Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held 10:30 – 13:30 on Wednesday, 4 September 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				
TB142/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**	**10:30**
TB143/19 (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**		
TB144/19 (D)	**Minutes of the Meeting held on 3 July 2019** To **approve** the minutes of the Public Board of Directors	**Chair**		
TB145/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB146/19 (D/V)	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal)	**NEDs EDs**	**30**	**10:40**
(V/P)	• **Patient Story: Hearing Impairment** To **receive** the Patient Story and **note** lessons learnt	**Michelle Kitson**		
STRATEGIC CONTEXT				
TB147/19 (D)	**Chief Executive's Report** (signposting results re: Business Cases) To **receive** key issues and update from the CEO	**CEO**	**10**	**11:10**
TB148/19 (D)	**Vision 2020** To **receive** the final version of the document	**DCEO**	**10**	**11:20**

Ref Nº.	Agenda Item	Lead	Duration	Time
QUALITY & SAFETY				
TB149/19 (P/D)	**Quality and Safety Reports:** a) Summary of Complaints & Compliments b) Monthly Mortality Report c) Quality Improvement Plan Update d) Safe Staffing: Monthly e) CQC Inspection Update & Letters from July and August Visits To **receive** the presentation and reports	**DoN/MD**	**45**	**11:30**
TB150/19	**Medical Appraisal & Revalidation Annual Report 2018-19** To **approve** the report	**MD**	**5**	**12:15**
PERFORMANCE & GOVERNANCE				
TB151/19 (D/P)	**Integrated Performance Report (IPR)** To **receive** the Integrated Performance Report	**COO**	**25**	**12:20**
TB152/19 (D)	**Financial Position at Month 4, 2019/20 including Business Cases Update** To **receive** the report	**DoF**	**10**	**12:45**
TB153/19 (D)	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report** To **approve** the annual report	**COO**	**5**	**12:55**
TB154/19 (D)	**Risk Management:** **Corporate Risk Register (CRR)** To **receive** the monthly corporate risk register reports.	**DoN**	**5**	**13:00**
TB155/19 (D)	**Items for approval/ratification** • **Leadership Strategy (DoHR)**	**Chair**	**5**	**13:05**
CONCLUDING BUSINESS				
TB156/19 (V)	**Questions from Members of the Public**	**Public**	**10**	**13:10**
TB157/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda	**Chair**	**10**	**13:20**
TB158/19 (V)	**Items for Forward Agenda – 2 October 2019** • Whole System Health and Social Care Economy Dashboard	**Chair**		
TB159/19 (V)	**Message from the Board** To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**		

TB160/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**		**13.30** **CLOSE**
TB161/19 (V)	**Date and time of next meeting:** **10:30, Wednesday 2 October 2019** Ruffwood Suite, Clinical Education Centre, Ormskirk & District General Hospital, L39 2AZ	**Chair**		

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

NHS
Southport and Ormskirk Hospital
NHS Trust

Register of Interests Declared by the Board of Directors 2019/20 AS AT 10 JULY 2019

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 September 2017**
BRICKNELL, Dr David	Non-Executive Director	**Pilkington Family Trust** **St Joseph's Hospice** **The World of Glass** **Pilkington Glass Collection**	**Nil**	**Nil**	**Director, St Joseph's Hospice** **Director, Pilkington Family Trust**	**Director, St Joseph's Hospice**	**Nil**	**Nil**	**Nil**	**9 April 2018**
CHRISTIAN, Mr Steven	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**28 June 2018**
COSGROVE Ms Juliette	Director of Nursing, Midwifery & Therapies	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 May 2018**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GORRY, Mrs Julie	Non-Executive Director	**Catalyst Choices C.I.C.**	**Nil**	**Nil**	**Nil**	**Project Adviser: Hospice of the Good Shepherd** 2017 to date **Specialist Adviser CQC** 2015 to date **Macmillan Cancer Information & Support Specialist** 2017 to date	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**9 July 2019**
HANKIN Dr Terence	Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 January 2019**

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MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB** **NDLM Ltd** **JSSH Ltd**	**CQC Holdings Ltd** (manufacturer of textile products)	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**9 July 2019**
MORGAN Mrs Joanne	Non-Executive Director	**Director of Alasdair Morgan Ltd**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**10 April 2019**
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**CEO Designate for Wrightington, Wigan & Leigh NHS FT**	**Nil**	**10 July 2019**
PATTEN, Ms Therese	Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Director of Human Resources	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**25 September 2017**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother, Mr Peter Shanahan is an Executive Director, Advisory on**	**Nil**	**Nil**	**Nil**	**25 January 2018**

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						the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust.				
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**	**Nil**	**9 April 2018**

DRAFT Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 3 July 2019

Ruffwood Suite, Clinical Education Centre, Ormskirk District General Hospital, L39 2AZ
(Subject to the approval of the Board on 4 September 2019)

Members Present

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

In Attendance

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

Apologies:

Gurpreet Singh, Non-Executive Director

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB123/19	**Chair's Welcome and Note of Apologies**	
	Mr Masom, as Chair, opened the meeting by welcoming members, attendees, Ms Deborah Lindley, Care Quality Commission (CQC), Mrs Caroline Griffiths, NHS Improvement (NHSI) and two members of the public. Apologies were noted from Mr Singh. The Clinical Negligence Scheme for Trusts, (CNST) and the Information Management & Technology reports, initially planned for the Private Board had been transferred to the Public Board and would be discussed later. The Chair stated that the meeting was the final Board for Mr Charles, Company Secretary, before his move to Japan. He thanked	

	him for his sterling work.	
TB124/19	**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.	
TB125/19	**Minutes of the Meeting Held On 5 June 2019**	
	The Chair asked the Board to approve the Minutes of the Meeting of 5 June 2019. **RESOLVED:** The Board **approved** the minutes as an accurate record.	
TB126/19	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **TB028/19: Monthly Mortality Report, including a summary report of the External Mortality Review: Standard Operating Procedures (SOP)** Dr Hankin advised the Board that the SOP had been reviewed and asked for the action to be removed due to the lack of appetite from doctors to do so. **Completed** **TB028/19: Monthly Mortality Report, including a summary report of the External Mortality Review: timeline of case reviews Completed** **TB031/19: Integrated Performance Report (IPR)** The trajectories for KPIs (where applicable) were in place. **Completed** **TB070/19: Chief Executive's Report** IM&T Implementation was an item on the July Board Agenda. **Completed** **TB093/19: Alert, Advise, Assure Report from Workforce Committee** The report was included on the July Private Board Agenda. **Completed** **TB107/19: NEDs & Executive's Visits/Walkabouts** The member of staff who was retiring had been appropriately recognised. **Completed** **TB112/19: Integrated Performance Report (IPR)** A single page report identifying total number of staff, available beds, deaths etc. was included in the IPR Update. **Completed** **TB114/19: Board Assurance Framework (BAF)** The Risk Appetite statement to be added to the abridged Annual Report 2018/2019. **Completed** **TB115/19: Claims & Litigation Report** This was included in the annual business cycle of the Audit & Risk	

	Committee. **Completed**	
TB127/19	**Patient and Engagement Issues including:** • **Non-Executive Directors (NEDs) & Executives' Visits/Walkabouts** • **Staff Story: Plaster Room Re-launch**	
	• **NEDs & Executives' Visits/Walkabouts** Mrs Morgan and Mr Nicholls were scheduled to visit wards to observe catering provision on Friday 5 July. The Business Case for supporting nutrition on dementia wards had been approved which included catering assistants to assist patients to eat their meals. Mr Nicholls had also spent time on Wards F & H and commented that staff were very engaged and motivated. The Chair was scheduled to visit the Spinal Unit with Dr Hankin week commencing 8 July. Mr Christian would be conducting an executive visit at the Ormskirk site. He had also spent half a day with the stakeholders of discharge planning teams which he had found insightful and informative. It was a useful perspective and had built rapport. Mr Shanahan had missed his regular Friday Red2Green visit on Ward 10b on 28 June due to attending an external meeting, and would be rescheduling this shortly. Ms Cosgrove and Dr Hankin had visited Ward 14a and the Spinal Injuries Unit, plus undertaken a general out and about session in the Emergency Access Unit (EAU). They had also given out preceptorship awards and pins. Dr Hankin added that whilst the orthopaedic wards were older in design and décor, and was not defining or detracting from the care given. Some wards with a better built environment could learn from the leadership seen on the older wards. Ms Patten advised about 'Operation Sparkle', a drive to de-clutter the environment on both the Southport and Ormskirk sites. Equipment had been repatriated and assets registered. Sept 19 Board – resources for eight wards at Southport, MDT room. Out to tender. Screenshots to share. Mr Nicholls drew attention to the 'Globetrotter Challenge' in which around 400 staff were participating. Activity had included a litter pick, sponsored walks and yoga and was focusing on working with others. The Chair had met with Rosie Cooper (Member of Parliament (MP) for West Lancashire) and Damien Moore (MP for Southport) who were keen to have the Secretary of State visit the Trust.	**DCEO**

- **Staff Story: Plaster Room Re-launch**

Mrs Kitson introduced Matt Parry, Plaster Room Manager who had been instrumental in re-launching the Plaster Room along with working collaboratively with colleagues across the Trust.

Mr Parry introduced himself and stated that gaps in the Plaster Service had been identified including limited visibility of the team which was perceived to have been left to itself to a certain extent.

Following a thematic review of pressure sores of Grade 3+, a review of the training given to Health Care Assistants in Accident & Emergency, which had previously taken ten minutes, was revised and an 8 hour session introduced to improve the standards and quality of care patients received and compliance with British Orthopaedic Associates standards. Additionally the process to order casts for patients was reviewed and the Order Comms system was put in place which had proved both efficient and speedy.

Mr Parry was pleased to report that the Tissue Viability Nurses for the Trust – the only plaster-led team in the country - had won an award for their work in reducing pressure sores and this method was being adopted across other Trusts. A number of requests for visits to see it in action had been received, with the focus of the team on education and 'getting it right'.

Evidence of the success achieved by the Team was illustrated in the case of a 94 year old patient with a pressure sore on the left heel who had been referred for amputation. Following a review by the Team, the pressure sore, which was 9cm x 6cm and down to the bone had healed with no need for amputation. Another case, in the community, related to a patient with a Category 4 heel pressure sore who had been affected for 24 months. Within 6 weeks of review the heel had significantly improved.

From a financial perspective, Mr Parry and his team had introduced cost savings for orthopaedic boots, reducing the cost from £32 to £9 each.

Mr Nicholls commented that he had met Mr Parry at the Trust's 2018 Open Day and he was a highly modest person who had gone beyond the call of duty, doing an incredible job of improving recovery and outcomes for patients. Mr Parry was a credit to the organisation and had been invited to join the National Working Group.

The Chair added his thanks, stating that the work undertaken by Mr Parry and his team had positively changed patients' lives. Mrs Gorry commented that the work was evidence of the values of the Trust, including listening to staff. She asked how the out of hours provision was managed, as the Plaster Team was only available Monday to Friday, 8.30am to 5pm and Mr Parry replied that all casts put on

	patients were reviewed within 72 hours. Mr Birrell asked about capacity and Mr Parry responded that the largest issue faced by the Team had been staffing numbers which was managed by re-scheduling the availability of the Team on both sites to work more efficiently. The Chair thanked Mr Parry for presenting the story and achievements of the Team. **RESOLVED:** The Board **received** the presentation and **noted** the lessons learned.	
STRATEGIC CONTEXT		
TB128/19	**Chief Executive's Report**	
	Mr Nicholls presented the report and started by referring to his recent appointment as Chief Executive of Wrightington, Wigan and Leigh and his subsequent resignation from the Trust. He stated that a spectrum of emotions had occurred and recorded his thanks to everyone for their kind wishes. A transition process would take place under the direction of NHS Improvement (NHSI) as the Trust remained a challenged provider. The strong and stable Executive Team he had been instrumental in implementing would continue their work, with Ms Patten leading on strategy, Dr Hankin on mortality, Ms Cosgrove on CQC and quality, Mr Shanahan on finance, Mr Christian on performance and Mrs Royds on recruitment and retention. Mrs Gibson asked how the impact of Mr Nicholls' decision would be managed and communicated to staff. Mr Nicholls responded that the decision had not been easy nor taken lightly. Non-Executive Directors were welcome to speak with him and he had met with staff-side to discuss the impact. He had increased his visibility throughout the Trust and talked to groups of staff. The simple message was that the Chief Executive had brought together a good team and changed the tone of the organisation. He noted that in the next months, the Trust would be half way through its three year programme of change. The focus for Mr Nicholls and his team continued to be to get the job done. The Team's focus would be 1. CQC visit: the Trust had a good story to tell, including that of staff like Mr Parry who was a living example of improvements. 2. Finances remained challenged and a clear handover plan would be provided. 3. Ms Patten's work on pre-consultation business cases, including clinical models and decisions would continue with regulators and commissioners.	

	The Chair commented that Mr Nicholls' resignation would be an opportunity to improve his profile internally and externally. **RESOLVED:** The Board **received** the report.	
QUALITY & SAFETY		
TB129/19	**Quality and Safety Reports were reported via a slide presentation showing highlights on the following :** a) Summary of Complaints & Compliments b) Monthly Mortality Report c) Quality Improvement Plan Update d) Safe Staffing: Monthly e) CQC Preparation Update	
	Ms Cosgrove informed the Board about the visit of Professor Brian Dolan, founder of 'End PJ (Pyjama) Paralysis' and the 'Last 1000 Days' movements, met hundreds of staff on a visit to the Trust in June 2019. He gave two lectures and walked around both hospitals meeting staff. By focusing on a patient's last 1,000 days, he aimed to help draw attention to where time was wasted, and what could be done differently for patients whose time was limited. 'End PJ Paralysis' focused on encouraging patients to stop wearing their nightwear during the day in hospital and get them up and moving. Prof Dolan stated that for every 10 days of bed-rest in hospital, the equivalent of 10 years of muscle-ageing occurred in people over 80-years old. The Trust would participate in a world-wide initiative, 10-12 July where staff would attend work in their pyjamas to highlight the issue **Infection Prevention and Control** • Operation Sparkle was launched across both sites and it provided an opportunity to tidy up and improve the environment for patients and staff by decluttering areas. The new Corporate Matron had led the work and had supported work across estates and facilities. • For a Quality Improvement project, the team was looking at why wards and clinical areas were not meeting their Hygienic Environment Action Team (HEAT) inspection standards, and how to embed improvement. **Medicines Management:** • The Medicines Management Team continued to work closely with the requests from the Model Hospital Team as part of the Use of Resources assessment. **CQC Update** • 91 of the Must and Should Do Actions had been completed (Green & Blue), 23 were on track to deliver (Amber), zero were Red 'not progressing to plan'.	

- Notification had been received of CQC Well Led Review 20– 22 August. Use of Resources assessment on 24 July. Unannounced core services inspection expected before 22 August
- Key Lines of Enquiry (KLOEs) Reviews had commenced in all clinical areas to review progress and identify any areas for further improvement, areas reviewed to date included: Adults A&E and Observation Ward, Ormskirk Theatres, Southport Outpatients, Wards 9b, 10a, 10b and 14a.

Research Achievements 2018/19

- The Trust had another successful year by recruiting 421 participants into National Institute for Health Research Clinical Research Network (NIHR CRN) portfolio research studies against the proposed NIHR target of 200. That was an exceptional achievement taking into account the staffing establishment.
- The Trust did not receive a reduction in NIHR funding for the financial year 2018/19 unlike the majority of other Trusts.
- The Trust recruited exceptionally well to the FUTURE Initiative (a study to develop a panel of healthy volunteers who would be asked to donate a small amount of blood which would then be genotyped) and had resulted in the Research Team being awarded the Trust's Time to Shine Award, which was presented to the team in October 2018.
- The Trust had been recognised as the top recruiting site, for the Fluid Optimisations in Emergency Laparotomy (FLO-ELA) study out of 49 sites across the UK.
- During 2018/19 the Trust made a significant contribution to the Clinical Research Network North West Coast (CRN NWC) Patient Research Experience Survey (PRES) by contacting our patients who had been involved in research.

National Inpatient Survey

Ms Cosgrove stated that the results of the survey were disappointing with the Trust response rate of 43% (533 patients) compared with the national average response rate of 45%. Of the scores compared to similar organisations, 52 were similar to the national average and performed better on 1 and worse on 10, mainly relating to discharge processes.

