risks may include:

- Clinical Risks: These are risks which relate to the provision of high quality patient-centred care e.g. Medication Errors, Patient Falls, and Patient Safety Risks
- Non-clinical Risks: These are risks associated with the environment in which patient care takes place including the use of facilities by staff, patients, contractors and other visitors e.g. Health and Safety Risks, Financial Risks, Reputational Risks, Information Governance Risks etc.

Risk can mean different things in different contexts. For the purposes of this Strategy and the associated operational procedures, the risks faced by the Trust have been refined into four (4) categories. Boundaries between the categories are not always clear and some risks may fall into more than one category:

Quality	These relate to risks which would impact on: • Patient safety and experience • Clinical outcomes • Compliance issues, for example, meeting statutory and non-statutory standards set by the Care Quality Commission, NICE, the NHS Resolution (formerly NHS Litigation Authority) and other regulatory or enforcement bodies • Reputational risks for example events which may damage the credibility or good name of the Trust

Health & Safety	These relate to risks which would impact on: • Infrastructure • Employee safety • The safety of visitors to the trust's premises • Compliance issues, for example, meeting statutory and non-statutory standards set by health and safety executive and other regulatory or enforcement bodies such as the Information Commissioner's Office and local fire authority
Strategic	These relate to risks which would impact on the long term strategic objectives of the Trust, which may be affected by legal and regulatory changes and changes in the business environment
Financial	These relate to risks which would impact on: • Income • Expenditure • Fulfilment of contracts • The correct application of standing orders, standing financial • instructions and the scheme of delegation

3. Strategic Aims of the Strategy

The Trust's key aims are to manage risks where they occur as part of normal line management responsibilities, and appropriately prioritise resources to address risk issues through the operational management and business planning processes.

Strategic aims for the Risk Management Strategy are;

- Compliance with relevant statutory, mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission (CQC)
- Consistent and effective risk management processes at all levels of the organisation
- Open culture where people feel encouraged to take responsibility for minimising risks
- The development of a learning culture to support improvements to the safety of services
- Integration of risk management into business processes, such as ensuring service developments, do not adversely impact on safety

Specific objectives for **2018** to **2021** are set out below. These objectives will be reviewed annually by the Quality and Safety Committee, Audit Committee and Board of Directors, Progress against them will be assessed six monthly by the above. They are:

- To maintain compliance with regulatory requirements
- To ensure robust governance arrangements and structures are in place
- To strengthen the incident and Serious Incidents investigation process so that investigations and actions are more robust.

Other key aims of the Strategy will be to:

- provide the highest quality care without risk to the health of those involved and within resource allocations;
- understand the risks that the Trust faces, their causes and measures to control them so that resources can be appropriately directed;
- enhance the Trust's stakeholder confidence;
- ensure that the Trust is compliant with statutory and regulatory requirements;
- achieve best value for money, thereby maximising resources for patient services and care;
- minimise the total cost of claims and other losses to the Trust through negligence and fraud and ensure that lessons are learned and changes in practice are implemented;

- encourage and develop risk management as an integral part of the Trust's culture; and ensure links to the strategic objectives;
- Clearly define the organisational arrangements to promote Clinical Business Units (CBUs)/ Business Units (BUs) and the individual's responsibilities in order to maintain an active risk register which is reviewed, monitored, and updated to ensure that actions are implemented to control, reduce and/or eliminate identified risks.
- Ensure that the *Board Assurance Framework* is utilised by the Trust Board as a planned, systematic approach to the identification, assessment, and mitigation of the risks that could hinder the Trust achieving its strategic objectives, providing assurances that the risks are being adequately controlled.

4. Scope

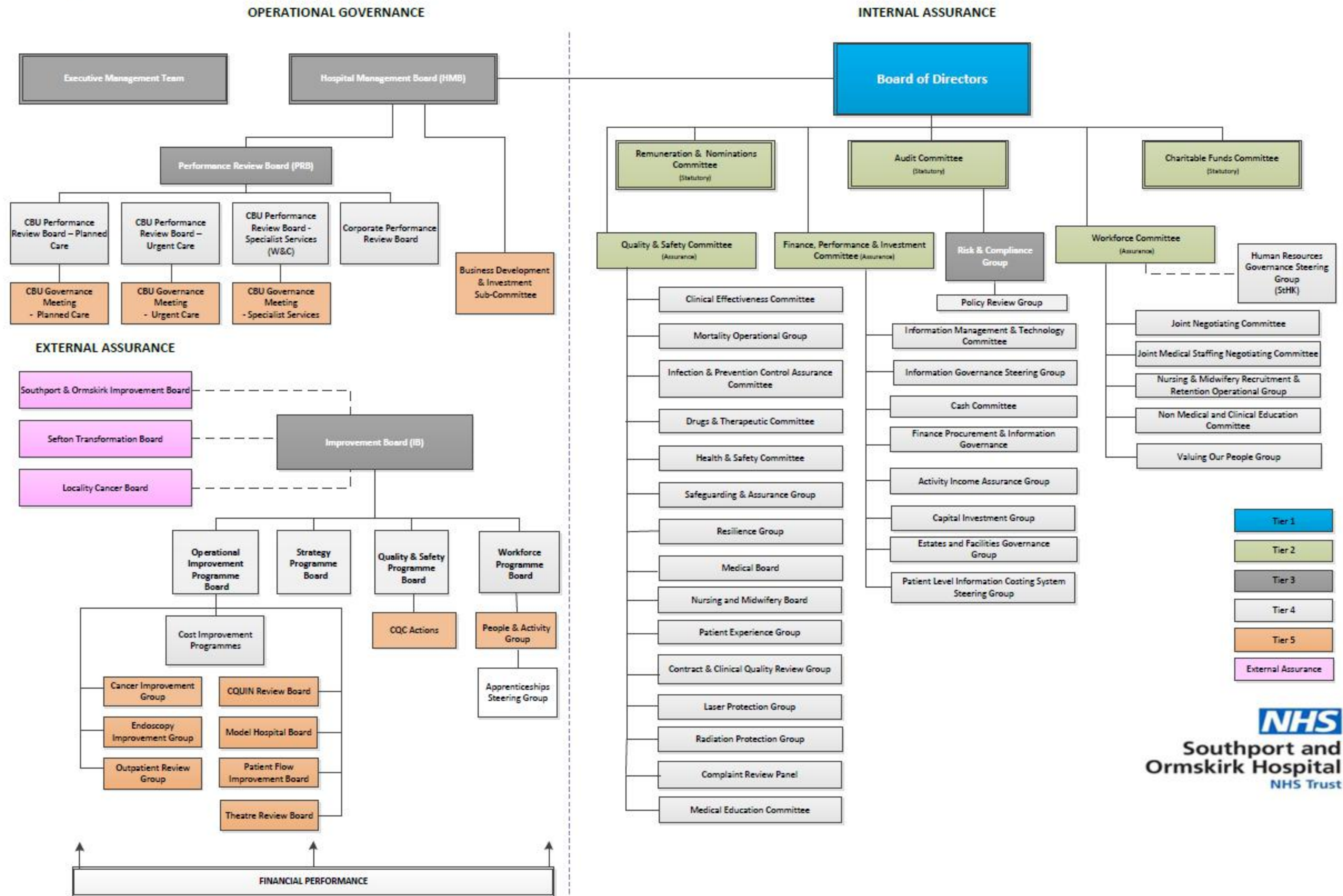
The objective of the *Risk Management Strategy* is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

The strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined in this strategy.
Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance.

Our Integrated Governance Structure sets out our approach to governance and escalation and informs the role of senior officers, committees and the Board in risk management. **See Figure 2**

Figure 2



5. Organisational Risk Management Approach and Responsibilities

All staff members in the Trust have responsibilities relating to risk management. The key risk management responsibilities are documented below:

Role	Responsibility
Chief Executive Officer	The Chief Executive Officer, as "*Accountable Officer*" has overall accountability and responsibility for risk management within the Trust, ensuring the implementation of an effective risk management system.
Executive Directors with Specific Responsibilities for Risk Management	The Executive Director of Nursing and the Company Secretary or equivalent have responsibility to ensure that the Trust has a robust Risk Management Strategy and Policy in place, integrated with the Trust's strategic objectives and governance structure. The Executive Medical Director has a responsibility to work with the Executive Director of Nursing and the Company Secretary or equivalent on all aspects of risks-clinical and corporate.
Executive Director of Finance/Senior Information Risk owner (SIRO)	The Director of Finance has overall responsibility for overseeing management of financial risks and advising the Trust Board of their implications directly and through the Audit Committee and the Finance, Performance and Investment Committee and ensuring that financial risks are clearly listed in the Board Assurance Framework.
Executive Directors / CBU Triangles (Associate Directors, Associate Medical Directors, Head of Nursing/Service)	These staff are responsible for the implementation of the risk management strategy and policy at corporate and service level including the establishment and continuous management of CBU and Directorate risk registers. They are responsible for managing risk within their Directorates and CBUs.
Company Secretary or equivalent	The Company Secretary or equivalent is responsible for development, monitoring and maintenance of the Board Assurance Framework (BAF) document and the management of corporate risks. The Company Secretary or equivalent will also undertake the role of Data Protection Officer (DPO) which is one of several nationally recognised controls to strengthen data handling and ensure accountability of information risk.
Assistant Director Integrated Governance	The Assistant Director, Integrated Governance supports the Executive Director of Nursing to review, develop and embed the Risk Management Strategy and policy across the Trust to ensure that there is an effective risk management system in place.
All Staff	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to agency staff.
Board of Directors	The Board of Directors is accountable and responsible for ensuring that the Trust has an effective process in place for identifying and managing all types of risk. The Board of Directors receives and considers reports from its committees as necessary.
Quality & Safety Committee	The Committee is established to provide assurance to the Trust Board on all aspects of quality and safety within the organisation. The Committee will operate as an oversight and scrutiny body recognising that the Executives are responsible for day to day

	operational delivery and management.
Finance, Performance and Investment Committee	The Committee is established to provide assurance to the Board on all aspects of finance, performance and integrated governance. The Committee will operate as an oversight and scrutiny body recognising that the Executives are responsible for day to day operational delivery and management.
Workforce Committee	The Committee is established to provide assurance to the Board on all aspects of workforce and organisational development. The Committee will operate as an oversight and scrutiny body recognising that the Executives are responsible for day to day operational delivery and management.
Audit Committee	The Audit Committee is a committee of the Board and is responsible for providing an independent and objective view of internal control and integrated governance.

6. The Board, Statutory and Assurance Committees with Overarching Responsibility for Risk Management

The high level committees with overarching responsibility for risk management are:
The Trust Board is responsible for establishing strategic objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and through the Trust Risk Register.

The Audit Committee, on behalf of the Board, reviews the establishment and maintenance of an effective system of internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives and also ensures effective internal and external audit.

The Quality and Safety Committee (QSC) provides assurance to the Trust Board that there are adequate controls in place to ensure high quality care is provided to the patients using the services provided by Trust.

The Finance, Performance and Investment Committee (FP&I) is responsible for scrutinising aspects of financial and other performance as requested by the Board. It will conduct detailed scrutiny of major business cases and proposed investment decisions on behalf of the Board and will regularly review commissioning contracts.

The Hospital Management Board (HMB) monitors risks as they impact on the operations of the Clinical Business Units and their link with corporate risks and the Board Assurance Framework (BAF).

The Executive Management Team (EMT) is the core leadership team for the Trust, and is responsible for developing, maintaining and supporting appropriate leadership behaviours and visibility within the Trust. It is responsible for ensuring the fullest clinical contribution to determining the strategic direction and its operational delivery.

The Committee monitors the delivery of the organisation's operational, quality, financial and performance targets, ensuring corrective strategies are agreed where required. It will:

- Implement this Strategy and in doing so encourage and foster greater awareness of risk management throughout the Trust
- Routinely review the Trust Risk Register.

- Ensure systems are in place to support delivery of compliance with legislation, mandatory NHS Standards, NHS Improvement, Care Quality Commission, NHS Resolution and other relevant bodies.
- Identify risks to compliance with the various statutory bodies.
- Monitor past and future external visits and any action plans in place to respond to any risks.
- Oversee implementation of the Trust wide policy management process.

7. Risk Management Policy Statement

Within the context of this commitment, the Trust will comply with all statutory and mandatory requirements creating the management arrangements and environment which recognises the management of risk as a key organisational responsibility. This requires that all managers and clinicians accept the contents of the strategy statement and the principles of risk management as one of their fundamental duties.

In addition, every member of staff will be encouraged to recognise their personal obligations and responsibilities for identifying and minimising risks. This requires a robust and on-going process whereby risks are not only identified but also assessed with the objective of securing improvements to service delivery and practices. The reporting of serious incidents, near misses, and errors is fundamental to this purpose.

The Trust has therefore adopted the following risk management statement and it is upon this that the Risk Management Strategy is based:

"Southport and Ormskirk Hospital NHS Trust is committed to the control of risks in a structured and organised manner to ensure that risks can be eliminated, reduced and /or controlled to an acceptable level thereby improving the experience and safety of patients, visitors and staff. This commitment is commensurate with the Trust objective to "deliver high quality, well-performing services."

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

Senior management will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

All Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks.

Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally

There will be active and frequent communication between staff, stakeholders and partners.

8. Compliance and Assurance

NHS Improvement (NHSI) has implemented a 'Single Oversight Framework' to ensure there is a clear compliance framework which ensures that all Trusts are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

The Board Assurance Framework (BAF) is designed and operates to meet the requirements of the *Annual Governance Statement*. The BAF, which is board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved.

The BAF is determined by the Board of Directors and is approved by the Trust Board. It is the means by which the Board holds itself to account and identifies the principal risks that could prevent the Trust delivering its strategic objectives and therefore the operational plan. It also provides a structure for the evidence to support the Chief Executive's *Annual Governance Statement (AGS)* within the *Annual Report.* The BAF maps out the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive either directly or via its statutory and assurance Committees (Audit; Quality & Safety; Nomination & Remuneration; Finance Performance & Investment (FP&I) and Workforce & Organisational Development) to evidence the effective operation of these controls.

There is a clear process for escalating high or significant risks to the Board. The Trust has introduced a Risk and Compliance Group designed to Ensure there is an effective and comprehensive system in place for pro-actively managing compliance Trust-wide and within each Corporate Business Unit through compliance and regulation registers. This includes developing and maintaining systems for the regular evaluation and monitoring of compliance and regulation against any relevant internal and external audit recommendations, external assessments (e.g. Care Quality Commission (CQC)), accreditations, service reviews, standards and criteria; as directed by the Board of Directors. Compliance registers will be reviewed at every other meeting of the Group, Policy Management, compliance with Provider Licence and Annual Governance Statement. The Escalation Schematic above illustrates the Groups approach to monitoring risks.

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

The Trust will develop measures for different categories of risk. For example it may inform a project to know what level of delay or financial loss it is permitted to bear, in the addition to using measures described in the *'Risk Matrix Severity definitions'* to define the likelihood and impact of risks; this can be used to define the maximum level of risk tolerable before action should be taken to lower it [Risk Appetite]. By defining its risk appetite, the Trust can arrive

as an appropriate balance between uncontrolled innovation and excessive caution. It will be used to guide managers on the level of risk permitted and encourage consistency of approach across the Trust, and ensure that resources are not spent on further reducing risks that are already at an acceptable level. See **Figure 3** below:

Figure 3 - Risk Appetite Statement

	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.

Allied to the management of risk is learning from situations. Sharing the learning through risk related issues, incidents, complaints and claims is an essential component of maintaining the risk management culture within the Trust. Learning is shared through Clinical Business Units Meetings and Trust wide Forums such as the Quality and Safety Committee and Clinical Excellence Committee. Learning is acquired from a variety of sources which include:

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

The Trust's goal is to be able to demonstrate this with practical examples of how working practices have changed as a consequence of good risk management.

9. Ensuring Compliance with National Standards

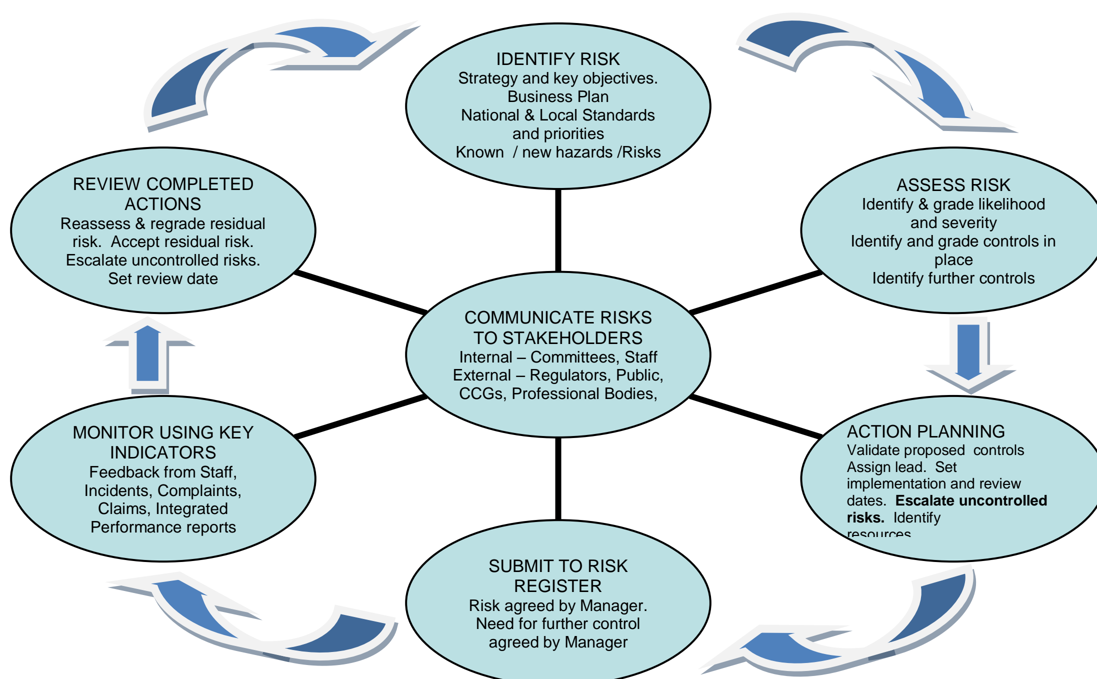
The Risk Team is responsible for facilitating and ensuring compliance with core risk standards this includes working in collaboration with the Assistant Director of Quality to ensure compliance with the Care Quality Commission outcomes, and formulates and monitors action plans pertinent to risk and the Assistant Director of Integrated Governance to ensure compliance with Health & Safety.

10. Risk Management System

The Institute of Risk Management defines Risk Management as: "*the process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure".*

Figure 4 below shows, risk management involves the identification, analysis, evaluation and treatment of risks or more specifically recognises which events may lead to harm and therefore minimising the likelihood (***how often***) and consequences (***how bad***) of these risks occurring. This risk assessment process is described in more detail in the Trust's *RM026*

Figure 4 – Risk Management Process.



Identifying Risks

The Trust has a standardised risk assessment tool to provide structure and a systematic approach to risk assessment however the content of each assessment may vary and will depend on the nature of the undertaking and the type and extent of the hazards and risks. Risks facing the organisation will be identified from a number of sources, for example:

- Risk arise out of the delivery of day to day work related tasks or activities.
- The review of strategic or operational ambitions.
- As a result of an incident or the outcome of investigations.
- Following a complaint, claim or patient feedback.
- As a result of a health and safety inspection/assessment, external review or audit report.
- National requirements and guidance.

11. Analysing/Assessing Risks

Risks and hazards are identified on a daily basis throughout the Trust by all staff members and the risks/hazards will vary significantly in consequence/severity and likelihood and hence the measures for addressing them will also vary. The purpose of assessing and scoring a risk is to estimate the level of exposure to a particular risk, which will then help to inform where responses to reduce or better manage a risk can be taken.