Safe Staffing

- Overall fill rate for May 2019 was 92.38%, a slight decrease on previous month.
- Trust vacancy rate for nurses and midwives had increased to 16.5% with the final upload of the 'new' establishment.
- The focus for the Clinical Business Units was the recruitment of clinical staff, linking with Cheshire & Mersey Workforce Collaborative through the Assistant Director of Nursing (Workforce).
- The overall Care Hours per Patient Day (CHpPD) for the Trust

	was 8.3 hours in May 2019. Further work was being undertaken with the Business Intelligence (BI) team to scrutinise the data and review the Trust's position. **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. **Clinical Negligence Scheme for Trusts (CNST)** The CNST incentive scheme was introduced in 2018/19 to reward Trusts for taking action in improving safety in Maternity. The expectation was that Trusts would be able to demonstrate the required progress against ten safety actions to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premium, approximately £318,000 for the Trust). Trusts' were expected to *provide a report to the Trust Board demonstrating progress with evidence against each of the 10 safety actions which would need to be signed off by Board and discussed with the Commissioners before submitting to NHS Resolution by 15 August 2019.* For 2019/20 (Year 2), Trusts would be expected to demonstrate achievement of all 10 safety actions to recover the element of their contribution and also receive a share of any unallocated funds Trusts not achieving compliance would not recover their contribution but might be eligible for a small discretionary payment to help them progress. The Trust was compliant with safety indicators with the exception of: **'SA 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?'** MSDS version 2 readiness questionnaire had been completed and returned to NHS Digital. MSDS version 2 had a different format than previously and upgrades to information systems were required. That had been completed on the Maternity Information system and applied to the BI system which was now being tested. Data for April 2019 submission June 2019 at which time we will have confirmation that all data quality criteria has been met **Action taken**: *Awaiting confirmation to ensure that data quality had been met and update accordingly*. **'SA 8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?'** There were gaps in compliance for: • Anaesthetists 40% compliant (as of 18 June 2019). 14 out of 30 still needed to attend training	**DoN** **DoN**

	• Operating Department Practitioner (ODP)/Recovery Staff were 36% compliant (as of 18 June 2019) Expected to achieve 90% by August 2019. **Action taken**: *Additional training dates had been facilitated to take place on 3 July, 8 August and 18 September 2019.* **Mortality** Dr Hankin presented the data which highlighted there had been demonstrable sustained improvement in mortality figures across all groups of diseases with the exception of acute renal failure. For the reporting period May 2018 to January 2019: • Summary Hospital Level Mortality indicator (SHM)I 1.18 down to 1.11 • Hospital Standardised Mortality Ratio (HSMR) 123.4 down to 104.5 • 'Rolling' HSMR was down to 86.3 • Pneumonia SHMI was 1.17 which was now within expected range • HSMR for other respiratory diseases remained too high • In hospital crude death rate 21.5 (31) which was below target, despite increased winter pressure The Chair thanked Ms Cosgrove and Dr Hankin for their work in comprehensively reporting on the issues which enabled the Board to fully understand them. Mr Birrell commented that it was a pleasing development to see reporting on Research & Development delivered to the Board and encouraged the Trust to participate in further research. He added that achieving 'End PJ Paralysis' would require secure storage and itemising laundry to return clothing to individual patients. AAAs Highlight Report from Quality & Safety Committee Dr Bricknell, in his role as Chair of the Quality & Safety Committee, presented the Alert, Advise & Assure Highlight Report (AAAs) report and highlighted that: • The Trust continued to fail to meet targets on Same Sex Breaches and the time spent on the Stroke Unit. • The Trust continued to fail on 62-day Cancer target and the Chief Operating Officer's report would be shared with the Finance, Performance & Investment Committee. **RESOLVED:** The Board **received** the monthly report	**DoN**
TB130/19	**Engagement Strategy**	
	Mrs Royds presented the Strategy which set out what engagement was, why it was so important, the key roles and the proposals to enhance engagement across the organisation. It was also linked to Vision 2020, Workforce & Organisational Development Strategy, and the Trust's values.	

- The four enablers of engagement included:
  - **Strong strategic narrative** about the organisation – Vision 2020
  - **Engaging managers –** focused on people, coaching and development opportunities etc.
  - **Employee voice -** throughout the organisation, challenging views, employees are seen as central to the solution
  - **Organisational Integrity –** Living the values

Employee engagement would be measured using:
- Annual NHS Staff Survey
- Friends & Family Test (quarterly)
- Local Pulse Surveys (quarterly)
- Feedback from Staff SOProud Conversations, Big Brews etc.
- Key Performance Indicators: turnover, sickness, appraisal compliance etc.
- Monitored through Workforce Committee

Success would be demonstrated by: Greater productivity
- Improved financial performance
- Improved patient care
- Increased innovation
- Healthy staff turnover
- Improved staff morale and wellbeing
- Improved Health & Safety performance
- Quality improvement as a continuum

'Big Conversation'
- Launched 19 June 2019
- Big Conversations consisted of 1.5 hour workshops
- Big Brews consisted of canteen sessions on both sites
- Big Walkabouts would take place during the day, evenings, nights and weekends
- Big Team Talks would be delivered locally
- Staff ideas/feedback/opinions on "what makes a good day?" in our organisation
- A review would take place in September 2019 to ensure that the approach was working
- Communication of issues/outcomes/action
- Ongoing engagement approach

So far staff had welcomed the initiative and were providing honest feedback. When asked to rate the Trust as a great place to work, on a scale of 1-10 (1 = unhappy 10 = happier) of the 275 responses received, 82% scored 5-10 on the scale.

The responsibility of the Board, Non-Executive and Executives was to develop a culture of engagement by:
- Living our values every day
- Making a commitment to staff development

	• Encouraging staff to challenge assumptions and voice their opinions • Showing staff they were valued • Act in an honest and consistent manner • Being visible and available to staff at all levels • Join in 'Big Conversation' – very welcome Mr Nicholls noted that the quarterly Impulse Survey had shown a modest improvement and Mrs Royds added that the general feedback was that *'it is getting better here'*. On the subject of completing the Staff Survey, staff have suggested that time be allocated so that they could undertake it. Mrs Gibson in her role as Chair of the Workforce Committee presented the Alert, Advise & Assure Highlight Report (AAAs) report which was taken as read. She commented she was keen to see how the plan for next steps would be undertaken and the feedback from it. Mr Nicholls stated that engagement of staff and the public would be separate processes at present. The Chair added that the process would be tracked by the Workforce Committee and all key milestones reported to the Board. **RESOLVED** The Board **received** the report	
PERFORMANCE & GOVERNANCE		
TB131/19	**Assurance & Performance**	
	Integrated Performance Report (IPR) Mr Christian highlighted key elements of the report and stated that 23 indicators had improved, 7 had remained the same and 29 had deteriorated. **Trajectory Update** Clinical and senior leaders had met to sign off each trajectory at the Hospital Management Board, ensuing that they were set within the context of Specific, Measureable, Appropriate, Relevant and Time bound (SMART) and with the ambition element being a key focus. Accountability would be through the Performance Review Boards for the Clinical Business Units (CBU) and the Hospital Improvement Board (HIB). **Improving Indicators** The Conversion rate, which included patients admitted directly to a ward or via an assessment ward was 19% in May 2019, down from 20% in April 2019 and 21% in March 2019. With a 10% increase in demand this was a significant achievement. The approval of a Business Case for Older Peoples Care would have a significant impact on continuing to manage it.	

Theatre Utilisation performance had continued to increase for the third month in a row. The approval of a business cases for Anaesthetics would also have a significant impact on continuing to manage it.

Deteriorating Indicators
May 2019 saw a further deterioration of fractured neck of femur repairs within 36 hours; this was in part due to Orthogeriatrician capacity.

Whilst performance of the A&E 4 hour standard was not at its desired level, the Trust was holding performance (4th best in the North West for May 2019) whilst many other trusts had seen a worsened position for that month which was a concerning national trend which started at the beginning of October 2018. Work was ongoing with community partners to address the demand.

May 2019 saw a further deterioration away from meeting the standard for Diagnostic Waits. Reasons included capacity (Radiology and Endoscopy) which had been addressed with temporary staff who had been inconsistent and patient choice of appointments. Skype interviews had now taken place for a Radiology Locum post.

Staff turnover had been increasing since January 2019. This was materially affecting several other areas of performance; including agency spend, as recruitment was not keeping pace with the number of leavers.

The Thornbury agency had continued to be utilised as a last resort which had proven costly. Work continued with NHS Professionals to be more effective and any temporary cover was approved for the Nursing Team by the Deputy Director of Nursing. Mr Shanahan added that the Procurement Team had considered the Tier 2 agency providers and it was anticipated that it would take three months to embed the process and have agreement with the framework.

The average length of stay had risen, with the numbers of patients medically fit for discharge increasing. Pressure had been placed on the community and an objective of the System Management Board was to ensure that those fit for discharge were discharged efficiently.

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 Mr Christian's report.

The Chair thanked Mr Christian for the presentation including the top/worst five indicators. Future reports would include trajectories against the forecast.

	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 service was underway. It was anticipated that that would highlight a number of potential gaps. The Committee assured on: • The Trust was 9th out of 136 nationally for A&E performance. **RESOLVED:** The Board **received** the IPR and the highlight reports from the assurance committees and the Hospital Management Board.	
TB132/19	**Financial Position at Month 2**	
	Mr Shanahan presented the report and key highlights. 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 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. Expenditure has not reduced from 2018/19 Quarter 4 levels. Contract discussions have not been finalised with West Lancashire CCG and NHSI/E will now arbitrate. Capital; all Trusts have been advised that capital plans for 2019/20 are significantly more than the funding available. It is unclear at the moment what impact this will have on the C&M HSLI allocation of £400,000 for IT projects. Ms Patten stated that the 6 Facet Survey tender was now complete and contract had been awarded. The survey is expected to take 16-18 weeks to complete. **RESOLVED:** The Board **received** the report	
TB133/19	**Risk Management:** **Board Assurance Framework (BAF) and Risk Register**	
	Mr Charles presented the BAF report. The six BAF risks had been further updated and made SMART, along with clear timelines to deliver improvement and reduce risk scores. They would be linked electronically to Never Events and	

	Serious Untoward Incidents. The Audit Committee would consider the BAF at its July 2019 meeting and would be taken to the Assurance Committees (two monthly) in advance of the October 2019 Board. Mr Charles also asked the Board to approve the Risk Management Strategy which was updated to take account of the refined strategic objectives, principal risks, approval of a Risk Appetite Statement and an updated Risk Escalation Process monitored via the Risk and Compliance Group The Chair commented that a tremendous amount of work had taken place along with discussion at three Board meetings. He also asked that the Board approve the Risk Management Strategy which would be further scrutinised by the Audit Committee at its July 2019 meeting. **Corporate Risk Register** This was presented by Ms Cosgrove. Dr Bricknell stated that the extreme risks which had been 'red' for a while were reviewed by the June 2019 Quality & Safety Committee. Ms Cosgrove was cautious that the risk should not be downgraded until the implementation of agreed actions. **RESOLVED:** The Board **received** the BAF and Risk Register reports	
TB134/19	**Corporate Governance Manual 2019/20**	
	Mr Charles presented the report. The statutory instruments, which consisted of Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegate had been reviewed and approved by the Audit Committee at its Extra-ordinary meeting on 22 May 2019. The Corporate Governance Manual 2019/20 included those documents and had been updated to include a governance framework including the legal and regulatory framework, Nolan Principles of public life, prime policies, Terms of Reference of the Board and its committees, their annual business cycles and Tool for assessing their performance and effectiveness. Due to the size of the document, a link had been provided to the intranet for ease of access*. It was noted that when outside the environs of the Trust, it would be useful to have an external, controlled area to access this. It was also proposed that a number of hard copies be made available.* **RESOLVED:** The Board **approved** the Corporate Governance Manual.	**CoSec**
TB135/19	**Quality Account**	
	Ms Cosgrove presented the Quality Account which had been approved, subject to the amendments by the Extra-ordinary Board	

	and Quality & Safety Committee. **RESOLVED:** The Board **ratified** the decision of the Quality & Safety Committee on 24 June 2019 which approved the Quality Account.	
PB079/19	**Information Management & Technology (IM&T) Strategy Update**	
	This item was originally planned to be included in the Private Board but was transferred to the Public Board. The six key areas which over the next four years would support a digitally mature and transformative IM&T environment were: 1. Delivering the Electronic Patient Record 2. Supporting Clinical Workflow 3. The Deteriorating Patient 4. Robust and efficient IT 5. Business Intelligence 6. Flexible Working and the Share Care Record The Strategy set out a programme of work centred on moving to a single, comprehensive, structured electronic patient record (EPR), through Medway (supplied by System C) and to improve the existing infrastructure to support our aspiration to extend the coverage of the basic EPR. During 2018/19 a number of the originally planned projects were completed. With the development of a new strategic plan for the Trust, the first steps of which were laid out in Vision 2020, the existing IT work programme still contributes to the new direction. The roll out of the project for Windows 10 to replace Windows 7 (which would be unsupported from January 2020) had begun by replacing 227 servers for better performance which also might benefit the performance of System-C. This project would enable staff logging on at any Cheshire & Mersey site to do so without impedance. Conversation took place about maintaining momentum and the necessity for addressing areas of improvement, i.e. the current IT strategy which did not make it clear how staff should be equipped with the necessary skills to operate in a fully digital environment nor how those skills could be better delivered. Mr Nicholls noted that for 2020/21 all Boards would be required to have a Chief Information Officer and Mr Birrell stated that that would be a major step forwards. **RESOLVED:** The Board **received** the IM&T Strategy.	
CONCLUDING BUSINESS		
TB117/19	**Questions from Members of the Public**	
	Mr John Ryan stated that relating to the Engagement Strategy it was a matter of concern that both Mr Charles and Mr Nicholls would be	

	leaving the Trust. Both had proven to be safe pairs of hands and had given good service. He asked if information management would have a seat (or Champion) on the Board. Mr Nicholls responded that his departure would present an opportunity to change the internal responsibilities and champions and would be addressed by himself and the Chair. The Chair agreed, stating that that was an opportunity for the Team and concerns relating to IM&T were valid.	
TB118/19	**Any Other Business**	
	Mr Charles took the opportunity to thank the Non-Executive Directors for their challenge and support throughout his tenure. When he arrived at the Trust in August 2017 there was no BAF in place and he had teamed up with Mr Birrell who had proved invaluable in bringing the BAF to where it was. He thanked the Board for its help and was encouraged by their kind words. His final day with the Trust would be 31 July 2019 but he would return in August for the CQC/Well Led interviews. The Chair added his personal thanks as his imminent departure approached. Mr Charles would be missed however he would no doubt be looking forward to his own future and the Board wished him well.	
TB119/19	**Items for Forward Agenda – 4 September 2019** • Annual Plan • IPR Trajectories • Balanced Score Card • Financial Recovery Plan • Winter Plan	
TB120/19	**Message from the Board**	
	•	**Communications**
TB121/19	**Meeting Evaluation**	
	Circulated following the Board meeting.	
TB122/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 4 September July 2019 Ruffwood Suite, Clinical Education Centre, Ormskirk, L39 2AZ	

There being no other business, the meeting was adjourned

Board Attendance 2019/20												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓	✓	✓	✓								
Jim Birrell	✓	✓	✓	✓								
David Bricknell	✓	✓	✓	✓								
Ged Clarke	✓											
Juliette Cosgrove	✓	✓	✓	✓								

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Julie Gorry	✓	✓	✓	✓								
Terry Hankin	✓	✓	✓	✓								
Joanne Morgan		✓	✓	✓								
Silas Nicholls	✓	✓	✓	✓								
Therese Patten	✓	✓	✓	✓								
Steve Shanahan	✓	✓	✓	✓								
Gurpreet Singh	**A**	✓	✓	**A**								
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓	✓	✓	✓								
Audley Charles	✓	✓	✓	✓								
Steve Christian	✓	✓	✓	✓								
Jane Royds	✓	✓	✓	✓								
A = Apologies ✓ = In attendance												

Public Board Matters Arising Action Log
as at 4 September 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB072/19	Apr 2019	**Assurance & Performance - IPR**	IPR should relate to the Trust's performance and include the explicit impact for system failure on the community, primary care, the third sector and the Walk-In Centres etc.	**COO**	Jun 2019	Aug 2019	**May Update** Due in June **June 2019** The COO is reviewing KPIs with system partners to create a whole system health and social care economy dashboard that will monitor overall effectiveness of the system. Due in September. **September 2019 Update** The Trust is working with system partners and consultants (Venn) to review the process and develop a capability tool to monitor KPIs and system capability. Modelling to be presented at September Finance Performance & Investment Committee.	**GREEN**
TB127/19	July 2019	**Patient and Engagement Issues**	Screenshots of the refurbished MDT room to be shared with Board	**DCEO/DoS**	Sep 2019	Sep 2019	**September 2019 Update** Communications issued. Plans will be brought to the September Board for circulation.	**GREEN**

Public Board Matters Arising Action Log
as at 4 September 2019

Southport and Ormskirk Hospital NHS Trust

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Blue	**Completed**

COMPLETED 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** MD requested action be closed as sufficient SOPs are available. **Completed**	**BLUE**
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**	**BLUE**

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Blue	**Completed**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB031/19	Jan 2019	**Integrated Performance Report (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**	**BLUE**
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**	**BLUE**

Public Board Matters Arising Action Log
as at 4 September 2019

Southport and Ormskirk Hospital NHS Trust

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Blue	**Completed**

COMPLETED 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 **Completed**	**BLUE**
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 reported that the staff member had previously retired and this had been appropriately recognised **Completed**	**BLUE**
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**	**BLUE**
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**	**BLUE**

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as at 4 September 2019

Southport and Ormskirk Hospital NHS Trust

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Green	**Progressing on schedule**
Blue	**Completed**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
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**	**BLUE**
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**	**BLUE**
TB134/19	July 20196	**Corporate Governance Manual 2019/20**	An external, controlled area to access the link for the manual. It was also proposed that a number of hard copies be made available.	**CoSec**	Sep 2019	Sep 2019	**September 2019 Update** **This is now on the website:** **https://www.southportandormskirk.nhs.uk/wp-content/uploads/2019/02/Corporate_Governance_Manual-June-2019-20.pdf**	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB147/19**	**Report Title**	**Chief Executive 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

- Care Quality Commission inspection
- £900,000 ward refurbishment programme
- North West Regional Spinal Injuries Centre
- Appointment of new chief executive
- A&E demand continues to rise

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

Care Quality Commission inspection

We were pleased to welcome a team from the Care Quality Commission (CQC) over the summer months for an inspection of Trust services. Unannounced inspections were conducted in:

- Urgent and emergency care at Southport
- Medicine and surgery at Southport
- Critical Care
- Children and young people's services
- End of life services
- Sexual health services
- Outpatients at Ormskirk

The team returned at the end of August to carry out the scheduled "well-led" element of the inspection. This final phase is a series of interviews with the Board and senior management team that tests the leadership of the Trust.