12. Risk Evaluation and Scoring

Risks are scored using a risk scoring matrix. The Trust has adopted a 5x5 matrix with the risk scores taking into account the impact and likelihood of a risk occurring. Each risk is assessed by estimating the likelihood of a risk happening and multiplying it by the impact of the risk if it did happen. The method for calculating these can be found at Figures 4, 5 and 6.

Trend shows the movement compared to the previous review – rising, stable, or reducing, and will be represented by an appropriate arrow.

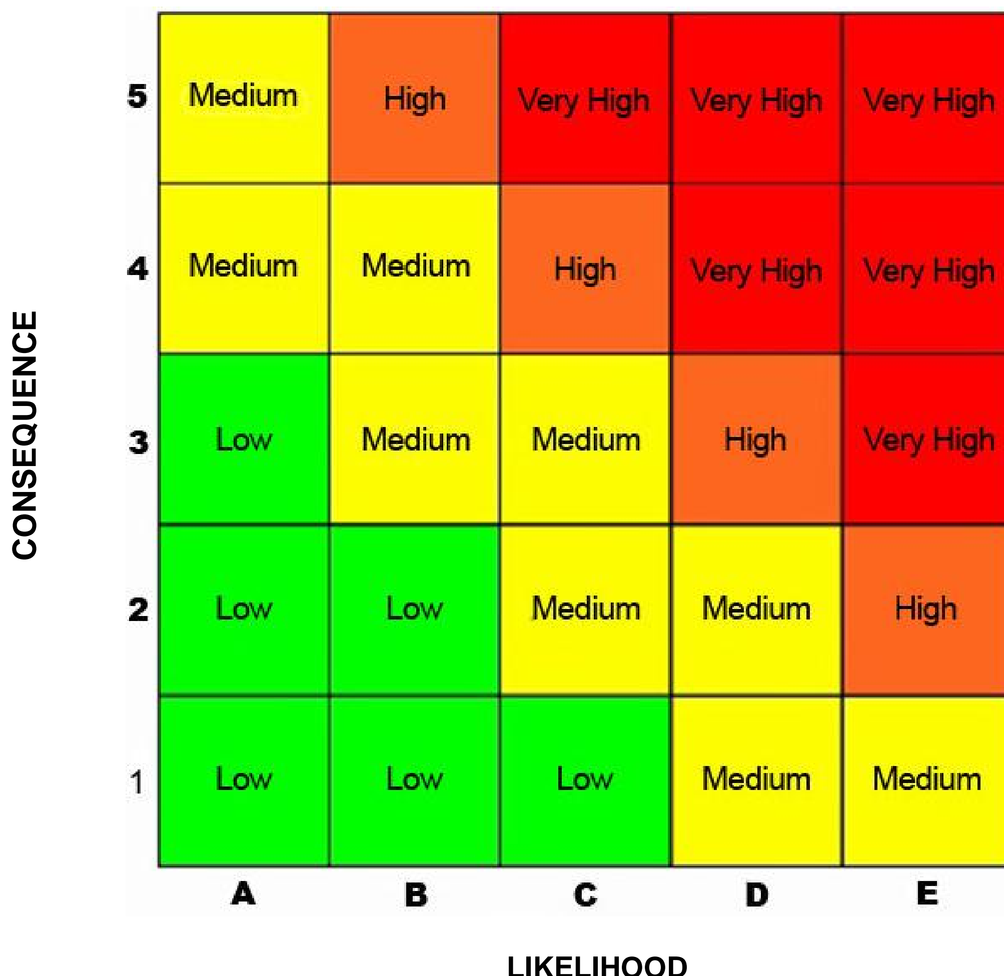
Review Date should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.

Risk Target is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to. When deciding the risk target, consider the following:

- What risk rating should an individual risk be managed down to in an ideal world?
- What level can the risk actually and practicably be managed down to? Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
- Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?

Having considered the above, assign the risk target a colour that best represents what is possible and practical to manage it down to, using the existing risk matrix.

Figure 4 – Risk Matrix



LIKELIHOOD

The risk scoring system is set out below at Figures 5 and 6:

Figure 4 - Likelihood (L) of Occurrence:

Rating	Description	Narrative
1	Rare	Highly unlikely, but it may occur in exceptional circumstances. It could happen but probably never will.
2	Unlikely	Not expected but there is a slight possibility it may occur at some time.
3	Possible	The event might occur at some time as there is a history of casual occurrence at the Trust or within the NHS.
4	Likely	There is a strong possibility the event will occur as there is a history of frequent occurrence at the Trust or within the NHS.
5	Almost certain	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the Trust or within the NHS.

Figure 5 - Consequence (C) of possible outcome

Domains	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Impact on the safety of patients, staff or public (physical/ psychological harm).	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional Intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 Days RIDDOR/agency reportable incident An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects A serious event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national

Domains	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
		Reduced performance rating if unresolved	Standards Major patient safety implications if findings are not acted on		standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Domains	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of Statutory Legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 % over project budget Schedule slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Domains	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25percent of total revenue budget Claim up to £10,000	Loss of 0.25–0.5 per cent of total revenue budget Claim(s) between £10,000 and £50,000 Debtor Invoice - <500k	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of total revenue budget Claim(s) between £50,000 and £100,000 Debtor Invoice ->500k	Non-delivery of key objective/ Loss of >1 per cent of total revenue budget Failure to meet specification/ slippage Claims - > £100,000 Loss of contract / payment by results Claim(s) >£1 million Debtor Invoice >1 million
Service/business Interruption **Environmental impact**	Loss/interruption of >1 Hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

13. Controls and Mitigation (Action Planning)

When considering the likelihood of a risk occurring, staff need to develop and consider the actions that can be put in place this may include consideration of the avoidance of risk – by not proceeding with an action which can produce the risk, reduction of the likelihood or impact of the risk occurring, transfer of a risk to another party or removal or elimination of the risk.

These plans to avoid or reduce risk are more commonly referred to as the risk action plan and are held on **DATIX** which is the system used to record risks within the Trust.

14. Assurance on Controls

Assurances on controls are the methods by which the organisation measures the effectiveness of the controls in place.

Assurance on the effectiveness of the controls is provided at all levels of the organisation through;

- Internal and external audit of control mechanisms
- Key Performance Indicators
- Benchmarking and Peer reviews
- Performance review processes
- Self-assessment and internal challenge

A key element of the Trust's risk management system is providing assurance that we manage risks effectively by ensuring the effectiveness of controls and actions being put in place to mitigate the impact of any risks.

15. Risk Registers

The Trust has a number of risk registers which are a log of risks of all kinds which threaten the delivery of services or objectives. It should be a live document which is populated through the risk assessment process. Risk registers operate at all levels in the Trust – at local level, CBU / BU level and Corporate level and are held on DATIX which is the system used to record risks within the Trust.

16. Board Assurance Escalation Framework

The Assurance Escalation Framework document contains information regarding internal and external assurances that organisational strategic domains are being met. Where risks to the organisational strategic domains and themes from the corporate risk register are identified, mitigations and subsequent action plans are mapped against them. The Assurance Framework will be used to inform the production of the Annual Governance Statement and will be interrogated by the Trust Board on a quarterly basis each year and quarterly by the Audit Committee.

17. Monitoring

Element to be Monitored	Lead	Tool	Frequency	Reporting	Lead for Actions
Objectives	CEO	Review progress in achieving objectives via BAF and Risk Register	6 monthly	Executive Management Team (EMT)	Company Secretary or equivalent (CoSec)
Governance structure – Risk Management Strategy: • The organisation's risk management structure, detailing all those committees and groups which have some responsibility for risk • How the board or high level risk committee(s) review the organisation-wide risk register • How risk is managed locally • Duties of the key individuals for risk management activities	CEO	Review of committee structure and Terms of Reference	Annually	EMT/Audit/ QSC/FPI/ Board	Director of Nursing/ Company Secretary or equivalent
Governance structure - TORs for the statutory and assurance committees committee(s) with overarching responsibility for risk: • Duties • Who the members are, including nominated deputies where appropriate How often members must attend • Requirements for a quorum • How often meetings take place • Reporting arrangements into the high level risk committee(s) • Reporting arrangements into the board from the high level risk committee(s)	CoSec	Terms of Reference of Board Committees are reviewed at least annually Annual reports for each committee reporting to EMC demonstrate-ing compliance with terms of reference, reporting and attendance.	Annually Annually	Board EMT	Company Secretary or equivalent Committee Chairs/ CoSec

Risk management process: • How all risks are assessed • How risk assessments are conducted consistently • Authority levels for managing different levels of risk within the organisation • How risks are escalated through the organisation	DoN/ CoSec	Review of risk management process /Audit	Annually	EMT	CoSec/ DoN
Board Assurance Framework	CoSec	Review of BAF risks and actions progress/ Audit	Quarterly	Board	CoSec

18. Education and Training

The Clinical Governance Team provides a programme of training in the use of risk assessment techniques to nominated risk assessors in the Trust. Risk awareness training is also provided at induction and mandatory training.

19. Dissemination

This Strategy will be circulated to all staff and uploaded onto the staff and public website.

20. Links to other policies

In order to support the risk management processes the Trust has systems in place to facilitate the management of risk in the organisation and they are described in detail in the following policy documents:

RM 06	Policy for Reporting and Management of Incidents (Including Serious Incidents, never Events and information Incidents).
RM 10	Policy and Procedure for Handling of Clinical Negligence/Employers and Public Liability Claims
RM 19	Concerns, Complaints and Compliments Policy
RM 22	Policy for Central Alerting System (CAS)
RM 24	Being Open and Duty of Candour Policy.
RM 26	Risk Assessment and Risk Register Process Policy
Corp 69	Freedom to Speak up: Raising Concerns Policy

21. Review

In order that this Strategy remains current, any appendices attached to the Risk Management Strategy can be amended and approved during the life time of the Strategy, without the entire document having to return to the Trust Board for approval. The Strategy will be reviewed and ratified every three years by the Trust Board or sooner if there are significant changes to policy at a national level.

Monitoring how this Strategy is working in practice

What key elements will be monitored? (measurable policy objectives)	All aspects of the Strategy
Where is this described in policy?	Section 13
How will they be monitored? (method + sample size)	Review of BAF and Risk Register
Who will monitor?	Executive Team
How Frequently?	Quarterly
Forum/Committee that will receive and review results	Internal Audit (MIAA), Audit Committee
Forum/Committee to ensure actions are completed	Executive Team, Audit Committee and Board of Directors
Evidence this has happened	MIAA Annual Audit Report on Risk Management; Reports and Minutes to Audit Committee, Quality and Safety Committee and Board of Directors -quarterly

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
3 July 2019

Agenda Item	**TB133/19c**	**Report Title**	**Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Senior Information Analyst & Datix Lead Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

- **2052** – Older People's Care. This risk is a replacement for risk 1917 (Quality of Older People's Care) and incorporates a greater breadth of risk, actions and quality improvement programme work.

Since the last meeting, no 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
- **2052** - 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

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

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

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

Previously Presented at:

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

JUNE 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 25/06/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-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	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	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↘	Risk Closed - replaced with Risk 2052 ⇓
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	12↓	=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	=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↓	=16
2052	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Older Peoples Care	Director of Nursing & Quality						!16

TRUST RISK PROFILE AS AT 25/06/2019

	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 2052 - Older Peoples 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	SO2

Opened	ID	ADO/Exec Lead	Risk Lead	Title
20/06/2018	1862	Director of Nursing & Quality	Fiona Barnes	Maintaining safe quality nursing care with current level of nursing & HCA vacancies

Description	If levels of Nurse & HCA staffing remains below funded establishment due to vacancies then patients may experience poor quality of care (safety & patient experience).

Controls		Gaps in 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 Tier 2 nurse agency in place		No formal Safety Huddle at w/ends Establishment review not undertaken on a 6 monthly basis with recommendations to the TB NHSp contract for review in 6 months T&F group for Retention with a focus on Recruitment, supported by NHSI Workforce Plan to be developed following Establishment review See risks 1132, 278 and high risk 1368.

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	12/06/2019	22/07/2019

Assurance		Gaps in Assurance	
	Workforce data (sickness & AL) Dedicated H roster Lead for N&M Establishment review process SOP ratified by HMB - May 2019 2 weekly E roster meetings & dashboard in place CQC inspection Monthly staffing report mandatory training Complaints Incident reporting Quality and safety reports Bi annual staffing reports		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		Action Plan Due Date		Action Plan Rating	
	Full details in smart-sheets - E roster compliance Prioritise template upload Clarify capacity to upload templates for new NER Continue 2 weekly meeting with HoN/M & Matrons		27/12/2019 27/12/2019 31/12/2020 31/12/2020 31/12/2020		Moderate Progress Made Moderate Progress Made Moderate

	NER - detailed plans on smart sheets - Model Hospital Understand current data submission Review Model hospital for S&O data Assess opportunity for savings based on new data Smart sheets has detailed plan - Finance. Upload budgets Inform Wd managers/Matrons of final e roster rota Upload new templates Smart sheets has detailed plan - Recruitment Identify HR recruitment team to support recruitment process Advertise relevant posts (RN, HCA, B4) Monthly review of vacancies, turnover & progress through R&R Steering group Smart sheets have detailed plan - New Roles (tNA) Process map current pathway Confirm JD & P spec Clarify training programme Clarify QIA role s & Responsibilities 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 Complete Nurse Establishment review based on national guidance		29/06/2018 31/01/2019 29/03/2019 31/05/2019		Progress Made Moderate Progress Made Moderate Progress Made Completed Completed Completed Completed
Latest Month Progress	The Nursing Establishment Review (NER) has been ratified by Trust Board. Work has commenced on the updating of health roster to align with NER. HR support has been identified to enable proactive recruitment of the vacancies within the NER. Recruitment Events have been planned across the year with an event planned for the end of June. The E-Roster policy has been updated.				

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

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	17/06/2019	22/07/2019

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

Action Plan		Action Plan Due Date		Action Plan Rating	
	Incorporate any Red Must Do Actions into CBU Risk Register work with communications team to engage widely with staff develop training for staff across the organisation Key leaders to access training with lead CQC executive/manager Establish confirm and challenge sessions for each action and core service to expedite progress against action Plan, and look at re-establishing the Quality Improvement Development (QID)Group To deliver against the 96 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.		17/07/2019 31/07/2019 28/06/2019 31/07/2019 17/07/2019		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 ongoing review and scrutiny 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. The communications plan continues to be rolled including a shared intranet area, a staff handbook, Executive Blogs and Board Packs. Use of Resources and Well led preparation has also been included in the preparation and development plans, both are on track.				

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		Gaps in Controls	
	- Service will begin a risk assessment in terms of the impact of the resignation on the service continuity and organisational reputation of any loss of local provision. Consideration of Southport to attempt to recruit locum consultant Consideration of Aintree to recruit a locum on behalf of Southport Or - collaboration including Clatterbridge to bring forward the longer term plans for haematology - oncology for the region.		- 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	25/06/2019	12/07/2019

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	02/09/2019 16/08/2019 27/03/2019	Action Plan Rating	Moderate Progress Made Moderate Progress Made Completed

Latest Month Progress	Locum consultant is now providing cover 2 days per week via Clatterbridge and Nurse Consultant starting 1 day per week from end of June. Weekly tele-conference between UHA, CCC and Trust to discuss on-going arrangements to ensure service is maintained reducing risk of patient breeches and long waits for follow-up patients. Meeting - arranged with COO, Medical Director and exec representation from UHA and Trust to discuss fragile services within organisation (one of which is haematology).

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to 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**	
13/06/2019	2052	Director of Nursing & Quality	Megan Langley	Older Peoples Care	

Description

If there is continued poor quality care delivered in particular to older people in Southport & Ormskirk NHS Trust, continue then harm may be caused to our older patients impacting negatively on their quality of life, function and experience. The areas of concern relate to specific practices:
•Deconditioning of patients
•The inappropriate use of bed rails
•Poor mouth care
•Poor nutrition assessment and management
•Poor hydration management
•Poor continence assessment and management
•Lack of interaction and social/cognitive stimulation increasing confusion and delirium
• A lack of education and training specifically in caring for older people
• A lack of end of life care education strategy within the Trust
•Limited availability of Geriatricians to provide holistic comprehensive assessment and advanced care management plans for patients in addition to limited clinical support for the Frailty Practitioners
•Inability to discharge patients home due to lack of resource to support at home particularly care and rehabilitation provisions in the community
•Poorly established pathway for patients with spinal fractures
•An environment not conducive to stimulating people and enabling them to maintain and maximise their function
•The lack of a formally agreed frailty pathway and model

Controls		Gaps in Controls	
	Red2Green rolled out - Therapy developing a competency and training for staff to be equipped to chair and challenge in a consistent way sustaining the Red2Green principles at board rounds across the Trust. Nutrition - New policy approved, New E-learning module provided to RNs on ward 10B with new care plans being tested - in addition to this, additional Dietetic support is being offered to this ward while they implement the new practices. Business Intelligence are working on a new collection of KPIs to measure and monitor improvement. Mouth Care- 5 staff completed Mouth Care Matters Train the Trainer programme- currently developing new policy, care plans and product availability. Dementia & Delirium - New cognitive risk assessment and care plan being trialed on 6 wards with new patient information leaflets and reporting of FAIR nationally on a new proforma as the screening tool has been changed. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Falls - 6 wards using new risk assessment, care plan and daily checklist with new e-learning module accessible to staff for completion. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Bedrails- 6 wards trialing new risk assessment, care plan and daily check - being reviewed after 1 month (end of June) for any amendments and further roll out. (Education included in falls e-learning module) Frailty Team delivering service M-F in AED and inreaching - continuing to work on competencies particularly around CGA completion. As part of the Red2Green, EndPJparalysis Get Up, Get Dressed, Keep Moving was introduced - this will be formally launched as a project in July as part of the Trust's QI work.		Care plans not always used appropriately and not all care plans are appropriate - these are being reviewed by the documentation group Falls and bed rails new risk assessment and care plans in 6 wards being trialed - need to continue roll-out. Inability to consistently staff additional care bay Training for staff re: older people risks not currently provided - New Training Programme to be launched end of July. 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 to be launched end of July. 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. Not yet commenced mouth care roll-out Documentation not conducive to providing person-centred care, this is to be reviewed as an entity July 2019 (particularly care plans and risk assessments) Clinical supervision for the frailty team lacking- exploring use of Leeds Buddy arrangement to support. Continence project not yet commenced- scoping session 25/6/19 to plan improvement work

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	13/06/2019	08/07/2019
Assurance	CQC Review						**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	Establish and develop staff knowledge, focus and education on patient function. Ensure appropriate equipment available, develop resource boxes specifically for patients with cognitive impairment, develop action planners for engaging and stimulating activities on the wards. Falls policy expired. Falls Education not established/provided. Falls documentation review. Falls reporting and KPIs to be reviewed. Falls strategy to be developed. Previous policy for nutrition screening did not comply with best practice or national guidance. Practices therefore did not align either. Establish Training Programme for Older Peoples Care Mouth Care provision of care - review of policy, care plan, education and care provision required. Establish a clinical pathway and practice for the assessment and management of continence for patients. This will involve writing a pathway/policy, care plans, education package and champions on the wards with a roll out plan for the new practices.						**Action Plan Due Date**	16/09/2019 16/09/2019 02/09/2019 31/12/2019 30/09/2019 28/10/2019	**Action Plan Rating** Little or No Progress Made Moderate Progress Made Moderate Progress Made Moderate Progress Made Moderate Progress Made Little or No Progress Made
Latest Month Progress	A new nutrition screening policy has been written and is awaiting approval. New practices are being tested on ward 10B with new care plans being trialed, a new e-learning module has been provided for staff to be educated and additional support provided by the Dietetic Team. New falls documentation is now being trialed on 6 wards with an accompanying education bundle on e-learning. Five members of staff attended Mouth Care (MCM) train the trainer day with HEE. A new mouth care policy is currently being created, care plans and reviewing of products underway. An education presentation will be developed and delivered as part of the older peoples training bundle. The plan is to roll out on 2 wards by the end of July. A scoping session is planned for 25/06/19 to establish a clinical pathway for continence. A programme to deliver training and education in Care of Older People has been prepared with roll out to begin at the end of July.								