The inspectors remarked that we are a very different Trust to when they last visited in November 2017.

They were overwhelmed by positivity, a willingness to engage and the hard work that has delivered so many improvements for patients. They were also impressed with how many staff readily volunteered to tell them about their great work

We expect a first draft of the report by the end of September or early October.

£900,000 ward refurbishment programme

The Hospital Management Board approved a £900,000 programme of improvements to eight wards at Southport hospital.

The first phase of work on wards 7A, 7B, 9A, 9B, 11A and 11B will run from September until December. Work on wards 10A and 10B will start in April, avoiding the busier winter period.

The improvements will focus on the central ward and sluice areas but will also include:

- Upgrades of patient bathrooms
- Staff locker rooms and upgraded staff toilets
- A multi-disciplinary team room in each area
- Improved storage for stock and linen
- Changes to fire doors in each ward to improve bed use and patient experience
- Adjustments to improve the experience of patients with dementia

This will be the first major facelift for these wards since the hospital opened in 1989.

This investment is a demonstration by the Trust of not only our commitment to quality but patients' experience of care. The improvements will also provide a brighter, more comfortable workplace for staff.

North West Regional Spinal Injuries Centre

In July, we took the difficult decision to temporarily close the North West Regional Spinal Injuries Centre at Southport hospital to new admissions.

This is to allow essential upgrading and deep cleaning of bathrooms following an increase in the incidence of patients with the Klebsiella bacteria. The decision has been taken in the best interests of patients and in accordance with guidance in our infection outbreak policy. The centre will open to new admissions in due course.

Existing patients are unaffected and will continue to receive treatment and rehabilitation. Patients requiring admission will be managed for the time being at their referring hospital.

Klebsiella is an antibiotic-sensitive organism found in the gut. However, it sometimes develops a resistance to some antibiotics, which is what has happened on this occasion.

This is an organism that doesn’t usually cause infections but when it does it is most likely to affect the urinary tract and people with long-term catheter use. When infections occur there are still effective antibiotics that can be used even though there is some antibiotic resistance. There is no risk to the health of the general public.

Appointment of new chief executive

Since my last report to the Board I have accepted the post of chief executive at Wrightington, Wigan and Leigh NHS Foundation Trust when Andrew Foster retires. I will leave the Trust on 31 October 2019.

I was appointed in December 2017 and had expected to be at Southport and Ormskirk much longer, so I’m naturally sad to be going so soon.

However, the dedication of staff over the past 18 months to transform the quality of care we give (and so evident during the CQC inspection) has helped build a fantastic foundation for my successor at what will still be my local hospital.

The Trust Board moved quickly to advertise the post and has been delighted by the interest shown. The Board hopes to make an appointment later this month.

A&E demand continues to rise

The Trust continues to experience record demand with a consistent 10% year-on-year increase in attendances at A&E.

Despite these challenges patients continue to wait much less time for transfer into hospital from ambulance; receive more timely treatment; and have a better experience of care in the department.

We continue to work closely with the local NHS and partners in local authorities and social on our preparations for the winter.

In brief …

MPs' visits. I was pleased to welcome Southport MP Damien Moore and West Lancashire MP Rosie Cooper to Southport hospital during August. Mr Moore was shown our now completed and refurbished A&E department as well as meeting me and the Trust Chair. Ms Cooper joined myself, the Chair, colleagues and Staff Side representatives to sign Unison's Respect Your Youth charter.

Pets as therapy. It's been a pleasure to start welcoming four-legged visitors to the Trust this summer. A new animals policy now means patients are able to benefit from pets as therapy dogs for the first time.

Hospital open day. I look forward to welcoming people from across West Lancashire, Southport and Formby to this year's Open Day on Saturday 7 September at Ormskirk hospital. Hundreds of people attended our first open day for many years at Southport hospital last September. I'm sure we'll see an equally good turnout at Ormskirk – hopefully with considerably better weather!

Silas Nicholls
September 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**PB148/19**	**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 X 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.

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

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

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

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

☐ Compliance	☐ Legal

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

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

This 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

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

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY IMPROVEMENT PLAN

CQC inspection has concluded with the well Led taking place on the 20th to 22nd August, the final report is expected in Autumn 2019
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. Monthly Quality & Safety Group meetings in progress to review and monitor progress, chaired by Director of Nursing, Midwifery, Therapies & Governance and within papers to the quality and safety committee.
SONAAS (ward accreditation) implementation plan continues to be rolled out, self-assessments are currently being completed on 15 wards and the assessment schedule is expected to commence in July 2019. In addition the Quality Matrons are facilitating mini quality reviews using CQC methodology in all 27 clinical areas, any good practice is highlighted as well as areas for improvement.

QI METHODOLOGY

QI training from NHS I commenced the 14 week programme in June 2019. Executive and senior managers attended the course. Their QI projects have been directly linked to our four Quality Priorities and a celebration event is planned for the 12th September to showcase this work

SAFE STAFFING

Nursing Establishment Review ratified by Trust Board in May 2019. Implementation plan managed through Workforce Improvement Board. Nurse Recruitment & Retention plan aligned to Nursing establishment review and are engaging with NHS Improvement Workforce Team.

MEDICAL WORKFORCE ENGAGEMENT

Medical Director reviewing timescales for Medical Engagement follow up visit, now expected December 2019.
The domains within the MES from May 2018 survey have been mapped to the outcome of the 'cultural review paper 'as presented to June 2019 Board.
Medical Workforce currently a KLOE and discussed as part of the trust monitoring process (QID)

QUALITY & SAFETY GOVERNANCE

On-going review of the risk registers and Risk and Compliance Group monthly to monitor progress.
Policy Review continues and the Policy Panels continue to ensure compliance with timescales for policy reviews
An improvement plan for the management of incidents, complaints and claims has been developed and this is being implemented following a process mapping exercise of the processes.

Key Achievements/Progress in Month – Quality & Safety

CQC Inspection completed
Work relating to the 4 quality priorities continues to move forward

Key Risks/Issues	Mitigating Actions	RAG
Significant clinical quality improvements required	Priorities agreed and resource in place to support delivery, 'KLOE Reviews' planned for all 27 clinical areas on both sites to test preparedness for CQC and identify areas for improvement	A
Slow progress made in relation to medical engagement	Review timescales for follow up survey after establishing baselines from 2018	A

Operational Performance (Exec Lead: Steve Christian)

RAG Rating

Progress

4 hour standard

The Trust attained 88.6% against the 4 hour standard for patients attending AED - missing its performance trajectory (90.3%) by 1.7% in July and was 3.3% down on July last year. The Trust was ranked 47 of 123 Trusts (much improved national ranking position against previous month). The Trust ranked 21 best in the North region out of 44 acute Trusts.
Issue: For the month of July 2019 Southport ED attendances were up by 10% against July 2018. 9 of the 10 highest ever Southport ED attendance days dates are in the 2019 with 4 dates in July 2019. Whilst the Trust conversion rate for an inpatient bed (excluding assessment units) has stayed at around 20% the increased volume of patients presenting to Southport ED has meant more patients are requiring admission. Therefore we have a greater demand for beds due to increased demand. The focus remains on reducing LoS to help manage this increased demand and in testament to our system we perform better than the national median (which we didn't do 12 months ago) however this itself isn't enough at this stage. In addition the Trust has experienced a 30% increase (July 2019 against July 2018) in the number of Medically Optimised for Discharge (MOFD) patients occupying an inpatient bed that no longer need to be in hospital if the services were in place across the community and primary care tiers.
Action: The Trust continues to focus on internal improvement opportunities and has an established Patient Flow Improvement Programme (PFIP) that oversee the improvement plan – however this alone will not drive 4 hour improvement and significant reduction in LoS / bed days. The Trust is engaging with the system on wider health and care economy actions and proposals given the increased demand and worsened position on MOFDs. The Venn work is coming to its end with final results being published at the end of August. The initial finding suggests capacity shortages in the intermediate care tier (both step up / down) across bedded and non-bedded services. All partners agreed from the outset the findings would be the priority of the system to support winter and this must be followed through to support continued improvement of the system UEC system.

18 week RTT

Whilst the trust continues to meet the 18 week standard, there is a continued deterioration in performance to 92.72% . In the first quarter alone there has been an increase in the PTL of 3.5% however long waiters are being managed with no risk to 52 week wait breaches. The Trust currently has medical resource shortages in the majority of specialties. There are a few of particular note:

Anaesthetics – currently the Trust has an unprecedented shortage of anaesthetists with a vacancy rate in excess of 40%. This is due to a number of factors most notably difficulty to recruit to positions and a severe national shortage. This is having an obvious knock on effect on planned care due to the requirement to cancel surgical sessions due to a lack of anaesthetic medical cover. In recent months the Trust has cancelled 38 theatre sessions due to that lack of cover. It has only been through goodwill of our medical staff and obviously financial incentives such as WLIs that we have been able to keep cancellations to that level. The Trust are attempting to recruit but also going through the process to future proof the service with an approved business case to transform the workforce via demand and skill-mix recruitment initiatives.
Community Paediatrics – the service sits outside of PBR and is for West Lancashire residents only. The service has been under funded historically and performance has seen gradual deterioration for the last 2 years as demand into the service has significantly increased. The CCG has recognised the funding gap and has approved the funding for an additional 0.6 WTE Community Paediatrician. The Trust is underway in recruiting and in the interim continues to manage the service through its single handed Consultant

Diagnostics
The two key service lines that are impacting upon performance for Diagnostics are :
Radiology –
Issue: National shortages within both the Radiologist and Radiographic workforce are having impacts on the delivery of diagnostics within the Trust. The Radiology team are currently at 40% vacancy (10 WTE). Of the positions filled only 5 of the 6 are substantive with 1 locum. This has resulted in delays for decisions to treat and hence delayed discharge back into the community. A performance improvement plan is in place.
Action: Recruitment is obviously high on the agenda with continuing sourcing of high cost locums to fill as many vacant sessions as possible. To support recover and maintain resilience the Trust has in place SLAs with another local provider and a private provider within the framework (PDS) to support outsourcing to support delivery of activity.
Endoscopy:
Issue: Due to recent national government briefings regarding Consultant contracts (tax rebate and pension allowances) the Trust has lost capacity within the service to manage demand (and further compounding this at a time when demand has increased).
Action: The Trust has been undertaking significant work in improving endoscopy performance which includes organisational change to allow for increased availability of endoscopy sessions from a nursing workforce point of view. There Trust has commenced in-house training of nursing staff to be able to perform endoscopy. The Trust has also engaged with external providers to assist medical staffing of endoscopy sessions through insourcing.

Operational Efficiency (Exec lead: Steve Christian)

RAG Rating

Progress

Theatre Utilization

The theatre efficiency group meets fortnightly and chaired by Steve Christian. The aim of the programme is to deliver an 85% utilization by 31st March 2020, showing month on month improvement. The progress is positive and overall utilization ahs improved by 5.7% against baseline.

Three Main Focuses:

- The Golden Patient - starting on time or early for the first patient on the list.
- On The Day Cancellations – decreasing avoidable cancellations.
- Scheduling – adequate scheduling processes to maximise existing available theatre time.

The Golden Patient	% On Time or Early Starts (Jan 19-Jun 19)	% On Time or Early Starts (Jul 19)
All Specialties	41.28%	57.6%

Cancellations	Jan 19 – Jun 19	Jul 19
All Specialties	9.63%	8.72%

Utilisation	In Session Utilisation (Jan 19 – Jun 19)	In Session Utilisation (Jul 19)
All Specialties	70.98%	75.7%

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. DNA rate remains at a rate better than national median and the recent test in the introduction of 48 hour pre clinic reminders have proven successful which the team are now working on making this a business as usual procedure. Another key feature which improves efficiency is the timely completion and recording of the outcome form.

Currently have a number of PDSA cycles happening across a number of different specialty clinics: Ophthalmology ODGH; Urology; Orthopaedics SDGH; and Dermatology. The tests are showing success, for example, Ophthalmology ODGH previously had 70-80 missing outcomes on each daily report

Actions:

- All clinic patient lists printed off – previously this did not happen, this enables reception/nursing staff to track patients.
- Outcome forms are completed at each appointment by the clinician, not all left to the end of clinic
- Patient is given the outcome form to hand to reception – nurse ensure this happens
- The outcome form is processed on medway and is then put into the evolve notes for scanning
- Note sent to scanning bureau and all scanned - this ensures a failsafe (previously forms shredded)

Outcome so far:

For the 4 weeks PDSA there have been no missing outcomes recorded. We will now be extending this PDSA out across other OPD clinics trust-wide.

Patient Flow

The Patient Flow Improvement Programme (PFIP) group meets fortnightly and chaired by Steve Christian. The aim of the programme is to improve 4 hour performance by optimising patient flow with a key focus in reducing stranded patients occupying an inpatient bed. For July, the number of patients with a LoS > 7 days occupying an inpatient stay reduced to 169 patients which has delivered the NHS I trajectory.

Actions:

- Away for SAFER engagement day and further ward visits planned to present always events in relation to discharge
- Establishing ward level leadership for the management of patient discharges – to embrace and bring together the clinical leadership and full MDT.
- "Right ward first time" – and an emphasis on reducing the number of patient outliers on wards that don't necessary specialise in patient's condition, through effective bed allocation that will be monitored
- through the bed meetings, thereby reducing LoS and additional bed days added to patients stay when
- on the wrong ward.
- Plan for every ward to have at least two discharges per day, one before lunch, and to monitor through the bed management and manager of the day each wards progress against expectations – tracking
- and acknowledging successes and supporting wards that ae struggling within the day.
- Publicising "What you need when you come into hospital"

Key Risks	Mitigating Actions	RAG
Achieving Constitutional Standards The key issues being: • Workforce – gaps in acute medicine physicians, radiologists, anaesthetics and geriatricians are clearly impacting on current performance and being able to sustain a consistent level of performance (across 4 hour standard, diagnostic and cancer in particular) • Increased demand and worsened performance in MOFD and super-stranded metric (this is an external factor that continues to impact on our ability to improve the efficiency of the Trusts operational services). A lack of a signed off winter plan that addressed the Venn recommendations – noting Venn was commissioned from regulators with a commitment from the system we would implement findings.	The introduction of the "Workforce Improvement Group" must focus on the timely recruitment of the critical posts that continue to provide challenges to maintain an effective and reliable service offer. On-going dialogue with CCG and system partners to determine root cause and the Venn work will help determine the gaps and the priority actions. The Trust continues to operate its escalation plan and SAFER start principles however this alone will not generate the required outcome. Discussion continue with system partners to strengthen the community / local authority offer. The system has introduced a Programme Executive Director to help align partners to a single improvement plan for Winter which should adopt the recommendations of the Venn review. To date, the system does not have a plan that ahs been signed-off.	R

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. Sickness absence rates have consistently decreased since January 2019 and have remained under 5%. This month sickness absence increased slightly to 5.05% in June 19 which is above the Trust 5% target for the first time in 4 months.