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.								
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 10 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**
	Likely (4)	Catastrophic (5)	20	20	Extreme risk	5	Moderate risk	25/06/2019	24/07/2019
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 26/07/2019	**Action Plan Rating**: Completed Moderate Progress Made
Latest Month Progress	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.								

<table>
<tr><td>Strategic Objective</td><td colspan="7">SO3 - Efficiently and productively provide care within agreed financial limits</td><td>Link to BAF</td><td></td></tr>
<tr><td>Opened</td><td>ID</td><td colspan="2">ADO/Exec Lead</td><td colspan="2">Risk Lead</td><td colspan="4">Title</td></tr>
<tr><td>15/01/2019</td><td>1942</td><td colspan="2">Director of Finance</td><td colspan="2">Steve Shanahan</td><td colspan="4">Eradicating the Trust's deficit by 2023/24</td></tr>
<tr><td>Description</td><td colspan="9">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.</td></tr>
<tr><td>Controls</td><td colspan="6">System Board set up to manage financial recovery of the health economy
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</td><td>Gaps in Controls</td><td colspan="2">Future clinical model still to be finalised and costed
Accuracy of PLICS and Model Hospital data
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</td></tr>
<tr><td rowspan="2">Risk Levels</td><td>Likelihood</td><td>Consequence</td><td>Risk Rating (Initial)</td><td>Risk Rating (Current)</td><td>Risk Level (Current)</td><td>Risk Rating (Target)</td><td>Risk Level (Target)</td><td>Date of Last Review</td><td>Date of Next Review</td></tr>
<tr><td>Likely (4)</td><td>Major (4)</td><td>16</td><td>16</td><td>Extreme risk</td><td>8</td><td>High Risk</td><td>26/06/2019</td><td>26/07/2019</td></tr>
<tr><td>Assurance</td><td colspan="6">Acute Sustainability Programme Board-currently fortnightly
Finance Performance & Investment Committee and Trust Board-monthly
Hospital Management Board-monthly
Performance Review Board-monthly</td><td>Gaps in Assurance</td><td colspan="2">Agency spend/vacancy rates</td></tr>
<tr><td>Action Plan</td><td colspan="6">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.</td><td>Action Plan Due Date</td><td>30/06/2019
31/01/2019
30/09/2019</td><td>Action Plan Rating

Actions Almost Completed
Completed
Moderate Progress Made</td></tr>
<tr><td>Latest Month Progress</td><td colspan="9">The Trust continues to meet with the NHSI team to review Model Hospital metrics. There is a regular review internally. The Trust and Sefton CCG's have established System Board to manage the Financial Recovery Plan.</td></tr>
</table>

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	1	Risk Description (*What could prevent the objective from being achieved*)	***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/Raw (*Showing the likelihood of a risk & its consequence when the risk was first put on the BAF*)	16 4x4 (Likelihood x Consequence)	Current (*Showing the current position after considering controls and assurances in place*)	12 3x4 (LxC)	Target (*A desired score after actions have been taken to reduce the score*)	8 2x4 (LXC)

DATIX Code:	TBC	**Risk Rating Tracker**	(*A brief outline of the treatment, journey/movement of the risk and any changes proposed*)
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: ***What systems, processes, policies, procedures, training, performance and effectiveness measures are in place to assist in the delivery of the objective***		**Sources and Level of Assurance: Where the Trust can *gain evidence that the controls relied on are not only in place but are effective* (E.g.: via reports and Internal & External Audits to and from assurance committees and Board)**	**Action Plan / Progress Notes: Actions needed to address gaps, ensuring there is proper mitigation of risks and notes of progress of said actions**
1. Quality Improvement Plan in place identifying four priorities for 2019/20 2. Reducing Avoidable Mortality Project including compliance with the	1	**Management assurance - *LEVEL 1, gained at operational tier.***	1. Delivery against the Trust Patient Flow Improvement Programme. 2. Establishing Documentation Programme with support from the PMO. Scope

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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. 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		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 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	of programme currently being defined, timescales to be agreed. 3. Delivery against Care of the Deteriorating Patient Improvement Programme. Progress includes • The trend for improvement in national mortality indicators continues. The SHMI has reduced to within the expected range. • Monthly performance based on HSMR continues to be improved, although this is yet to include the spring period which in previous years has been challenging to flow and mortality. • From a disease specific perspective, AKI and bronchitis/LRTI remain a challenge and work is ongoing through the AKI steering group to improve this position. Changes have already been made which are expected to be reflected in the coming months in data reported through AQ. 4. Deliver the External Mortality Review Action Plan. 5. Delivery against Care of Older People Improvement Programme (Please see update and progress in Risk 2052 on the Corporate Risk Register). 6. Establishing Infection Prevention Control Improvement Programme with support from the PMO. Scope of programme currently being defined, timescales to be agreed. 7. Establishing Medicines Management Improvement Programme with support from the PMO. Scope of programme currently being defined, timescales to be agreed. 8. Medical job plans to be finalised (including allocated time for clinical and educational supervision and clinical audit) 9. Further enhance the shared learning across relevant Business Units from incidents, complaints and audits through CBU training, dissemination of lessons learned bulletins. An Integrated Governance Improvement Plan is in place until 2020, progress so far includes weekly complaints meeting, CBUs to review all open incidents and risk registers currently being cleansed and access rights reviewed. 10. Ward Accreditation Programme (SONAS) to be rolled out across the Trust. All fifteen phase one wards assessed by March 2020. Progress so far includes draft assessment tool shared with Heads of Nursing for their initial approval Approved assessment tool presented at Matrons and Ward leaders meeting along with discussion regarding self-assessment requirements– completed May 2019 11. Implement recommendations from Nurse Establishment Review. Timescales and progress. Introduce new nursing roles, implementation plan being rolled out – ongoing 12. Delivery against Must and Should Do CQC Actions Please see update and progress in Risk 1902 on the Corporate Risk Register).
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board-LEVEL 2** 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-LEVEL 3** 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: ***Where the Trust is failing to put controls, systems, processes, policies, procedures, training, performance and effectiveness measures in place and/or failing to make them effective***	**Gaps in Assurances:** ***Where the Trust is failing to get evidence that its controls are sufficiently effective to give assurance to a monitoring body like a committee or the board.***		**Review Update Description: (Summary description of current position of the risk after examining the actions in place and linked risks if applicable)**

Southport and Ormskirk Hospital NHS Trust

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	1987-Haematology/Oncology service 1862-Nursing/HCA vacancies 1688-Anaesthetic Staffing 2052-Older Peoples Care 1902-CQC Compliance	**Number of linked Incidents**	**Add:** 5 SUIs (inc 1 Never Event)	**Last Review Date** June 2019	**Next Review Date** September 2019

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Board Assurance Framework Report

Southport and Ormskirk Hospital NHS Trust

Risk ID:	2	Risk Description (*What could prevent the objective from being achieved)*	***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/Raw (*Showing the likelihood of a risk & its consequence when the risk was first put on the BAF*	16 4x4 (Likelihood x Consequence)	Current (*Showing the current position after considering controls and assurances in place)*	16 4x4 (LxC)	Target (*A desired score after actions have been taken to reduce the score)*	12 3x4 (LxC)

DATIX Code:	**TBC**	**Risk Rating Tracker**	(*A brief outline of the treatment, journey/movement of the risk and any changes proposed)* This risk has been discussed at the June 2019 Finance, Performance & Investment Committee. The risk remains Extreme and there are 2 risks linked to the corporate risk register. There is 1 Serious Untoward Incident linked to the risk..
Executive Director	Chief Operating Officer		
Assurance Committee	Finance, Performance & Investment Committee		
Strategic Objective	**SO2** - Deliver services that meet NHS constitutional and regulatory standards		

Controls: ***What systems, processes, policies, procedures, training, performance and effectiveness measures are in place to assist in the delivery of the objective***		**Sources and Level of Assurance: Where the Trust can *gain evidence that the controls relied on are not only in place but are effective* (E.g.: via reports and Internal & External Audits to and from assurance committees and Board)**	**Action Plan / Progress Notes: Actions needed to address gaps, ensuring there is proper mitigation of risks and notes of progress of said actions**
1. Regulatory information provided to staff in update sessions. 2. Committee structures in place to monitor compliance. 3. .Finance, Performance & Investment Committee 4. Improvement Group 5. Performance Review Board	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	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

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6. An integrated approach between corporate, operational and governance teams. 7. Quality Impact Assessments for all service changes and CIPs that are considered 8. Professional standards 9. Trust policies and procedures 10. Risk Management Strategy and culture 11. Ward accreditation scheme pilot commencing in April 12. Quality and independence of QIA's by DoN and MD 13. External peer reviews 14. Completion and Submission of Annual Quality Report 15. Exec and NED leads in place for key CQC areas 16. Patient Safety included in Exec , NED and senior staff walk rounds		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. 6. Monitoring of the Activity Plan for 2019/20 with regulatory functions 7. Reports to Improvement Group 8. Reports to Performance Review Board	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 9. Put in place effective strategy to ensure that the Trust does not appear as an outlier due to the nature of the benchmarking data
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 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 Constitutional Standard: 14 day GP referral to Outpatients 5 Constitutional Standard: 62 day GP referral to treatment (and associated Cancer Standard measures) 6 Integrated Performance Report 7 Vision 2020 Priority Area Highlight Reports to Hospital Improvement Board 8 Internal audit metrics 9 High level performance metrics 10 Result of Local Audits 11 Board assurance visits	
	3	**Independent / semi-independent** 1. Regular meetings with NHS Improvement 2. CQC Inspection Report (2018) Good' for the Trust 3. Maintenance of CQC Registration 4. CQC Visit 5. CCG Meetings monthly 6. NHS Improvement monthly returns 7. Result of National Audits	
Gaps in Controls: ***Where the Trust is failing to put controls, systems, processes, policies, procedures, training, performance and effectiveness measures in place and/or failing to make them effective***		**Gaps in Assurances:** ***Where the Trust is failing to get evidence that its controls are sufficiently effective to give assurance to a monitoring body like a committee or the board.***	**Review Update Description: (Summary description of current position of the risk after examining the actions in place and linked risks if applicable)**
1. Lack of strategy to counter 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	The risk remains Extreme despite a number of initiatives and action plans in place to mitigate the gaps in controls.

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		7. Mortality: above expected limits for some time			
Number of linked Risks	1987-Haematology/Oncology service 1688-Anaesthetic staffing	**Number of linked Incidents**	**Add:** 1 SUI	**Last Review Date** June 2019	**Next Review Date** September 2019

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Board Assurance Framework Report

Southport and Ormskirk Hospital NHS Trust

Risk ID:	3	Risk Description (*What could prevent the objective from being achieved)*	***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/Raw (*Showing the likelihood of a risk & its consequence when the risk was first put on the BAF*)	16 4x4 (Likelihood x Consequence)	Current (*Showing the current position after considering controls and assurances in place)*	16 4x4 (LxC)	Target (*A desired score after actions have been taken to reduce the score)*	12 3x4 (LxC)

DATIX Code:	**TBC**	**Risk Rating Tracker**	*(A brief outline of the treatment, journey/movement of the risk and any changes proposed)* This risk has been discussed at the June 2019 Finance, Performance & Investment Committee. The risk remains Extreme and there are 2 risks linked to the corporate risk register. There is no Serious Untoward Incident linked to the risk..
Executive Director	Director of Finance		
Assurance Committee	Finance, Performance & Investment Committee		
Strategic Objective	**SO3** - Efficiently and productively provide care within agreed financial limits		

Controls: ***What systems, processes, policies, procedures, training, performance and effectiveness measures are in place to assist in the delivery of the objective***		**Sources and Level of Assurance: Where the Trust can *gain evidence that the controls relied on are not only in place but are effective* (E.g.: via reports and Internal & External Audits to and from assurance committees and Board)**	**Action Plan / Progress Notes: Actions needed to address gaps, ensuring there is proper mitigation of risks and notes of progress of said actions**
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	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	1. Delivery of control total in 2019/20 at end of financial year 2. Delivery of CIP for 2019/20 at end of financial year 3. Achieve NHSI Use of Resources Risk Rating – 3 4. Manage Agency Spend vis a vis NHSI cap

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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) 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		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 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: ***Where the Trust is failing to put controls, systems, processes, policies, procedures, training, performance and effectiveness measures in place and/or failing to make them effective***	**Gaps in Assurances:** ***Where the Trust is failing to get evidence that its controls are sufficiently effective to give assurance to a monitoring body like a committee or the board.***	**Review Update Description: (Summary description of current position of the risk after examining the actions in place and linked risks if applicable)**
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	The risk remains Extreme despite a number of initiatives and action plans in place to mitigate the gaps in controls.

Number of linked Risks	1942-Eradicating Trust deficit 1987-Haematology/Oncology service 1688-Anaesthetic staffing	**Number of linked Incidents**	**Add:** None	**Last Review Date** June 2019	**Next Review Date** September 2019

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Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

<table>
<tr><td>Risk ID:</td><td>4</td><td>Risk Description
(What could prevent the objective from being achieved)
Lack of staff engagement and poor staff morale could impact on Trust reputation and the ability to attract the required workforce.</td><td colspan="6">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</td></tr>
<tr><td>Risk Appetite:</td><td>OPEN</td><td>Risk Scores:</td><td>Initial/Raw
(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF</td><td>12
3x4
(Likelihood x Consequence)</td><td>Current
(Showing the current position after considering controls and assurances in place)</td><td>12
3x4
(LxC)</td><td>Target
(A desired score after actions have been taken to reduce the score)</td><td>8
2x4
(LxC)</td></tr>
<tr><td>DATIX Code:</td><td>TBC</td><td rowspan="4">Risk Rating Tracker</td><td colspan="6" rowspan="4">(A brief outline of the treatment, journey/movement of the risk and any changes proposed)

This risk was presented at Workforce Committee in June 2019. It remains high.</td></tr>
<tr><td>Executive Director</td><td>Director of Human Resources & Organisational Development</td></tr>
<tr><td>Assurance Committee</td><td>Workforce Committee</td></tr>
<tr><td>Strategic Objective</td><td>SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated</td></tr>
<tr><td colspan="2">Controls: What systems, processes, policies, procedures, training, performance and effectiveness measures are in place to assist in the</td><td colspan="3">Sources and Level of Assurance: Where the Trust can gain evidence that the controls relied on are not only in place but are</td><td colspan="4">Action Plan / Progress Notes: Actions needed to address gaps, ensuring</td></tr>
</table>

delivery of the objective		*effective* (E.g.: via reports and Internal & External Audits to and from assurance committees and Board)	there is proper mitigation of risks and notes of progress of said actions
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 5. Monitoring exercises undertaken on annual basis to ensure compliance on junior doctor rotas 6. Annual Workforce Planning exercise with operational and clinical teams 7. Shared decision making and review of risks with Joint Local Negotiating Committee 8. Organisational Development Strategy 9. Health and Wellbeing strategy and action plan 10. Staff engagement and awareness programme in place 11. CBU Staff induction 12. Corporate staff Induction 13. Mandatory training 14. PDR process and training 15. Robust employment checks (FPPT) 16. Disclosure Barring Service 17. Professional Bodies Checks and Balances for clinicians (NMC/GMC) 18. Duty of Candour/Safe Care 19. Sickness Absence Policy 20. Speak Up Champion & Guardian 21. Recruitment Strategy 22. Retention Strategy 23. Annual staff Appraisal 24. Freedom to Speak Up Guardian in post 25. Equality & Diversity Lead in post 26. OD Manager in post and Workforce and OD Strategy in place 27. NHS Elect support for staff engagement, values and behaviour 28. NHSI Nursing Retention Programme 29. NHSI Health and Wellbeing Project 30. Nursing Retention Improvement Plan	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. 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~~ 10. Junior Doctor Forum held quarterly for concerns to be raised. 11. Education and development processes in place 12. Appraisal compliance and training attendance monitored 13. Staff Survey & Quarterly Staff FFT/Survey 14.	1. During 2019/20 the Trust will develop and enhance Clinical & nursing roles to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANPs, Consultant Nurses, ER Practitioners. 2. During 2019 there a new programme for recruitment of Drs from India for Gynaecology will be developed 3. The 2019 Operational Plan will include the requirement for increased number of consultants 4. By the end of August 2019 the Regional Training Programme Directors who manage the junior doctor rotation programme will highlight shortages to the Lead Employer 5. Deliver against Quality Improvement Programme to maximise utilisation of E-Rostering by the end of 2019. 6. During 2019/20 the Director of Medical Education (DME) will ensure training requirements are met and will report to the Trust Medical Director and externally to HEN 7. Deliver against Quality Improvement Programme to reduce Time to Hire to 8 weeks (advert-offer) by the end of 2019. 8. Engagement sessions with a cross section of staff to ask for feedback and priorities in relation to staff survey will take place during June 2019. 9. The Trust will develop 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 with meetings and focus groups from June to December 2019. 10. Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019. 11. Development of a Recruitment and Retention Strategy by the end of 2019.
	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 6. National Medical Revalidation process ensuring competent doctors 7. Quality Visits by NEDs and EDs 8. Time to Hire	
	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	

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	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: ***Where the Trust is failing to put controls, systems, processes, policies, procedures, training, performance and effectiveness measures in place and/or failing to make them effective***	**Gaps in Assurances:** ***Where the Trust is failing to get evidence that its controls are sufficiently effective to give assurance to a monitoring body like a committee or the board.***	**Review Update Description: (Summary description of current position of the risk after examining the actions in place and linked risks if applicable)**
1. Gaps in junior doctor workforce 2. Regional Training Programme Directors manage the junior doctor rotation programme and do not highlight shortages to the Lead Employer 3. Rota management system not fully utilised 4. Training requirements are not always met 5. Delays in recruitment of staff 6. Lack of local in year feedback in relation to staff views / staff surveys 7. Lack of focused resource for staff engagement 8. Recruitment and retention strategy 9. Low attendance at Essential Skills Training Programmes	1. Sickness absence above target but improved to 4.8% 2. Appraisal Rates below target 3. Time to hire is longer than expectations 4. Lack of talent pipeline for nursing and specialist medical roles 5. Overall staff engagement scores are lower than average which impacts on Trust reputation. 6. Reliance on agency staff to fill gaps in rotas for nursing and medical staff 7. Low completion rates for Exit interviews	Risk remains high but a robust action plan is now in place to mitigate the gaps in control.