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 – Nursing Recruitment and Retention steering group established to continue delivery
Exit Interview process, reviewed and relaunched to ensure meaningful data is captured, analysed and utilised going forward
Reduction in time to hire programme reporting to Model Hospital and WIB

LEARNING AND DEVELOPMENT

CBU's have worked with HR to set trajectories to increase mandatory training rates to stretch target of 95%
CBU's have worked with HR to set trajectories to increase appraisal rates to 85%
Work in partnership with AQuA to deliver a Board Development Programme – commenced July 2019 – draft plan to Board Sept 2019
Scoping 4 x leadership/management development programmes – Triumvirate, New Consultants, 2 x management programmes for all staff
Apprenticeship levy supporting new roles i.e. Trainee Nursing Associates, Assistant Practitioners , Advanced Clinical Practitioners

HEALTH AND WELLBEING

Reviewed and updated the Health and Wellbeing Strategy for the Trust and supporting action plan.
Reviewed and updated the Health and Wellbeing (sickness absence) action plan for NHSI project.
To lead on this year's Flu campaign – 2019/2020 CQUINN is for 80% of frontline healthcare workers to be vaccinated.
Provide 'mental health first aid' to staff, 'Mental Health First Aid Training' completed.
Ensure compliance with Key Performance Indicators for pre-employment screening, reducing time to hire.
Ensure compliance with Key Performance Indicators for management referrals, supporting attendance and expediting return to work whenever possible.

OD, CULTURE AND STAFF ENGAGEMENT

SoProud Big Conversations & Big Brews launched June 2018 – focus on values & behaviours and how to make SOHT a great place to work – to inform a values & Behaviours Framework March 2020
Staff Engagement Strategy approved by Board July 2019
Leadership Strategy approved at WFC July 2019 – to Board Sept 2019
Talent Management Self-Diagnostic Tool – Member of pilot group (August 2019) – waiting online link
Ensure the Trust meets its statutory Equality and Diversity obligations

HR IMPROVEMENT PRIORITIES

Workforce efficiencies programme model delivery

WORKFORCE (1)

AMBER

Key Achievements/Progress in Month

- Workforce Improvement Board - held 2 weekly – driver diagrams & action plans in place
- Review held with C&M cluster trusts to establish shared position on renewal/ extension/ review of contract position of NHS Professionals – final contract discussions in place with challenges from 1 cluster Trust impacting ability to deliver.
- 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. HRD presentation now planned for August 2019. Review in progress of savings opportunities by Trust the contract offers.
- Tier 2 agency cascade implemented for nursing contributed 411 hours in July.
- Proactive increase in availability of allocation ward shifts with enhanced bank rate for nursing implemented reviewing data of impact of school holidays contributed 637 hours in July.
- Model Hospital HR directorate reviews completed with revised business case to be presented to August BDISC and HMB.
- The new Supporting Attendance Policy has been implemented with training now being delivered across the Trust. The majority of managers have received training on the new policy and the sickness absence trend over the last 4 months is a sustained reduction rate below 5%. The policy will be reviewed when it has been implemented for 6 months. The review is planned for 6th September 2019.
- Sickness absence has slightly increased lightly in month to 5.05% which is the first time in 5 months that sickness absence has gone above the Trust's 5% target. Sickness absence improvement has been encouraging 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 70.41% for July 2019 which is a continued decrease from May 2019. This is the 3rd month that compliance has decreased and has bucked the monthly improvement trend. All CBU's have been asked to present their revised PDR improvement plans report to meet 85% improvement at the July 2019 Performance Review Boards. Unfortunately due to the unannounced CQC inspection the PRB meetings were stood down therefore they will be presented at August's meetings. In examining the drop in performance last month, it was established that the calculation of the figure had been changed to the ESR calculation which has impacted on the performance. However, despite it being anticipated that compliance would increase again next month this has yet to happen.
- Core mandatory training remains above the Trust target >85%
- Board Visibility initiatives ongoing
- AQuA Board Development programme commenced July 2019 and draft plan to be presented to Board (Sept) based on skills audit, values, behaviours, individual & group development
- Monthly Valuing our People Group meetings to deliver Workforce & OD Plan
- SOProud Conversations commenced June 2019 – "Big Conversations & Big Brews" - asking staff how to make this a great place to work with a focus on values & behaviours
- Staff Engagement Strategy approved at Board July 2019
- Shadow Board Programme on schedule for September 2019 – 9 delegates confirmed
- Discussion to design communications plan for Staff Survey to commence Aug 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, networking and infrastructure work has began to be undertaken in order to support the additional workstations, contractors have been sourced and have began 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 – attained final sign off at policy ratification group.
- Coaching Strategy under development (sept 2019)
- In-house coaching service being finalised ready for launch Aug 2019
- Leadership Development Strategy approved at WFC – to Board Sept 2019
- Accepted as member of pilot group for the Talent Management Diagnostic Assessment Tool – awaiting link to online tool (Aug 2019)
- OD Manager commenced 13th May 2019, OD Facilitator commenced July 2019
- "Introduction to QI" - 1st cohort delivered by NHSi June 2019 – 17 projects identified – project support through NHSi & PMO – celebration event Sept 2019
- Review of format and behavioural contract of the Workforce Committee
- Q1 Staff Friends and Family Test and Pulse check results provided to the Trust at July's Workforce Committee
- Appointment of Assistant Director of Health and Wellbeing commenced in post 1st July 2019
- Staff turnover has increased 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.
- New Company Secretary appointed following a successful in- house recruitment campaign and assessment centre
- Bespoke SO Proud Conversation undertaken with some of the HR team following TUPE of staff back into the organisation
- Development of agency rate approval process giving more accountability to divisions and clinical directors; to be implemented August.
- Commencement of 3 QI projects within HR focusing on agency spend due to effectiveness of rostering, sickness absence and time to hire.
- Completion of use of resources submission.
- OD committed to work with managers & teams throughout SONAAS roll out
- Commencement of in house recruitment to CEO post, post currently out to advert and the Chairman is being given weekly updates on progress from the Trust's recruitment team.
- Role out of monthly pulse check to temperature check staff engagement.

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. Policy under review at 6 months post implementation. Date set for review discussion with all key stakeholders 06/09/19.	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 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 dive to in breaches of KPI targets required. Meetings being set up with CBU's to understand roles and responsibilities within the process.	A
Capacity of the HR Business Services Team - There are a significant number or Organisational Change pieces of work to come out of the CIP and Model hospital work which will cause a significant amount of pressure on the operational HR business services team.	Temporary funding secured from E&F to support the volume of support and work being undertaken in that CBU.	R
QI Training Programme – to develop a training action plan following the end of the NHSi 'Introduction to QI'	Head of E,T&OD contacted AQuA, COO & Head of PMO to discuss next steps.	R
HR resource lacking in order to deliver on the key workforce priorities as the HR Business Case has not been approved	Review of business case undertaken with NHSi to ensure that the ask is fit for purpose. NHSi approved the business case in June 2019. Business case required to go back to BDISC in August 2019. A decision has been made to support the recruitment of x2 12 month B3 Recruitment administrators to support the recruitment team.	R

2019/20 FINANCIAL PLAN (1)

RAG Rating

Key Achievements/Progress

FINANCIAL CONTROLS - *continue to control spend and deliver CIP*

Current performance

The Quarter 1 position after PSF and FRF was a deficit of £3.886 million against a plan of £3.914 million (£27,000 better than plan). This was only achieved after the assistance of non-recurrent income and expenditure (£1.3 million).
The month 4 YTD position after PSF and FRF is a deficit of £5.431 million against a plan of £4.889 million, £543,000 worse than plan.
All contracts have now been agreed following formal arbitration with West Lancashire CCG.
Year to date, elective activity is 6% lower than plan which, in the main, has been caused by vacancies in Consultant Anaesthetists. Outpatient activity is 7% above plan.
A&E attendances 5% above plan. Non elective activity is below plan but income is significantly over performing against the plan.
Income from Specialised Commissioning and NHSE is lower than plan due to chemotherapy and dentals services activity, caused by vacancies in medical staff.
Other income is over performing due to funding received from NHSI for quality as well as non-recurrent technical adjustments in month 3 (VAT reclaim for salary sacrifice).
Expenditure levels in month 4 are consistent with previous months and remain too high to achieve the year end control total. Monthly pay expenditure has continued at the levels experienced in Quarter 4 of 2018/19.
Month 4 YTD agency spend is £3.795 million; spend has increased in July; total spend in month was £966,000, 8.1% of total pay (Medical £563,000, Nursing £303,000 and other £100,000).
The Trust agency cap for 2019/20 is £4.891 million which the Trust's Operational Plan highlighted could not be achieved is forecast to be breeched in month 6.
Bank spend in month 4 is £942,000 (7.9% total pay), the same as June; YTD spend is £3.698 million.
There is evidence that nurse agency (and total nurse expenditure) is reducing. Medical agency costs remain high. Bank and agency expenditure is key area of focus for the Trust to improve its financial position.

Key actions

Weekly meetings to be established with the Executive team for CIP and the wider financial recovery plan with a focus on the operational detail behind both of these areas
Elements of the financial recovery plan will include; Reduction in high cost temporary spend (this will cover bank, agency, interim staff and waiting list initiatives);
Line by line review of all current budgets; plan to put the delivery of the CIP programme back on track;
Plan of action on how the work on fragile services will be delivered; Make best use of NHSI support on offer such as the Model Hospital.

Cost Improvement Programme

Trust original CIP plan of £6.3 million (excluding £372,000 of FYE of 2018/19 schemes) was to be delivered by £4.5 million expenditure reductions and additional income of £1.8 million from BPT. Following contract agreement with our main commissioner the Trust needs to deliver £6.3 million of expenditure reductions.

Progress re plan

At month 4, the Trust had transacted £2.647 million of CIPs, this is an improvement of £1.451 million compared to previous month.
To date, £5.827 million of schemes have been identified and are being progressed towards delivery; when the finance team applies the risk adjustment to delivery, the Trust is forecasting delivery of £5.057 million, a gap of £1.276 million.

Key actions

To ensure that the CIP gap continues to close, the Trust is working on the development of further CIPs which currently have no value and of those linked to Model Hospital and C&M Collaboration at Scale.

2019/20 FINANCIAL PLAN (2) | RAG Rating

Key Achievements/Progress

CAPITAL PLAN – *deliver planned investment programme focusing on IT, medical equipment and improvements to ward environments*

The plan for 2019/20 is a gross capital spend total of £5.1 million (this excludes IFRIC 12 additions of £1.3 million, £1.2 million of which is for the GE Radiology equipment replacement programme). There continues to be significant investment in IT with £1.7 million invested in 2019/20 , which includes projects designed to improve patient flow and patient records, along with work on IT infrastructure and security. The rolling programme of replacing and updating Medical Equipment continues with investment of £1.0 million in 2019/20. The Estates capital plan includes a 6 Facet Survey to help steer future investment and support strategic intent. Other estates improvement schemes are designed to improve existing properties and enable service delivery targets to be achieved, increasing patient safety and improving patient experience. Total planned spend for Estates and Facilities in 2019/20 is £1.7 million.

Progress re plan

Actual spend YTD is £737,000 (planned spend year to date of £1.9 million) with a further £857,000 committed expenditure. Comparing this against the annual plan, £5,103,000 excluded donated and GE radiology assets, then the Trust is at 31.2% of the plan at the end of July 2019.

The Southport ward upgrade project is due to start on 2nd September 2019 with a finish date for 6 of the wards before Christmas. It is managed with a monthly Project Board together with a weekly technical and operational meeting involving all key members including the contractor. Wards 10a and 10b works are being deferred until April 2020 and will be built into the 2020/21 capital plan. This is to manage the final costs of the scheme, £840,000 for 2019/20 and £150,000 in 2020/21. The original scheme budget for the ward upgrades is £600,000 plus £100,000 for replacement of the nurse call system.

The emergency bathroom refurbishments in the Spinal Injury Unit to address the Klebsiella infection risk is being funded out of capital contingency.

TRANSFORMATION - *drive delivery of programmes including GIRFT, Model Hospital, theatre and outpatient efficiency*

GIRFT *– increase in productivity; consistent quality; better patient experience; reduced cost of joints*

Model Hospital
Focus with the NHSI Model Hospital team

- Medical Job Planning - appropriate medical job plans; reduction in WLI's
- Nursing – e-Rostering and review of Clinical Nurse Specialists
- HR - improvement in "time to recruit"; improved retention rates; reducing reliance on agency
- Facilities Management car parking tender and catering; Portering capacity and demand analysis; catering efficiency
- Medicines Management
- Procurement

Theatre Efficiency – productivity improvement; reduce late starts and cancellations; improve patient experience
Outpatient Efficiency – reduce DNA rates; reduce waiting times; opportunity to reduce number of clinics

2019/20 FINANCIAL PLAN (3)

RAG Rating

Key Achievements/Progress

Key Risks/Issues	Mitigating Actions	RAG
Underlying expenditure levels will not reduce to pre Q4 2018/19 levels, the basis of the expenditure plan.	*Nurse establishment business case funding was 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.*	R
Income plan has been revised down following contract discussions. *There is a risk that the BPT and repatriation of activity will not be achieved.*	*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.*	R
New CIP target for expenditure reduction of £6.3 million	*Development of Trust Financial Recovery plan (part of overall System Recovery Plan).*	A

ACUTE SUSTAINABILITY

RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

Over the past month the Acute Sustainability for Southport and Ormskirk has focused on finessing the new models of care through a series of check and challenge processes that have tested the clinical principles of the model, the emerging patient pathways through the model and the modelling assumptions that will address the case for change. The work on the Fragile Service review has completed its first phase with initial findings on all current and potential fragile services provided by the Trust. A suite of expertise has been commissioned that will provide robust analysis and evidence around the delivery of the care models to ensure that they address the challenges raised in the case for change.

CLINICAL SCENARIOS

As part of the second round of testing, the Women & Children's models have taken a 'dragon's den' type approach using the themes from the first round of testing around GP impact, patient experience, impact on community services and innovation as their key areas of challenge. Frailty has established a virtual design group that have developed focused patient pathways that span the system and, alongside Urgent & Emergency Care are doing further testing along similar lines to the Women & Children's approach. Expertise has been brought in to provide a framework to robustly assess the impact on equality and quality to feed into the development cycle. A wider stakeholder event is planned for September which will be the start of a series of engagement activities that will bring in the broad variety of stakeholder voices into the development of the models.

ESTATES SOLUTIONS

GB Partnerships have been commissioned to undertake and produce an estate feasibility and options appraisal study for the draft pre consultation business case. This study will build on the clinical models of care work. The requirement is for a review of the estate options, to support clinicians and service leads in establishing the feasibility of a short list and preferred option and the potential to proceed to development.

FINANCE SOLUTIONS

The Sefton Transformation Finance Directors Group met in June to review and recommend the finance and activity work being undertaken by MIAA solutions to the AOG

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 finalisation of clinical models which will impact on the PCBC timescales	PCBC initiation plan in development with clear scope, impact, timescales for development, resource requirements and options appraisal process. Secure estates lead to identify sources of capital and coordinate any work to submit bids for that identified capital.	R
The lack of current and projected clinical workforce to enable the delivery of the care models will have an impact on the success of the programme as a whole	Sefton Worforce programme to be established and align issues across the STP footrint External Expertise secured from Attain to quantify the challenge for S&O and support the development of solutions	R

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB149/19a**	**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 July and the improvements put in place following closure of complaints in June 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 ✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	✓ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change

Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance	☐ Legal
☐ Engagement and Communication	✓ Quality & Safety
☐ Equality	☐ Risk
☐ Finance	☐ Workforce

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

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

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

July 2019

1.0 Introduction

This report provides a breakdown on the number of compliments, complaints, concerns received in the month of July, 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 58 in total and F Ward receiving 21 compliments in the month.

The Urgent Care Business Unit received 49 Compliments, with the Short Stay Unit and the Wheelchair Service receiving the highest number (11) followed by the Physiotherapy department with 10.

The Women & Children's Business Unit received 13 compliments, of which 6 related to 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 18 formal complaints were received in July.

The Urgent Care business unit received the most complaints (10), with the Short Stay Unit and Ward 14B both receiving 2 complaints in month. Planned Care received 6 complaints, of which 2 related to the Surgical Assessment Unit (10B) and Specialist Services received 2 complaints.