Number of linked Risks	1862 – High level of nursing/HCA vacancies	**Number of linked Incidents**	**Add:** None	**Last Review Date**	**Next Review Date**
				June 2019	September 2019

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Board Assurance Framework Report

Southport and Ormskirk Hospital NHS Trust

Risk ID:	5	Risk Description Lack of management development to develop leadership skills.	*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/Raw *(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF*	12 3x4 (Likelihood x Consequence)	Current *(Showing the current position after considering controls and assurances in place)*	12 3x4 (LxC)	Target *(A desired score after actions have been taken to reduce the score)*	8 2x4 (LxC)

DATIX Code:	TBC	Risk Rating Tracker	*(A brief outline of the treatment, journey/movement of the risk and any changes proposed)* This risk has been presented at Workforce Committee in June 2019. Risk remains high.
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: *What systems, processes, policies, procedures, training, performance and effectiveness measures are in place to assist in the delivery of the objective*		**Sources and Level of Assurance: Where the Trust can *gain evidence that the controls relied on are not only in place but are effective* (E.g.: via reports and Internal & External Audits to and from assurance committees and Board)**	**Action Plan / Progress Notes: Actions needed to address gaps, ensuring there is proper mitigation of risks and notes of progress of said actions**
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	1	**Management assurance** 1. National Staff surrey (annual) 2. Quarterly Staff Friends and Family survey 3. Monthly KPIs for controls 4. Performance Reports (monthly)	1. By the end of 2019 the Aspirant Managers programme will be rolled out via Shadow Board 2. During 2019/20 the Executive Team and Non-Executive Directors will participate in quality visits/walkabouts 3. A Talent Management Programme will be developed by Q4 2019/20 4. The Trust will continually monitor sickness absence on a monthly basis

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. 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		5. Quarterly Speak up Guardian Reports 6. Report from Guardian of Safe Working – Quarterly to Board 7. PDR training on-going 8. Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board 9. Monthly reporting to Workforce Committee 10. CBU Governance meetings 11. Workforce Improvement Board (WIB)	during 2019/20 5. Engagement sessions with a cross section of staff to ask for feedback and priorities in relation to staff survey will take place during June 2019. 6. The Trust will develop 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 with meetings and focus groups from June to December 2019. 7. Implement a programme of appraisals to ensure quality and compliance to meet 85% by September 2019. 8. Enhance the development programme for middle managers by March 2020. 9. Develop a Recruitment & Retention Strategy by December 2019. 10. Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019.
	2	**Reports and Metrics monitored at monthly Assurance Committees and/or Board** 1. Increase in managers attending training programmes 2. Mandatory training data 3. Absence data 4. Turnover data 5. FTSU Guardian data 6. Staff Engagement Scores 7. Sickness data 8. Guardian for Safe Working Exception Reports	
	3	**Independent / semi-independent** 1. CQC regulatory inspection 2. National Workforce and Wellbeing Charter - 2018 3. NHS Staff Survey 2018 4. NAVAJO Chartermark 5. Health Watch Sefton 6. Workforce Race Equality Scheme Reporting 7. Workforce Disability Equality Scheme 8. Annual ED&I Report	

DRAFT

Southport and Ormskirk Hospital NHS Trust

49. Workforce and OD Strategy 50. Model Hospital support					
Gaps in Controls: ***Where the Trust is failing to put controls, systems, processes, policies, procedures, training, performance and effectiveness measures in place and/or failing to make them effective***		**Gaps in Assurances:** ***Where the Trust is failing to get evidence that its controls are sufficiently effective to give assurance to a monitoring body like a committee or the board.***		**Review Update Description: (Summary description of current position of the risk after examining the actions in place and linked risks if applicable)**	
1. Succession Planning – not fully in place 2. Insufficient visibility of Executive Team and Non-Executive Directors 3. Talent management programme – not fully developed 4. Ongoing challenges of engaging effectively with all staffing groups due to rota patterns 5. Lack of quality of appraisals being carried out and insufficient numbers. 6. Lower than expected attendance at non-mandatory training eg. leadership training 7. Requirement for further development of middle managers 8. Poor response rates in relation to staff views / staff surveys performed quarterly 9. Recruitment & retention of staff remains a problem 10. Some processes need embedding within CBUs and across the organisation to ensure robust Ward to Board communication and escalation 11. Staff Engagement Strategy		1. Staff Survey Engagement score not significantly improved in year 2. PDR compliance currently below target 3. Sickness absence above target but reducing		Risk remains high but a robust action plan is now in place to mitigate the gaps in control.	
Number of linked Risks	None	**Number of linked Incidents**	**Add:** None	**Last Review Date** June 2019	**Next Review Date** September 2019

DRAFT

Board Assurance Framework Report

NHS Southport and Ormskirk Hospital NHS Trust

Risk ID:	6	Risk Description (*What could prevent the objective from being achieved)*	**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/Raw (*Showing the likelihood of a risk & its consequence when the risk was first put on the BAF*	15 3x5 (Likelihood x Consequence)	Current (*Showing the current position after considering controls and assurances in place)*	15 3x5 (Likelihood x Consequence)	Target (*A desired score after actions have been taken to reduce the score)*	9 3x3 (Likelihood x Consequence)

DATIX Code:	TBC	**Risk Rating Tracker**	(*A brief outline of the treatment, journey/movement of the risk and any changes proposed)* This BAF risk has been to HMB as part of the new BAF. Risk remains extreme.
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		

DRAFT

Controls: ***What systems, processes, policies, procedures, training, performance and effectiveness measures are in place to assist in the delivery of the objective***		**Sources and Level of Assurance: Where the Trust can** ***gain evidence that the controls relied on are not only in place but are effective*** **(E.g.: via reports and Internal & External Audits to and from assurance committees and Board)**	**Action Plan / Progress Notes: Actions needed to address gaps, ensuring there is proper mitigation of risks and notes of progress of said actions**
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 ▪ Minutes of Monthly Contract Review Meetings	1. Develop, implement and deliver the agreed organisational transformational CIP Schemes. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to HOIB. 2. Recruitment to substantive positions to reduce agency spend. 3. Establish a Strategic Task and Finish group with executive and non-executive membership to provide assurance to the Trust Board on the robustness of the development and delivery of the Acute Sustainability Programme. To commence in June 2019 and meet monthly. 4. Report progress on the delivery of the Operational Plan using the Single Improvement Plan. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to HOIB. 5. Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019 and monitored by the Acute Sustainability Programme Delivery Group.

	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 7. Finance Reports include contractual and commissioning issues, where relevant reported to Board 8. Progress of agreeing contracts reported via Finance to Board 9. Business Cases involving commissioners reported, where these occur, reported to Board	
	3	**Independent / semi-independent** 1. CQC Inspection Report (2017) 2. Clinical Senate Reports 3. Minutes of Network/Alliance meetings 4. Update reports from Community Partnership Network 5. Quarterly review against plan (Titration system) 6. Monthly meetings with CCGs	

Gaps in Controls: ***Where the Trust is failing to put controls, systems, processes, policies, procedures, training, performance and effectiveness measures in place and/or failing to make them effective***	**Gaps in Assurances:** ***Where the Trust is failing to get evidence that its controls are sufficiently effective to give assurance to a monitoring body like a committee or the board.***	**Review Update Description: (Summary description of current position of the risk after examining the actions in place and linked risks if applicable)**
1. Financial constraints for delivery of facilities improvements 2. Delay in delivering Transformational CIP Schemes 3. 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 4. Operational plan in development 5. Communication and Engagement Strategy	1. Trust significantly adverse from financial plan (June 2019)	Risk remains extreme and there are significant gaps in control relating to finance, whole system engagement, the Operational Plan and Communication and Engagement strategy. A meeting has been arranged with COO, Medical Director and Exec representation from UHA and Trust to discuss fragile services within organisation (one of which is haematology). The Trust continues to meet with the NHSI team to review Model Hospital metrics. There is a regular review internally. The Trust and Sefton CCG's have established System Board to manage the Financial Recovery Plan.

Number of linked Risks	1942-Eradicating the Trust's deficit by 2023/24 1987 – Haematology/Oncology service	**Number of linked Incidents**	**Add:** None	**Last Review Date** June 2019	**Next Review Date** September 2019

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NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	TB134/19	**Report Title**	**Corporate Governance Manual 2019/20**
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

It is good practice to review and update the statutory instruments at least annually. These instruments: Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation were approved at an extra-ordinary Board of Directors in May and are incorporated into this document. These are only part of a legal and regulatory framework to which the Trust must adhere.

The NHS Act 2006 (amended Health & Social Care Act 2012) and subsequent regulations set out the legal framework within which the Trust operates. The Accountable Officers' Memorandum requires Trust Boards of Directors to adopt schedules of reservation and delegation of powers, set out the financial framework within which the organisation operates and how business is conducted and decisions made. These are incorporated into three (3) key documents: Scheme of Reservation & Delegation (SORD), Standing Financial Instructions (SFIs) and Standing Orders (SOs). Implementation of these key statutory instruments will only be effective when there is synergy between them. As well as being incorporated in this Manual, these documents can be accessible via the Trust's website and Intranet.

This Manual also contains a number of other extremely useful documents which provide valuable information about the Trust's corporate governance systems and processes. Having in one place key documents like the Integrated Governance Framework, the Assurance Framework, the statutory and assurance committees' terms of reference, their annual work plans and their performance and assessment tool provide a snapshot of the role and function of the Board and its committees

All staff, especially senior managers, who have decision-making powers are encouraged to read these key documents so that they can be fully apprised of the context in which decisions are made in the Trust and be in a position to advise their direct reports.

This document is not only a useful reference guide but a tool that provides valuable information for preparation for CQC Well Led and being able to speak eloquently about how the Trust is governed and its key governance principles.

Compliance with these documents is required of the Trust, its Executive and Non-Executive Directors, officers and employees, all of whom are also required to comply with the Trust's Legal and Regulatory Framework

This document is a key reference guide for all senior managers and staff in the Trust and should be given some attention.

Because of the size of the document it is not being incorporated in the Board pack, instead a link is being sent where it can be accessed at: http://intranet/quality-risk-and-governance/corporate-governance/

The Contents Page gives an outline of the key elements within the Manual:

Contents

1. Foreword by Chair & Chief Executive .... Error! Bookmark not defined.
2. Definitions .... Error! Bookmark not defined.
3. Introduction .... Error! Bookmark not defined.
4 The Trust's Integrated Governance Structure .... Error! Bookmark not defined.
5 The Trust's Assurance & Governance Framework .... Error! Bookmark not defined.
6 The Role, Structure and Composition of the Board............... Error! Bookmark not defined.
7. Who's Who.. Error! Bookmark not defined.
8. Terms of Reference for the Board, Statutory, Assurance and other Key Committees and Groups.. Error! Bookmark not defined.
9. Board & Committees Performance & Effectiveness Tool....... Error! Bookmark not defined.
10. Code of Conduct for Board Members .... Error! Bookmark not defined.
11. Code of Conduct for NHS Managers .... Error! Bookmark not defined.
12. Prime Policies and Strategies... Error! Bookmark not defined.
13. Procedure for Amending the Corporate Governance Manual Error! Bookmark not defined.