The following themes were identified:

- Basic Care
- End of Life
- Admissions/transfers/discharge procedure
- Clinical treatment
- Communication

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

In Women and Children's CBU have developed local safer surgical standards LOCSIPPS form which includes documenting if the patient has been informed, verbal consent to treatment and post procedure observations

Planned Care CBU have noted a number of improvements

- When Medical review is requested and does not happen then the nursing staff must escalate, to the Bed Managers and Matrons who should be empowered to contact Consultants directly
- Recording of Fluid Balance charts to be monitored to ensure accurate recordings.
- Planned care departmental Lessons learned to include the need to review "normal" CT images when symptoms persist.
- Management of clinical records
- All adverse incidents, including radiology discrepancies, must be reported at the time the incident has been detected by Trust staff

Urgent care has noted some improvement work and communications with families going forward.

- To continue review of the complaints process and provide additional training for staff responding to complaints.
- To highlight to the medical teams the delay in performing diagnostic tap – to promote a proactive approach and ensure medical staff communicate with teams to highlight individual patient's needs and expedite procedures if required.
- Monitor compliance of nurse call bells that are left within patient reach on the ward.
- Share complaint and concerns with staff to ensure lessons learnt and to ensure staff expedite future referrals to dietician
- To discuss with staff and emphasis lack of care is not acceptable.
- Review ward leaders checklist to aid with the monitoring of the quality of documentation provided.
- Consider the use of NG feeding and ask patient if they would like one, even if distressed by the procedure
- Provide family with key improvement information in 6 months' time, which includes quality improvements in nursing care, compliance of nursing documentation

Urgent Care have requested help from the bereavement group following a complaint, this includes

- Access to the Hospital Trust after hours (family not informed of how to access the building).

- Follow-up with families following unusual or unanticipated or unexpected deaths

2.2 Concerns

There have been a total number of 37 concerns raised this month. Many were requests for information, but other concerns related to communication, staff attitude/behaviour, clinical treatment, appointment dates and patient property.

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 key areas of improvement work within the Trust.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB149/19b**	**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 **Amanda Halsall,** Information Analyst		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

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

1.0 Measuring Mortality

- Summary Hospital-level Mortality Indicator (SHMI) – 12 month rolling published up to December 2018
- Hospital Standardised Mortality Ratio (HSMR) – Rolling 12 month and in month for March 2019
- Disease-Specific Mortality Ratios – March 2019

2.0 The External Mortality Review Board Assurance Action Plan: Update August 2019

3.0 Appendices

Appendix 1: Mortality Dashboard August 2019 (Dr Foster Mortality Data June 2019)
Appendix 2: Distribution Performance Graph, June 2018.

Recommendation

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

Strategic Objective(s) and Principal Risks(s) (*The content provides evidence for the following Trust's strategic objectives for 2019/20)*	
Strategic Objective	**Principal Risk**
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☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

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

Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance	☐ Legal
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☐ Equality	☐ Risk
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Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

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

1.0 Measuring Mortality

Executive Summary

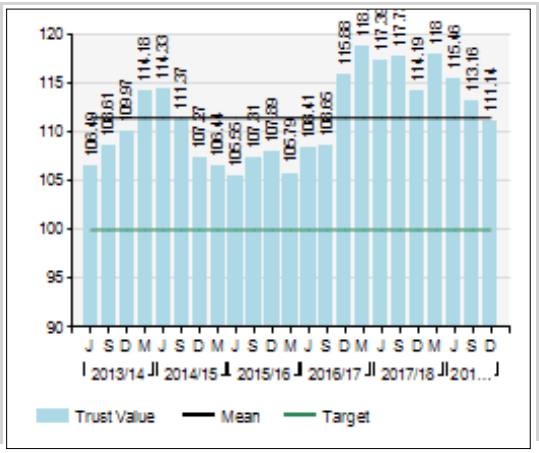
- This months' report reflects a strong performance from a data perspective.
- Quarterly SHMI still formally awaited from NHS Digital.
- Reviews of conditions of low severity (LRTI/Bronchitis/UTI) agree with previous suspicion that the issue is more related to the decompensation of chronic illness / frailty or in a smaller number of case – a missed diagnosis of sepsis. Ongoing work aimed at reducing decompensations requiring admission, better rehabilitation, or better planning for what happens in the event of deterioration – such as the use of Anticipatory Clinical Management Plans will improve care in these areas.
- Mortality screening in June shows significant improvement to baseline and this will improve further in July.

Key national and local mortality indicators

	2018/19									2019/20			Target
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
Rolling 12 Month HSMR	117.5	116.0	114.8	112.8	112.3	112.0	102.9	98.7	94.8				*100.0*
Monthly HSMR	123.5	96.1	99.1	75.7	91.3	105.3	84.7	81.5	82.8				*100.0*
SHMI			113.2			111.1							*100.0*
Local HSMR Bronchitis	169.7	157.8	152.8	136.6	136.6	138.1	133.0	118.4	105.9	↓			*100.0*
Local HSMR LRTI	171.2	159.1	154.0	137.6	137.4	138.9	134.1	119.5	106.8	↓			*100.0*
Local HSMR Pneumonia	135.8	126.2	128.8	121.7	122.1	120.1	112.6	104.8	103.7	↓			*100.0*
Local HSMR Septicemia	87.1	87.3	87.7	89.9	89.7	90.2	81.1	79.1	80.0				*100.0*
Local HSMR Stroke	123.5	126.1	114.8	107.9	110.1	112.0	100.3	100.2	103.5	↓			*100.0*
Local HSMR UTI	125.0	112.6	116.4	114.9	123.5	120.0	106.2	109.0	80.0				*100.0*
Local HSMR Acute Renal Failure	108.6	104.2	96.8	96.1	107.4	128.8	126.8	115.0	101.3	↓			*100.0*
Mortality Screens - %	92.21%	72.73%	58.90%	53.45%	58.82%	50.62%	63.44%	61.67%	44.44%	35.16%	32.93%	54.17%	*90.00%*
SJRs			33.0	21.0	13.0	7.0	13.0	4.0	9.0	6.0	5.0	9.0	*0.0*
2nd Review			0.0	2.0	2.0	0.0	2.0	0.0	0.0	0.0	0.0	1.0	*0.0*
In Hospital Deaths	77.0	66.0	72.0	59.0	69.0	81.0	94.0	60.0	72.0	91.0	82.0	48.0	*77.0*
In Hospital Deaths Crude Rate	26.6	21.1	22.2	17.4	20.6	24.4	27.4	19.2	21.5	30.1	25.6	16.0	*31.0*
LD Deaths	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	*1.0*
Steis Incidents	4.0	8.0	1.0	10.0	2.0	3.0	4.0	6.0	3.0	4.0	5.0	5.0	*5.0*

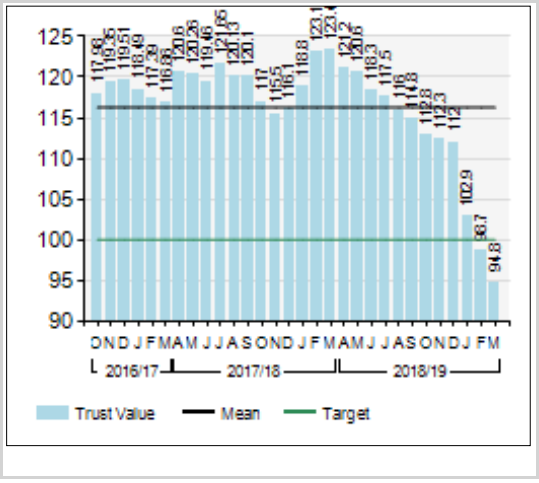
Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

SHMI - Summary Hospital Level Mortality Indicator



The latest quarterly release of the SHMI is still awaited. As such, this months' comment reflects the previous months. Ongoing quality improvement work and improvements in clinical best practice will be reflected in the SHMI. The information approach remains to ensure that the trust produces and reflects accurate information on the patients it treats. Ongoing education work to reduce the amount of signs and symptoms coding and ensure accurate recording of co-morbidity is now usual business.

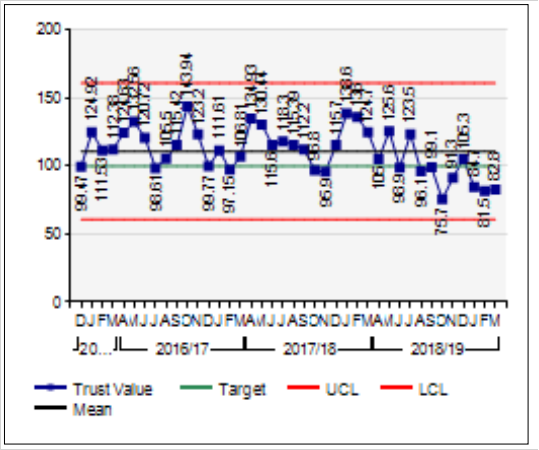
HSMR - Hospital Standardised Mortality Ratio (*Rolling 12 month*)



Rolling HSMR has recorded below 100 for the past two months. This reflects the improvements made over the past 1 -2 years in quality of patient care, response to deterioration, availability of senior clinicians, improved pathways for high risk conditions, better surveillance and response to early warning scores, improved governance structures, improvements in the recording of patient co-morbidity and better recognition of palliative care.

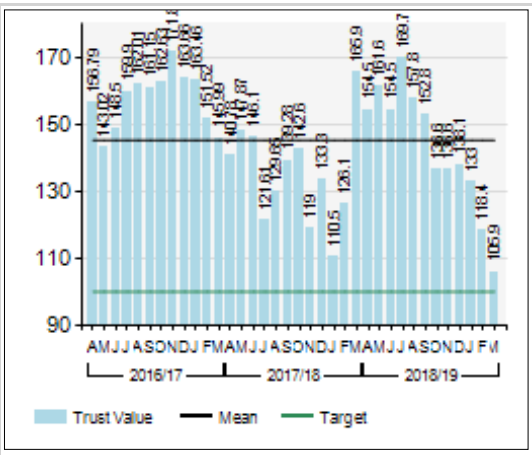
Work remains on-going in each of the areas described above. The focus of many inter-linked trust projects including frailty, deterioration and flow is anticipated to continue to effect the HSMR and the SHMI.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



In month HSMR remains acceptable. This is despite challenging flow conditions and high bed occupancy rates. The factors listed as relevant to the rolling HSMR are as pertinent to the monthly position. Examination of the disease specific position allows targeted examination and intervention.

Local HSMR Bronchitis



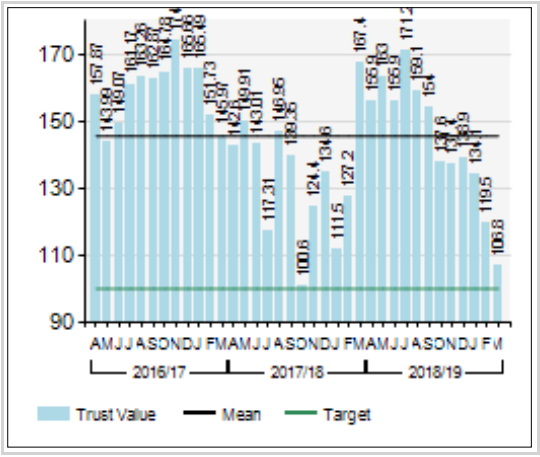
Bronchitis and LRTI are a focus area. Findings so far are that patients are not dying from these conditions, but from other significant chronic co-morbidity, such as pulmonary fibrosis or cardiac failure which has become decompensated by infection. When admitted to hospital there is frequently good clinical evidence of infection, but the underlying conditions are frequently not represented as the reason for admission, and therefore do not feature as the diagnosis for coding.

In other cases sepsis has been missed and incorrectly labelled as simple infection.

The numbers for both are small. A process is being developed to ensure correct coding of these episodes and ongoing education about recognition of sepsis continues.

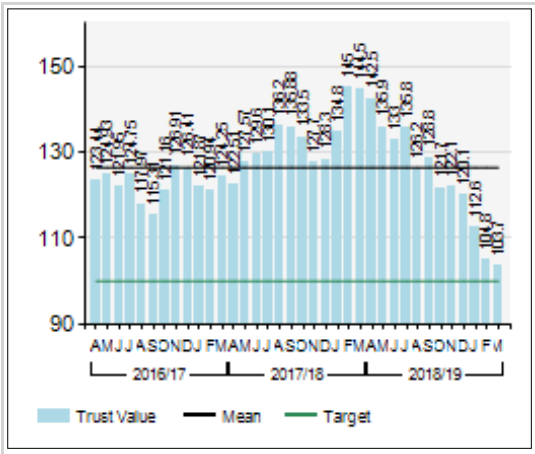
This demonstrates the importance of understanding the reasons behind the data and it accuracy.

Local HSMR Lower Respiratory Tract Infection



See Bronchitis

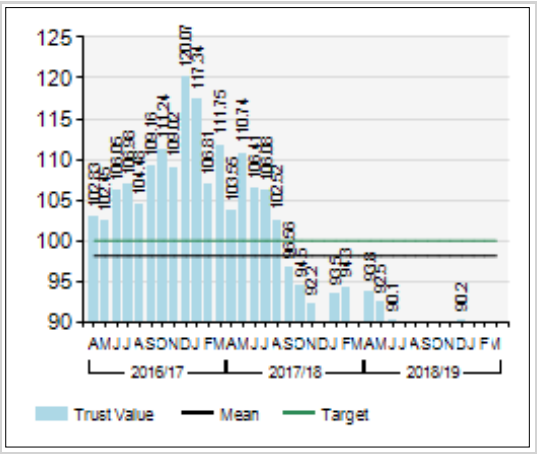
Local HSMR Pneumonia



The HSMR for pneumonia shows an improved position. This is likely reflecting improved awareness of the over-diagnosis of pneumonia in medical staff, better access to alternative diagnostic tests for heart failure such as pro-BNP testing, improved recording of co-morbidity in the frail, elderly population which is susceptible to the condition, better identification of palliative care, better identification and escalation of septic patients with pneumonia to critical care, better awareness through targeted education of the risk of patients receiving high oxygen concentrations on general wards and the importance of maintaining mobility in patients and getting out of bed.

Work continues in each of these areas, work also continues on standardisation of the nasogastric feeding process to improve nutrition, hydration and safety of NG feeding.

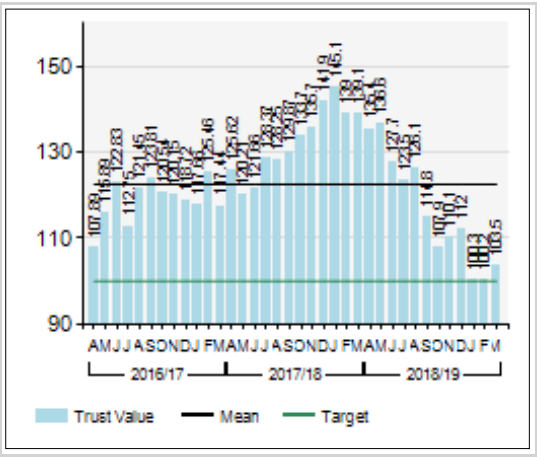
Local HSMR Septicemia



The trusts processes for sepsis are now well embedded with a focus on delivery of antibiotics within an hour of diagnosis. Our performance in this area remains strong. Areas of work remain ensuring a senior review within 2 hours of diagnosis of sepsis and collecting blood cultures within 1 hour of sepsis diagnosis.

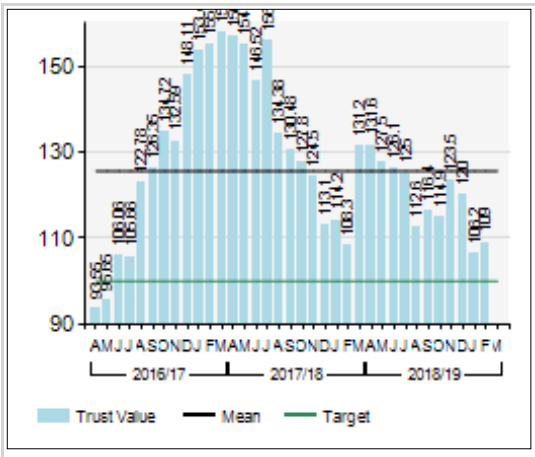
Learning from SJRs and incidents includes ensuring that a diagnosis of sepsis is actively considered whenever infection is diagnosed and ensuring any investigations performed in difficult cases are reviewed promptly.

Local HSMR Stroke



The SMR for stroke again represents an improved position. This is likely due to the iterative development of the stroke unit, improved patient flow meaning more patients are managed within the acute stroke unit instead of outlying wards, improved identification of palliative care and improved documentation of co-morbidity.

Local HSMR Urinary Tract Infection

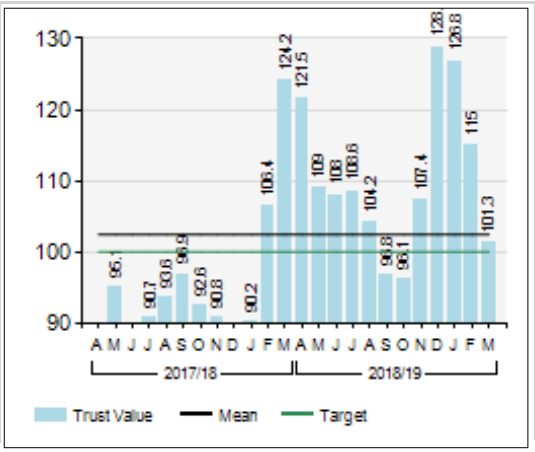


UTI, much like LRTI/Bronchitis is not a diagnosis that usually results in hospital admission unless the diagnosis is actually sepsis of urinary origin, or the UTI is on a background of significant chronic co-morbidity or frailty which has become decompensated.

Reviewing the small numbers of UTI deaths, this has proven to be the case. Interventions to ensure that staff diagnosing urinary tract infection actively consider sepsis and education to ensure that urinary tract infection is only diagnosed appropriately are ongoing.

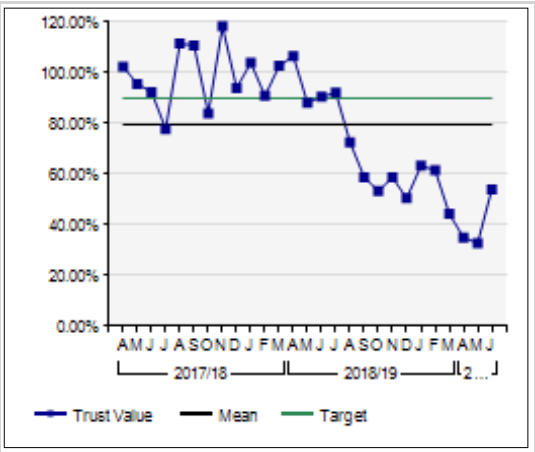
Reducing UTI rates and rates of gram –ve sepsis are important aims. Interventions aimed at reducing catheter rates, maintaining nutrition and hydration, continence and mobility will assist this.

Local HSMR Acute Renal Failure



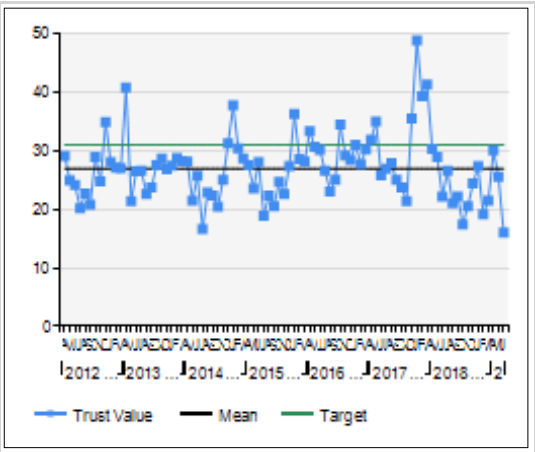
The HSMR for acute renal failure (AKI) fluctuates widely. This requires further evaluation, but may be linked to small numbers of direct AKI deaths. The trust has introduced an AKI pathway which is becoming embedded. We await the effect on AQ process data of the AKI alert system which flags up AKI patients to critical care outreach every 12 hours.

Mortality Screens - % Deaths Screened



Screening rates reported show an improvement to the baseline of the previous 9 months. This is subsequent to an education drive. Evaluation of the process suggests that the limiting factor is the quality of the IT infrastructure in the bereavement office. Four ipad computers have been deployed and configured to allow easy access to the screening tool. Early indications are that this has been successful. The screening rate for July has been reported to MOG as 89%.

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



Crude mortality rate at 16% is the lowest recorded on the current data. This is not subject to any form of standardisation, and therefore is only a very raw marker of performance and subject to significant monthly variation.

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

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 16th August 2019 (Latest information is shown in bold)
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	25%	G	The Patient Flow Improvement Programme (PFIP) consists of two work streams: 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, aggregated patient delay and to hit agreed targets for flow into the ambulatory care units. **A team from Planned Care has been set up to deliver quality improvement and increased efficiency in Surgical Ambulatory Emergency Care as part of the NHS Surgical Ambulatory Emergency Care collaborative. The project is due to be delivered by March 2019.** Progress is monitored through the Patient Flow Improvement Programme and is reported into the Improvement Board.
		a. Alternative to admission	Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams					15%	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. **An End to End Process Review Meeting in September will review the process mapping which has already been undertaken with the Trust's Head of Patient Flow and community partners. Strata are also meeting with A&E Stakeholders at the end of September to discuss opportunities for alternatives to admission.** 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.					20%	A	**One of the objectives of Work Stream Two (of the PFIP) is improving Criteria Led Discharge to support flow and length of stay. The group has been clear that the key to good Criteria Led Discharge is clear medical documentation and planning. Improving medical documentation so that it is clearer (for easier use by nursing staff) is one of the key discussion points at the 'A Way For Safer' Engagement Events (which are being held with the Director of Nursing for Urgent Care across the wards in August). This is also to be discussed by the Associate Medical Director for Urgent Care at Consultant Engagement Meetings in September.**
		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 (CLIN CORP 81 Early Warning Track & Trigger System Operational Policy) has been ratified is live in the Trust's internal on-line Policy Portfolio.** 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.

External Mortality Review (EMR) & RCA Cases Action Plan

EMBAR

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

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Red	Significantly delayed and/or of high risk - not expected to recover
Amber	Slightly delayed and / or of low risk - can be recovered
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	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 16th August 2019 (Latest information is shown in bold)
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	**The Trust's Clinical Education Lead has included the revised AKI Pathway (April 2019) into the Trust's 'Doctors in Training: Working Handbook'** 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.
	EMR Action 2	Improve awareness of Sepsis	Improve awareness of Sepsis 6 guidelines and monitor adherence.			Apr-18	Jul-18	100%	B	**The Trust's Clinical Education Lead has included the Sepsis Pathway into the Trust's 'Doctors in Training: Working Handbook'** 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	The Associate Director for Patient Safety and the Trust's Clinical Education Lead are looking at incorporating the Pneumonia Care Pathway into the junior doctors' training programme. The Pneumonia Care Pathway is live on the wards.
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. - 5 SAS doctors and 8 Clinical fellows have been employed 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	**A final evaluation of the pilot on Ward 10A (Medical Ward) is planned forSeptember. There are currently outstanding IT fixes required to support findings of the PDSA cycles. A PDSA exercise was undertaken to amalgamate the EBR with the Red to Green Board Round but this did not work. The two are now linked through the attendance of the Discharge Facilitator at both meetings.** **Once a robust and approved model has been developed, the plan is to roll out across wards in line with the ward refurbishment programme (a private room and screens will be required on every ward).**

EMBAR

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

Blue	Activity completed
Red	Significantly delayed and/or of high risk - not expected to 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 16th August 2019 (Latest information is shown in bold)
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	Mar-21	7%	R	**A project scoping session to look at nursing documentation took place on the 16th July with ward managers and staff nurses from across Urgent Care and Planned Care. to review nursing risk assessment booklets and care plans. Feedback from the group was that time to complete documentation was the main blockage.** **Clinical Noting is a long way off on the IT Roadmap and so discussions are underway with the Medway Team to add three key documents to the electronic Medway (Patient Administration System) to support the nursing teams with the completion of documentation.**
	RCA Action 3	Clinical Documentation Audits	Publish and regularly audit against agreed standards for clinical documentation; to include the completion of pathways of care for key medical conditions and legible prescribing. This should form part of structured feedback to medical staff.				Ongoing	50%	G	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.				Mar-21	5%	A	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.				Mar-20	15%	A	The Gosport audits completed within Southport and Ormskirk Hospital Trust have shown significant levels of assurance apart from the documentation of clinical indications for drugs (apart from those who are actually dying which is better) and the high incidence of pneumonia as cause of death. Required activity is to be scoped into 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	Mar-20	20%	G	**As part of the NHSI Quality Improvement Programme, a mini improvement project is being undertaken on Ward 9A (Short Stay Unit) to review and improve the way that observations are taken, documented and reviewed. PDSA cycles are currently being undertaken, supported by coaching calls with NHSI. The final presentation on progress and findings is to be given at the QI Celebration Event at the hospital on 12th September.** 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,	RAM 2 ('Appropriate Escalation')	Associate Medical Director of Patient Safety	Jan-19	Jun-19	80%	G	**The Trust's NEWS2 Policy (CLIN CORP 81 Early Warning Track & Trigger System Operational Policy) has been ratified is live in the Trust's internal on-line Policy Portfolio.** Link Nurses (on each ward) have been trained with the remit to cascade training. An electronic training module is being investigated. **Training models are being reviewed to ensure appropriate support of the link nurse programe.**
	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			Jan-19	Jun-19	80%	G	As detailed above, a mini improvement project is being undertaken on Ward 9A (Short Stay Unit) 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 support escalation of the deteriorating patient.

EMBAR

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

Blue	Activity completed
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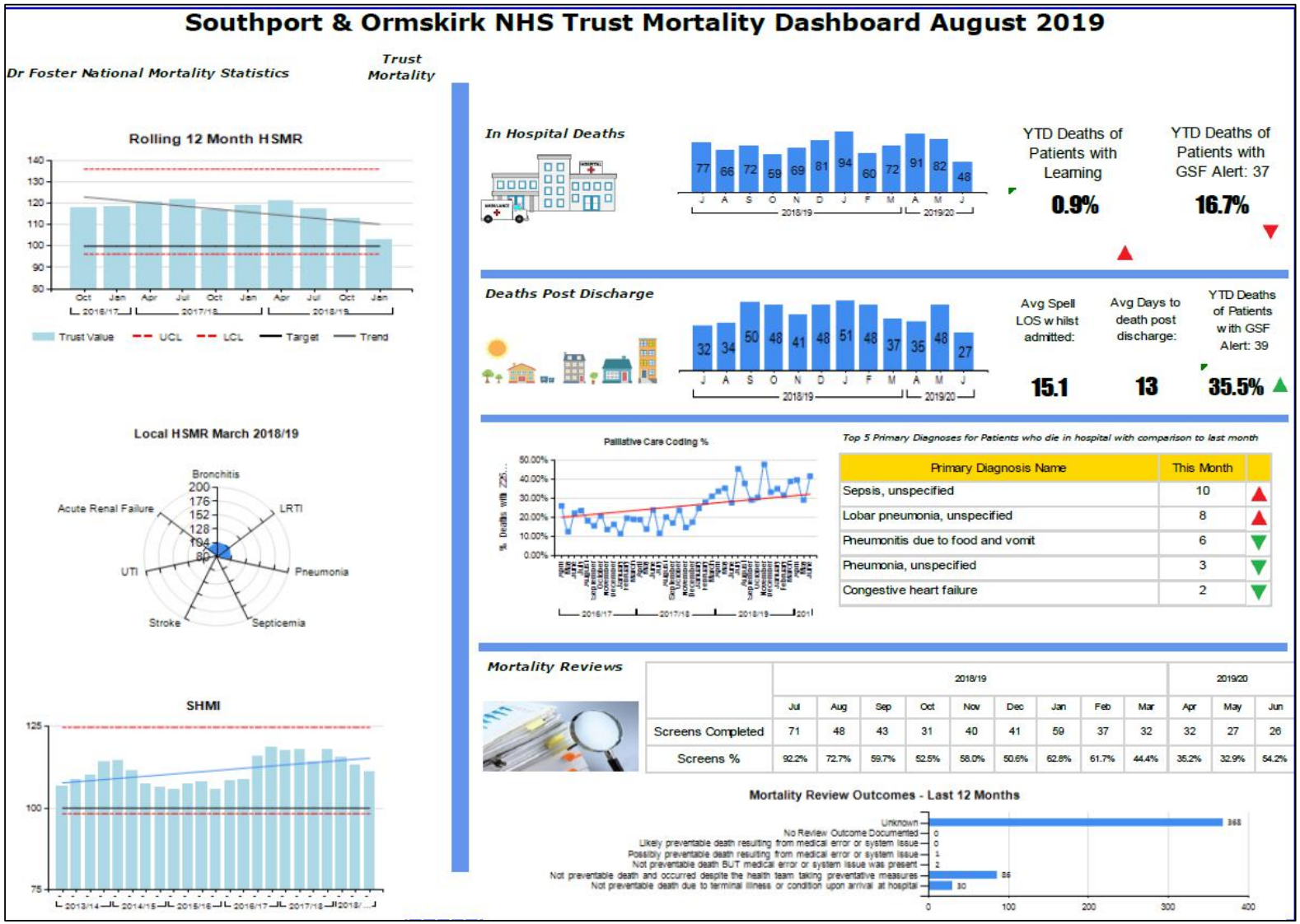
	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 16th August 2019 (Latest information is shown in bold)
Specialist Services	RCA Action 7	Management of Diabetes	Review and update the trusts policy and approach 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	10%	A	A replacement Band 7 Diabetic Specialist Nurse has been recruited and is due to start in a full time capacity in October (this is contrary to previous reporting that there were to be two full time Band 7 Diabetic Nurses).
	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	10%	A	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.

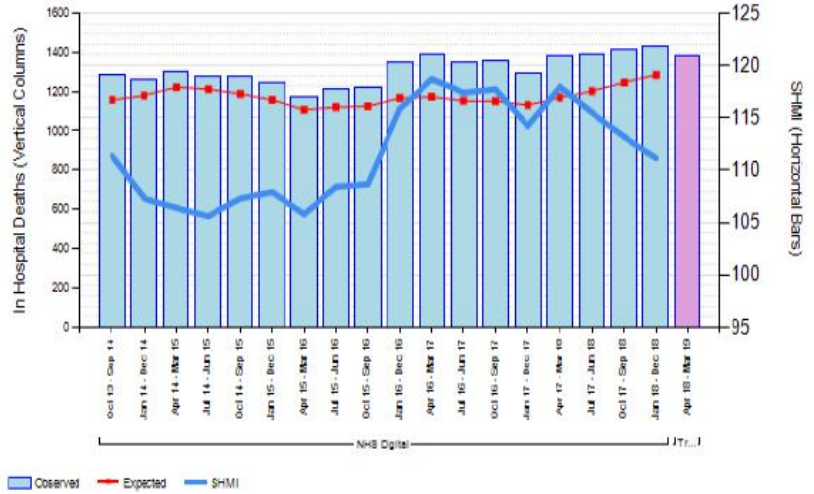
3.0 Appendices

Appendix 1: Mortality Dashboard – Reporting Month August 2019 for Reporting Data June 2019



SHMI Breakdown

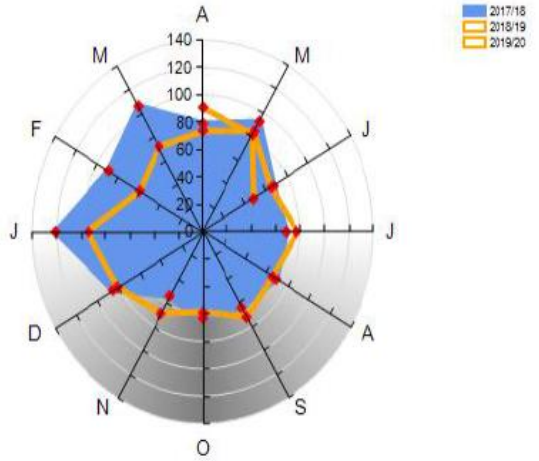
Southport & Ormskirk Hospital NHS



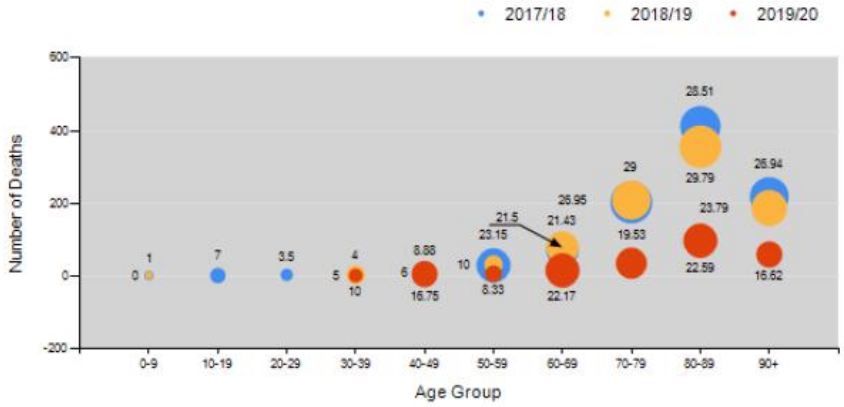
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