Recommendation:

The Board is asked to **approve** the Corporate Governance Manual

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*
Linked to Regulation & Governance *(the report supports …..)*	
CQC KLOEs	**GOVERNANCE**
✓ Caring	✓ Statutory Requirement
✓ Effective	☐ Annual Business Plan Priority
✓ Responsive	✓ Best Practice
✓ Safe	☐ Service Change
✓ Well Led	
Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance	✓ Legal
✓ Engagement and Communication	✓ Quality & Safety
✓ Equality	✓ Risk
✓ Finance	✓ Workforce
Equality Impact Assessment If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
The Manual was discussed at the Hospital Management Board and if approved by the Board will be uploaded onto the Trust's Intranet and Trust Website.	
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

NHS Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	TB135/19	Report Title	Amendment to the Development and Management of Procedural Documents (Corporate 68)
Executive Lead	Audley Charles, Company Secretary		
Lead Officer	Audley Charles, Company Secretary		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The Policy for Development and Management of Procedural Documents was approved at the Board in September 2018. It did not make provision for the extension of a policy. There are some policies which fall into this category, for example, when national guidance are being updated and would be released within a short timeframe.

The Policy has been updated to take account of this and a *Procedural Document Extension Application Form* added.

This provision will not be a substitute for authors and Policy Leads reviewing and updating their policies via the normal process.

The Form is attached and a link given to the updated Policy
http://nww.southportandormskirk.nhs.uk/policies/view-policy.asp?id=1363&type=0

Recommendation

The Board is asked to **approve** the amendment to the Policy

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

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

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

If approved the amended version will be placed on the Trust's Intranet

Previously Presented at:

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

Procedural Document Extension Application Forms

There are circumstances when instead of reviewing a policy it is best to extend it to take account of national guidance being updated. This must not, however, be used as an excuse not to review and update policies in the normal scheme of things. The Form below must be filled out and extension approved by the Policy Review Group

<table>
<tr><td>Document Title</td><td colspan="3"></td></tr>
<tr><td>Document Reference</td><td colspan="3"></td></tr>
<tr><td>Date due for review</td><td colspan="3"></td></tr>
<tr><td>Proposed date of extension</td><td colspan="3"></td></tr>
<tr><td rowspan="3">Rationale for extension</td><td colspan="2">Awaiting updated national guidance
Date expected……………………….</td><td></td></tr>
<tr><td colspan="2">Await service provider to update relevant policy/procedure
Service provider is ………………………………………….</td><td></td></tr>
<tr><td colspan="2">Other Reason (please state) …………………………………...
………………………………………………………………………</td><td></td></tr>
<tr><td>Extension agreed</td><td>Yes</td><td colspan="2">No</td></tr>
<tr><td>Reason for rejection (if appropriate)</td><td colspan="3"></td></tr>
</table>

Author / Reviewer disclaimer

I agree that throughout any extension period, the content of the document remains relevant and fit for purpose across all relevant areas within the Organisation.

Procedural Document Author / Reviewer Name……………………………………………..

Procedural Document Author / Reviewer Signature……………………………………………..

Approval Committee Name:

Approval Committee Chairperson Name:…………………………………………………

Approval Committee Chairperson Signature…………………………………………………

Date extension agreed / rejected:………………………………………………………….

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

3 July 2019

Agenda Item	**TB135/19**	**Report Title**	**Quality Account**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Janette Mills, Head of Audit and Effectiveness		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

At the Extra-ordinary Board held on 22 May, it was agreed that due to timing issues related to receipt of feedback from the Trust's stakeholders that powers would be delegated to the June Quality & Safety Committee to approve the Quality Account and that the July Board would be asked to ratify the Committee's decision.

The Quality and Safety Committee at its meeting held 24 June 2019 **approved** the Quality Account subject to some amendments. The amendments are in the main editorial and do not materially impact on the substance of the document. The amendments are shown below:

"Page 4 Chief exec statement - can we add in paragraph 5 "Investment in staffing, INCLUDING PROVISION OF 24 / 7 CRITICAL OUTREACH TEAM, equipment....."
-Page 7, section 1.4.1, remove the picture which as the fold down bed.
-Page 8, sentence at top of page add – "will positively impact on this going forward. The red bag scheme is helping to provide a better care experience for care home residents by improving communication between care homes and hospitals. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items.
-Page 8 – As an outcome of this pledge, the facilities assistant pilot was implemented
-Page 8 – in October. The facilities assistant supported
-Page 9 – The opportunity for staff (delete the a) to attend board meetings to share
-Page 14 – A nurse establishment review covering……….
-Page 14 – Due to be ratified by Trust Board (delete) and replace with This was approved by Trust Board
-Page 15 – formatting of table has gone funny
-Page 25 – paragraph beginning S&O NHS Trust has full face (3rd Line)….less that seven day services….change to less than seven day services
-Page 25 – number 3 paragraph, second line particularly– patients…remove the – so just particularly patients
-Paget 27 – picture with booklet should be loneliness not lonliness
-Page 28 – Cancer services first paragraph last word should be under-performing (not under-preforming)
-Page 28 – Paragraph 4 (Results from) the last line word should be improvement (not improve)
-Page 28 – Paragraph 5 – Remove "Currently there are 229 prostate patients…….positive results"
-Page 28 – Paragraph 5 last sentence should say – "Cancer alliance funding for both these roles will finish in April 2020, and the subsequent business cases are currently underway"
-Page 28 – Paragraph 6 – Delete the sentence – "unfortunately this has been suspended due to the

resignation of the CNS………support this service"
-Page 29 – 1.10 Women and Children's – change the opening paragraph to – Women's and Children's Services are working on the development of a new clinical model through a clinically led approach which describes a future state based on a focus of improving outcomes for women and babies. The model describes an intention to deliver a local maternity service with midwifery and consultant led pathways alongside a community based birthing unit"
-Page 29 – 1.10 Women and Children's – delete the whole paragraph "in the new model of care"
-Page 30 – The HUB – 3rd sentence – The Ainsdale Women's and Children's Pilot Hub Project aims is (remove is) to provide
-Page 30 – Freedom to Speak up – 3rd sentence – change resolved to resolve
-Page 31 – statement from directors attached for inserting as whole page
-Page 32 – Priorities spelt wrong in in line 3 of the 1st paragraph "prioritis"
-Page 33 – second paragraph change to – "The Trust is also engaged with a number of national collaboratives which enable us to share and implement best practices across a wide number of Trusts…
-Page 35 – keep in the heading "Improvement and changes made following National Clinical Audit Projects" as regulated text
-Page 37 – paragraph 7 remove "and the NIHR supported ? of them"
-Page 40-41 – can you include "partially achieved" in the orange boxes and "fully achieved" in the green boxes
-Page 46 – SHMI – line 3 change it to It
-Page 51 – End of 4th paragraph, should not be a full stop but a comma and a lower case w (,which is an improvement from the previous year of 94%)
-Page 53 – Sharing stories across **C**linical **B**usiness **U**nits
-Page 54 – 3.7 – no full stop, comma and lowercase w (take part in this survey, which gave us a response rate of 40.4%)
-Page 63 – pressure ulcers – should be "There is a multi-disciplinary"

Because of the size of the document (79 pages) it is not attached especially as Board members had already had sight of it; instead a link to it can be found here: The Link will be supplied on Monday after all stakeholder responses have been incorporated and will be to NHS Choices website.

Recommendation:

The Board is asked to **ratify** the decision of the Quality and Safety Committee on 24 June 2019 to approve the Quality Account.

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	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*
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)*	
Once completed the Quality Account will be updated onto NHS Choices portal	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	✓ Quality & Safety Committee ☐ Remuneration & Nominations 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

Southport and Ormskirk Hospital NHS Trust

Minutes of the Extra-Ordinary Public Section of the Board of Directors' Meeting
Wednesday, 22 May 2019
Ruffwood Suite, Clinical Education Centre, Ormskirk L39 2AZ

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

Members Present

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

In Attendance

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

Apologies:

David Bricknell, Non-Executive Director
Pauline Gibson, Non-Executive Director Designate
Jo Morgan, Non-Executive Director Elect
Terry Hankin, Executive Medical Director

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
ETB 001/19	**Chair's Welcome and Note of Apologies**	
	Mr Masom as Chair opened the meeting by welcoming members and attendees and outlined the purpose of the meeting was to approve the sign off of end of year statements as endorsed by the Audit Committee earlier in the day. Apologies were received from David Bricknell, Pauline Gibson, Jo Morgan and Terry Hankin.	
ETB 002/19	**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.	
ETB 003/19	**End of Year Documents**	

	Mr Birrell, as Chair of the Audit Committee, asked the Board to approve the following end of year documents as recommended by the Audit Committee subject to some amendments which were noted.
	
	The documents were:
	
	• Annual Report 2018/19
	•
	• Annual Governance Statement 2018/19
	
	• Annual Accounts 2018/19
	
	• Statutory Instruments
	  o Standing Orders
	  o Standing Financial Instructions
	  o Scheme of Reservation & Delegation
	
	He also asked the Board to grant delegated powers to the June Quality and Safety Committee to approve the Quality Accounts with the July Board being asked to ratify that decision.
	
	RESOLVED:
	The Board **approved** the end of year documents as **recommended** by the Audit Committee and **delegated powers** to the June 2019 Quality & Safety Committee to **approve** the Quality Account subject to ratification by the Public Board at the July 2019 meeting.	

CONCLUDING BUSINESS		
ETB 004/19	**Any Other Business**	
	No other business was discussed.	
ETB 005/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 3 July 2019 Seminar Room, Clinical Education Centre, Southport & Formby District General Hospital, PR8 6PN	

There being no other business, the meeting was adjourned

DRAFT

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												

DRAFT