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

In Hospital Deaths Seasonality Distribution

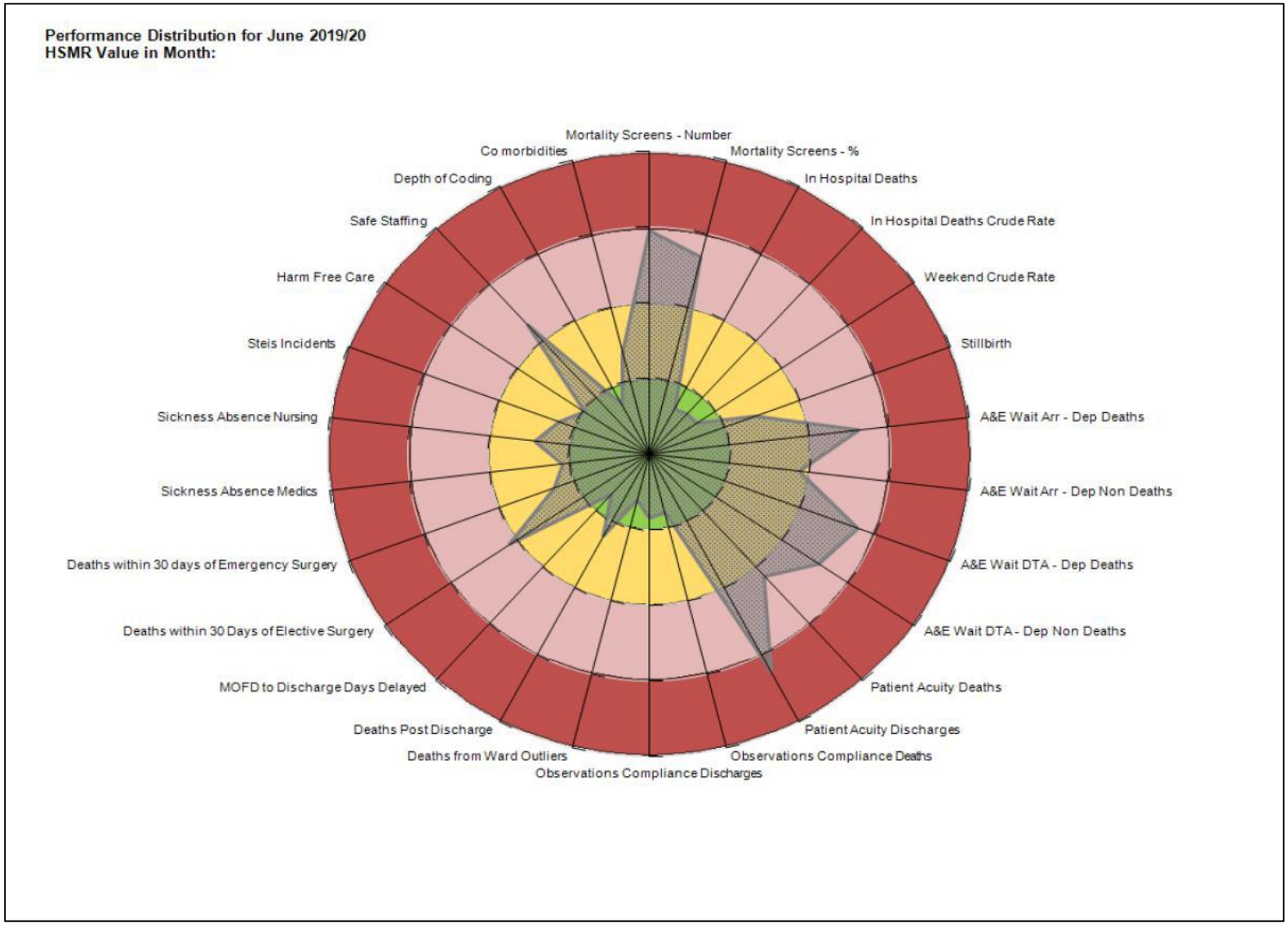


In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



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

Appendix 2: Performance Distribution, June 2019



Southport and Ormskirk Hospital NHS Trust

TRUST BOARD
4 September 2019

Agenda Item	**TB149/19c**	**Report Title**	**Quality Improvement Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Paul Jebb, Deputy Director of Nursing		
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

The Board is asked to note 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	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

Linked to Regulation & Governance

CQC KLOEs	GOVERNANCE
✓ Caring	✓ Statutory Requirement
✓ Effective	☐ Annual Business Plan Priority

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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE JULY 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. An update in relation to KPI development can be found at Appendix A.

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.

Any areas for improvement identified during the recent CQC inspections associated to the four quality priorities will be incorporated into the reporting framework, key themes from the inspection have been included in the table below.

Care of the Older Patient:

The Business case has been approved and recruitment has commenced

S&F Care Home Forum has been established, which will work alongside a quality improvement forum with system partners (NWAS, LCFT and CCG) to support local homes in working towards and demonstrating work on their CQC KLOEs.

Nutrition, Hydration & Mouth Care

E-learning Module is now available on ESR being launched in parallel with the ward roll-out of the new care plan, training has also been delivered on the Older Peoples Care Training Programme, with over 160 people due to have attended by the end of November

5 members of staff now Mouth Care Matter Trainers delivering training on the Older Peoples Care Training Programme. Ward roll out of new policy, care plan and targeted education to be commenced in September.

Nutrition and Hydration finger menu launched and to be reviewed and development of a pictorial menu required, awaiting new Dietetic Lead starting in post October 2019.

Dementia & Delirium

New strategy approved and launched

Delirium and Dementia pathway including case finding question, identification of risk and completion of the 4AT, as well as care planning, Hospital Passports and patient information leaflets have been launched and continue to be rolled out. Currently on 6 wards and expected to have rolled out across the Trust by the middle of September 2019. Dashboards are being developed to demonstrate improvements

Draft pathway for 24 hour care agreed with West Lancs pending final check and challenge prior to move to a trial. S&F do not currently have provision for crisis hours and 24hour care but we are in conversation with CCG and provider to discuss options and a trial.

Dementia E-learning Tier 1 available to all staff on ESR. Tier 2 delivered face-to-face as part of the older peoples care training programme which commenced in July. Tier 2 can be done via e-learning but feedback is better for face-to-face. Champions need to be re-established; the Admiral Nurse and Dementia & Delirium Specialist posts are currently within the recruitment process.

Family, Carer and Relative support to be developed in partnership with Michelle Kitson (Matron, patient experience) when the Dementia and Delirium Team are in post. Enhanced communication and refreshing of John's Campaign to be encompassed - target team starting date November 2019.

Discharge Pathways

West Lancs HomeFirst Pathway Established, Therapy Recruitment to support expected to be in post by September 2019, currently achieving 1-4 HomeFirst discharges per week, target of 8 per week consistently by the end of the year. On-going meetings with WL Social and CCG to continue drive.

Spinal Fractures Draft pathway developed, checked and challenged and amendments being made based upon this. Patient information leaflet being developed, Assessment proforma for first assessment using ASIA to be developed and a review template for neurological screening has been created. Group meeting regularly to progress, next meeting September 2019.

Continence

The continence care group has been established and have met and scoped out work the work programme

Training and Education being delivered as part of the Older Peoples Care Training Programme and will be delivered with roll-out of new documents on the wards.

New Assessment and Care Planning Documents to be developed

Information and resources to be developed by group

Continence assessment to be incorporated into Therapy and CGA Frailty Assessments.

End of Life Care

The Team from Queens Court are delivering a 1.5 hour session monthly as part of the Older People's Care Training Programme.

A piece of work exploring DNACPR completion, with a view to looking at developing rolling education sessions for medics on the process, legalities, risks and feedback form themes once reviewed.

The frailty team have developed a process to enable a flagging system on medway so that these patients are highlighted to the frailty team on arrival.

Creating an Enabling Environment

A launch of Get up, get dressed and keep moving including educating staff, enhancing equipment availability and educating patients, families and carers on the importance of bringing in clothes and getting out of bed has commenced on 9A.

Red2Green rolled out, SOP written, to be checked and challenged then lunched with a rolling programme needed to continually educate staff on how to chair and challenge at MDT board rounds.

Fit2Sit to be worked on with AED & NWAS including chair provision review

As part of the review to improve the ability of all staff to get patients up, dressed and moving, equipment needs to be identified and then a charitable funds bid to be

written to purchase necessary equipment to enable wards to prevent deconditioning.

Falls

Policy approved and uploaded and the falls strategy will now need to be developed.

Falls Bundle being piloted on 6 wards and to be fully rolled out by mid-September 2019.

Falls Education being delivered as part of the Older Peoples Care Training Programme and wards are being encouraged to complete the e-learning module on ESR when they commence using the new bundle.

New dashboard to be developed with agreed KPIs from the Falls Group, BI to support in development.

Improvement areas identified from CQC Inspection – July 2019

- The service was not meeting requirements of the Mental Capacity Act for every patient who lacked capacity (A&E)
- Limited use of 'this is me' booklets and passports (Medicine)

Care of the Deteriorating Patient:

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.

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

Improvement areas identified from CQC Inspection – July 2019

- We saw evidence of action not been taken when National Early Warning Scores indicated it should have been (Medicine)

Infection Prevention and Control (IPC):

No MRSA bacteraemia (the last MRSA bacteraemia was in September 2017)

No CVC (Central Venous Catheter) infections in Critical Care and the 12 monthly rolling PICC (Peripherally Inserted Central Catheter) associated blood stream infection/1000 device days is zero

The IPC operational group continues to meet bring together clinical and non-clinical teams to work together on IPC issues

Estates work will commence in Autumn relating to ward layouts on the Southport site and this will be completed by early 2020.

Estates work in the Regional Spinal Unit continues and the Trust has contacted Public Health England to establish a peer review following the Klebsiella outbreak

Improvement areas identified from CQC Inspection – July 2019

- Ward 15A with side room doors open (Medicine)
- No sink for washing equipment on the medical day unit (MDU)

Medicines Management:

In response to matters raised by the CQC core services review July 2019 and feedback from pharmacy focus group, a number of issues around medicine management were raised.

We commissioned our own report by Julie King, independent consultant in July 2019.

A serious incident was also raised by the pharmacy focus group in relation to the management of 'take home' proscriptions containing Controlled Drugs.

NHSI convened a quality summit in response to concerns raised and the Trust responded as follows:

- A Medicines management development plan has been formulated to capture all the issues raised and they have been divided into work streams designed to deliver over a number of time frames.
- Immediate plan 26-30th July - All items identified in the CQC letter and via verbal communication identified and corrected, bar one remaining signature related to stock rotation of IV fluids.
- As executive lead, the medical director has met weekly with the Medicines Management development team to develop the documentation which defines the individual work streams using project management support.
  The work streams are –
  - Storage and checks/temperature management
  - policies/record/training/ordering
  - delivery/TTOs/Audits/governance/sustainability
- A concern was raised about releasing TTOs containing CDs without a contemporaneous 'wet' signature, the prescription being initially generated electronically. This may be in breach of policy and national guidance. The matter is being managed as a serious incident and we have sought advice from NHSI. We have appointed as an external case investigator Professor Liz Kaye
- The practice has stopped and will seek reassurance from Professor Kaye as part of her investigation.

Improvement areas identified from CQC Inspection – July 2019

Medicines Management:

• Self-administration, • Medicines charts, • Thickener not securely stored on the stroke ward, • Out of date medicines • Medicines unavailable • Gaps in prescription chart • Issues with disposing of drugs. • Controlled drugs cabinet which did not appear to meet requirements • Temperature checks for fridges were not consistently completed

4. QI TRAINING

The introductory to Quality Improvement training has now took place and we have our celebration event on 12th September to report on the QI projects that have been worked on throughout the recent training.

The QI team have developed a newsletter and a twitter profile (@SOQIWay) to engage and learn from others internal and external to the Trust.

Conclusion

Any risks identified as being high have been or are already included in our Quality Improvement Plan to support improvement

5. RECOMMENDATION

The Trust Board is asked discuss progress identified in this report in relation to the Quality Improvement and agree the Quality Improvement strategy.

Southport and Ormskirk Hospital NHS Trust

TRUST BOARD

4 September 2019

Agenda Item	**TB149/19d**	**Report Title**	**Monthly** Safe Nurse & Midwifery Staffing Report
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery Therapies and Governance		
Lead Officer	Carol Fowler Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The Trust boards highlight report for July 2019 is set out below:

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 July 2019.

Alert

- Trust vacancy rate for Registered Nurses has increased in month reflective of commencement to the establishment uplifts and natural attrition in month.
- For the month of July 2019 the Trust reports safe staffing against the national average (90%) at 88.25%.

Advise

- The draft Clinical Indicators Dashboard is shared with the Trust board in line with national guidance.
- CHpPD reporting remains under review to support accuracy of data reporting

Assure

- No harm events have occurred to our patients due to staffing levels

Recommendation

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

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 / Committee / Group or Trust without needing to formally approve

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

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

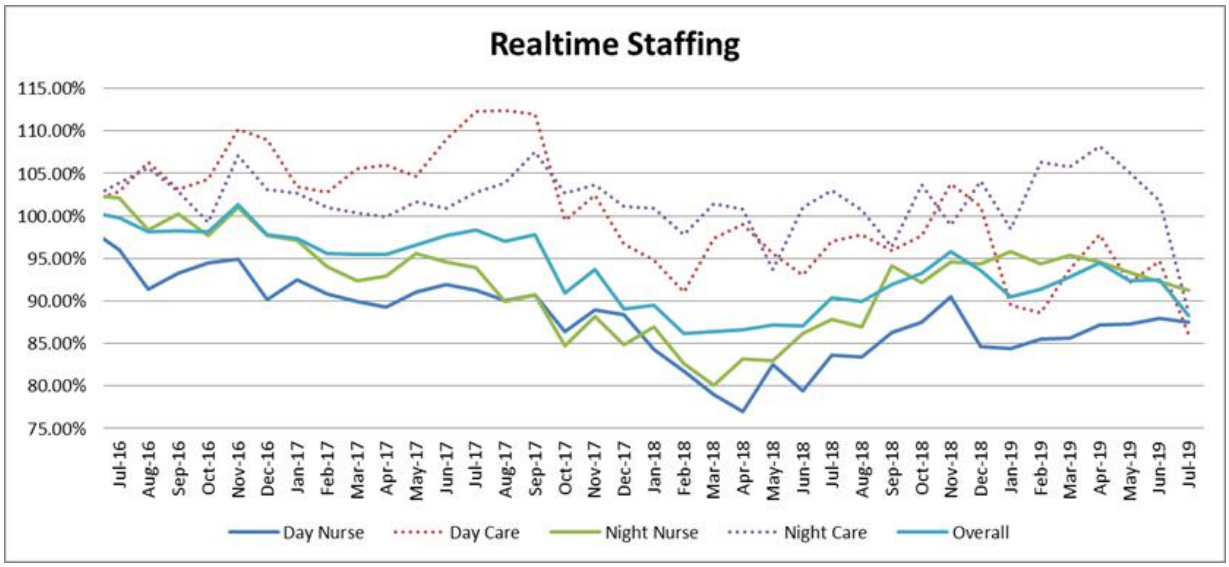
For Information: Literally, to inform the Board / Committee / Group

1. Introduction

This report provides an overview of the staffing levels in July 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 July 2019 was 88.25% (appendix 1).

- 87.52% Registered Nurses on days
- 86.09% Registered Nurses on nights
- 86.09% Care staff on days
- 88.61% Care staff on nights



The overall CHPpD for the Trust has increased in month to 9.8 hours (appendix 1) and slightly above the national average of 7 hours CHpPD, Planned care clinical business unit (CBU) report overall 10.2, Urgent Care CBU 7.7 and Women's and Children's 23.0 overall. Further scrutiny into maternity figures (28.0) has identified recent changes to rostering reflects the increase to CHpPD reporting. Areas that are not overnight inpatient areas are now reported within the data and this will be reviewed and amended for further reporting.

2. July Safe Staffing

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

	Funded WTE	Contracted WTE	Vacancy
Registered	947.11	786.85	160.26
Non-registered	443.60	362.89	80.71
Total	1,390.71	1,149.74	240.97

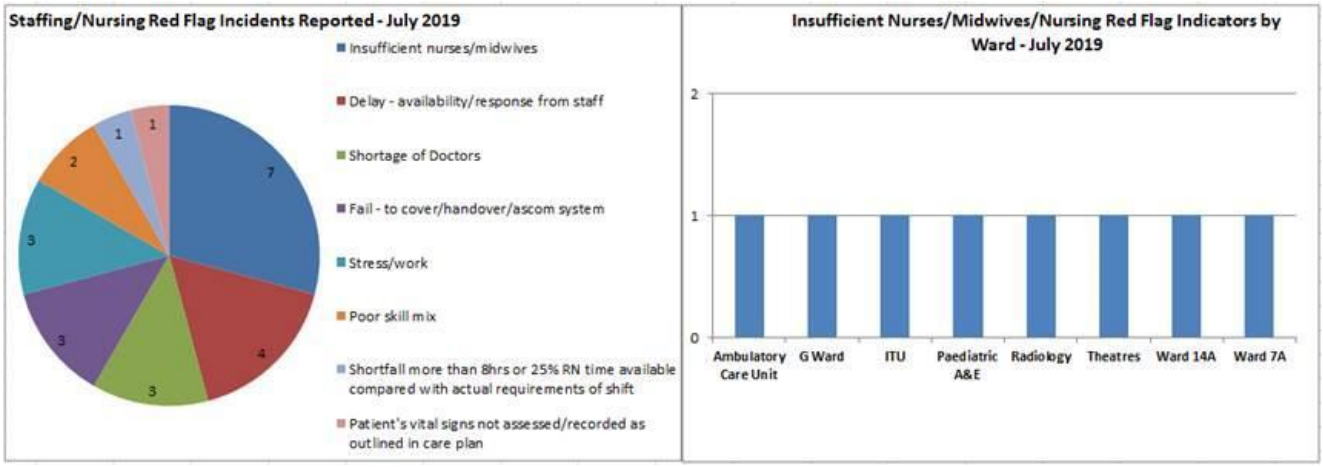
Funded establishment has increased in month for registered nurses. This combined with monthly natural attrition is shown in vacancy reporting in month. Active recruitment to posts is in place.

Roster performance support and challenge meetings are fully embedded within the clinical business units supported by the Key Performance Indicators (KPI'S) within the dashboards. Development to the dashboards has commenced to support additional reporting measures and extended reporting from 4 weeks to 8 weeks. This delivers improved rigorous scrutiny of roster performance within the CBU's.

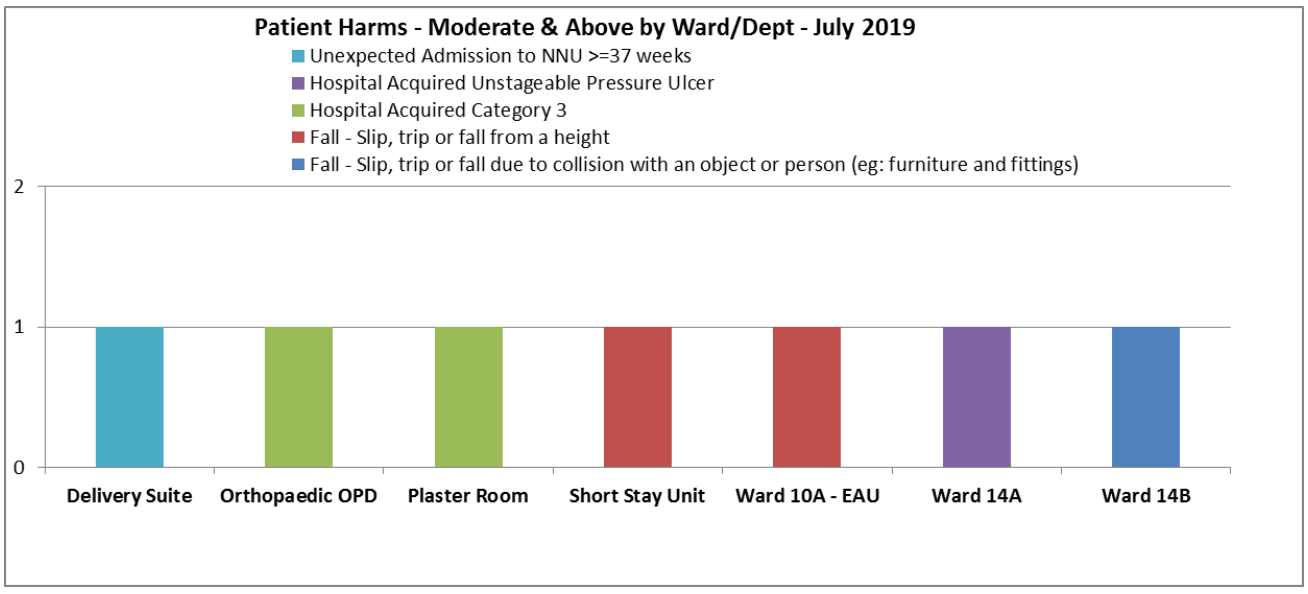
Trust vacancy rate for Registered Nurses has increased in month reflective of commencement to the establishment uplifts and natural attrition in month.

3. Staffing Related Reported Incidents July 2019

In July 24 staffing incidents/nursing red flags were reported, 10 less than June 2019. 8 of these incidents highlight insufficient nurses/midwives or nurse shortfalls (with 2 red flag incidents as highlighted in the table below), almost half the number reported in June (15). No harm was identified as a result of these incidents.

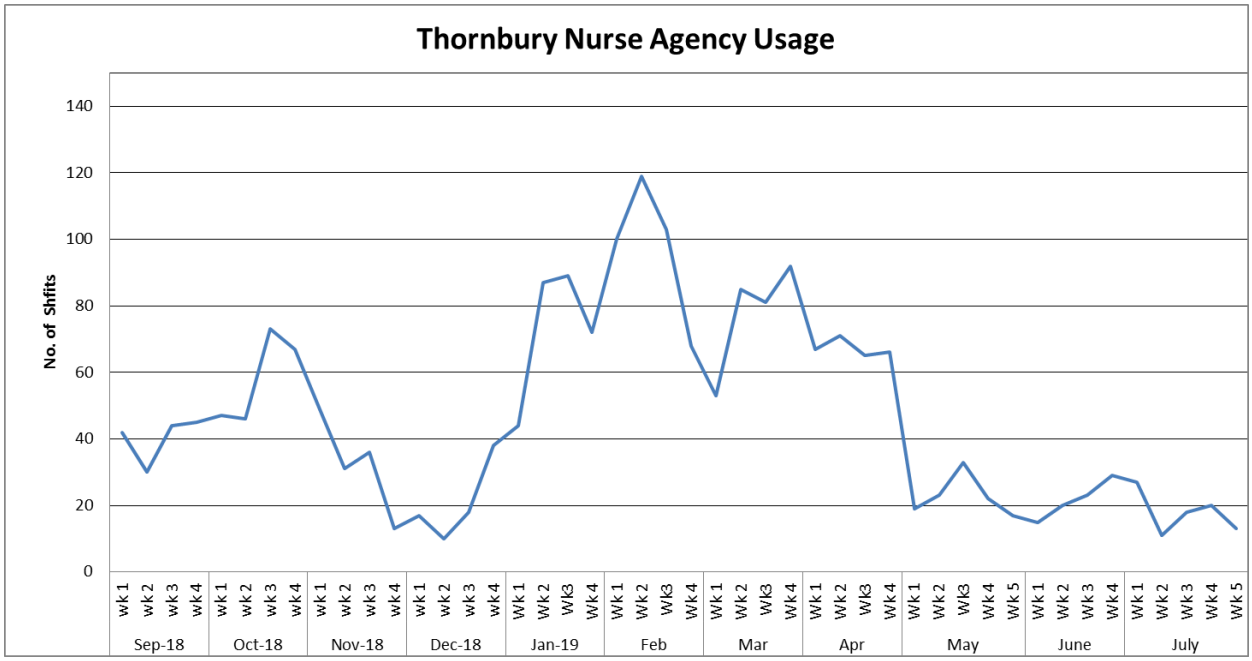


In July 7 moderate or above incidents were reported in July, 3 less than reported in June. Within the 7 incidents were 3 falls and 3 pressure ulcers.



4. Non Framework Nurse Agency Usage

We have been proactively sourcing nurse agencies that are within the framework to supplement NHSp and replace Thornbury as 'Tier 2' suppliers. It is proposed that this will be reflected and reported in the ongoing off framework agency reporting in the graph below. A draft risk assessment to review the current and future off framework agency utilisation has commenced.



July increase in Thornbury usage (Hrs) by 5%

5. Clinical Indicators Dashboard v3

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. Incorporate the Matrons monthly Quality Care Indicators in the future is planned. 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 Trust board is asked to receive the content presented in this paper and support the on-going plans to achieve and sustain compliance against Safe Staffing Plan.

Carol Fowler
Assistant Director of Nursing – Workforce

Appendix 1: Care Hours per Patient Day (CHPPD) – July 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	1,309.50	1,254.00	1,931.50	1,564.00	1,100.75	1,016.25	755.00	716.50	822	95.76%	80.97%	92.32%	94.90%	2.8	2.8	5.5		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	820.50	771.50	370.00	417.50	734.00	686.00	363.50	339.50	255	94.03%	112.84%	93.46%	93.40%	5.7	3.0	8.7		
E A U	300 - GENERAL MEDICINE	1,595.00	1,360.50	1,102.25	1,046.75	1,090.50	923.50	743.00	714.75	528	85.30%	94.96%	84.69%	96.20%	4.3	3.3	7.7		
FESS Ward	300 - GENERAL MEDICINE	1,773.50	1,202.97	1,417.50	1,627.00	1,112.50	941.98	723.25	836.75	851	67.83%	114.78%	84.67%	115.69%	2.5	2.9	5.4		
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,600.75	1,143.23	1,491.25	1,423.75	1,091.75	973.75	1,171.00	1,181.50	806	71.42%	95.47%	89.19%	100.90%	2.6	3.2	5.9		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,669.25	1,616.75	1,468.50	1,375.98	1,182.00	1,119.50	813.00	752.00	897	96.85%	93.70%	94.71%	92.50%	3.1	2.4	5.4		
Short Stay Unit	300 - GENERAL MEDICINE	1,495.00	1,218.75	1,534.75	1,357.75	1,129.50	1,021.50	1,095.50	1,047.50	865	81.52%	88.47%	90.44%	95.62%	2.6	2.8	5.4		
Ward 15a General Med	300 - GENERAL MEDICINE	1,235.25	1,170.08	1,637.75	1,448.50	1,229.00	1,054.50	1,331.50	1,286.33	728	94.72%	88.44%	85.80%	96.61%	3.1	3.8	6.8		
Stroke Ward	300 - GENERAL MEDICINE	1,390.50	1,242.48	1,251.25	1,384.75	1,117.92	1,046.42	738.00	726.00	567	89.35%	110.67%	93.60%	98.37%	4.0	3.7	7.8		
Rehab & Discharge Lounge	314 - REHABILITATION	1,465.92	1,175.75	2,159.10	1,612.33	739.50	703.50	1,128.50	996.50	735	80.21%	74.68%	95.13%	88.30%	2.6	3.5	6.1	Y	Reviewed and managed within trust processes
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	2,002.00	1,416.42	2,419.67	2,037.57	1,143.50	1,047.50	2,201.50	1,493.50	878	70.75%	84.21%	91.60%	67.84%	2.8	4.0	6.8	Y	Reviewed and managed within trust processes
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,258.50	1,236.00	1,368.00	1,251.50	737.58	725.08	394.00	382.00	458	98.21%	91.48%	98.30%	96.95%	4.3	3.6	7.8		
Ward H	110 - TRAUMA & ORTHOPAEDICS	743.50	582.00	743.00	368.00	743.00	494.00	357.00	176.50	88	78.28%	49.53%	66.49%	49.44%	12.2	6.2	18.4		
Surgical Ward	100 - GENERAL SURGERY	1,343.25	1,050.00	1,213.75	1,189.25	736.00	723.50	532.50	659.00	530	78.17%	97.98%	98.30%	123.76%	3.3	3.5	6.8		
Spinal Injuries Unit	400 - NEUROLOGY	3,873.50	3,343.08	3,704.00	3,355.25	2,892.50	2,737.50	1,496.50	1,427.00	1124	86.31%	90.58%	94.64%	95.36%	5.4	4.3	9.7		
Ward G	101 - UROLOGY	1,783.00	787.75	1,352.50	803.00	1,064.00	668.75	698.50	386.33	229	44.18%	59.37%	62.85%	55.31%	6.4	5.2	11.6		
TOTAL		**25,358.92**	**20,571.27**	**25,164.77**	**22,262.88**	**17,844.00**	**15,883.23**	**14,542.25**	**13,121.67**	**10361**	**81.12%**	**88.47%**	**89.01%**	**90.23%**	**3.52**	**3.42**	**6.93**		

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		4,089.67	4,124.33	2,346.25	1,530.50	3,651.00	3,780.00	842.00	704.00	0	100.85%	65.23%	103.53%	83.61%					
Ambulatory Care Unit		835.50	372.50	703.50	435.00	350.67	230.67	0.00	0.00	52	44.58%	61.83%	65.78%	#DIV/0!					
TOTAL		**4,925.17**	**4,496.83**	**3,049.75**	**1,965.50**	**4,001.67**	**4,010.67**	**842.00**	**704.00**	**110**	**91.30%**	**67.82%**	**64.45%**	**83.61%**	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	4,876.00	4,007.50	1,197.25	897.75	4,093.00	3,577.00	1,116.00	624.00	374	82.19%	74.98%	87.39%	55.91%	20.3	4.1	24.3		

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														#DIV/0!	#DIV/0!	#DIV/0!		
Maternity Ward	501 - OBSTETRICS	8,410.00	8,796.75	1,836.30	1,833.50	3,604.00	3,481.00	1,109.00	1,121.50	544	104.60%	99.85%	96.59%	101.13%	22.6	5.4	28.0		
MAU	501 - OBSTETRICS														#DIV/0!	#DIV/0!	#DIV/0!		
TOTAL		**8,410.00**	**8,796.75**	**1,836.30**	**1,833.50**	**3,604.00**	**3,481.00**	**1,109.00**	**1,121.50**	**544**	**104.60%**	**99.85%**	**96.59%**	**101.13%**	**22.57**	**5.43**	**28.00**		

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	1,117.75	1,120.50	76.75	76.75	1,104.00	1,080.00	0.00	0.00	195	100.25%	100.00%	97.83%	#DIV/0!	11.3	0.4	11.7		
Paediatric Unit	420 - PAEDIATRICS	2,194.25	2,011.25	1,170.00	911.25	1,485.53	1,245.53	420.00	360.00	348	91.66%	77.88%	83.84%	85.71%	9.4	3.7	13.0		
TOTAL		**3,312.00**	**3,131.75**	**1,246.75**	**988.00**	**2,589.53**	**2,325.53**	**420.00**	**360.00**	**543.00**	**94.56%**	**79.25%**	**89.80%**	**85.71%**	**10.05**	**2.48**	**12.53**		
PLANNED		15,879.75	12,422.75	11,998.17	9,902.32	11,409.58	9,973.33	6,796.00	5,148.33	3681	78.23%	82.53%	87.41%	75.76%	6.1	4.1	10.2		
URGENT		19,280.33	16,652.85	17,413.60	15,223.81	14,529.08	13,497.56	9,704.25	9,301.33	7106	86.37%	87.42%	92.90%	95.85%	4.2	3.5	7.7		
W&C		13,397.75	13,421.25	3,477.80	3,187.75	6,937.53	6,538.53	1,925.00	1,877.50	1087	100.18%	91.66%	94.25%	97.53%	18.4	4.7	23.0		
TRUST TOTALS		**48,557.83**	**42,496.85**	**32,889.57**	**28,313.88**	**32,876.20**	**30,009.42**	**18,425.25**	**16,327.17**	**11,874**	**87.52%**	**86.09%**	**91.28%**	**88.61%**	**6.1**	**3.8**	**9.87**		

Green- 80% and above
Red- Under 80%

Clinical Indicators Dashboard

NHS Southport and Ormskirk Hospital NHS Trust

Jul 19	Care Hours Per Patient Day (CHPPD) - Non Registered	Care Hours Per Patient Day (CHPPD) - Registered	Friends & Family - % That Would Recommend	HR - Sickness Absence Rate - Nursing - Non Registered	HR - Sickness Absence Rate - Nursing - Registered	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	Number of Nursing Vacancies	Number of Nursing Vacancies - Non Registered	Number of Nursing Vacancies - % Non Registered	Number of Nursing Vacancies - Registered	Number of Nursing Vacancies - % Registered	Patient Falls - Moderate / Major (/ Death (Related	Pressure Ulcers	Realtime Staffing - Staffing against Minimum Compliance	RM - Medication Incidents - Omitted Doses for Non-clinical Reasons	Safety Thermometer - Percentage of Patients With Harm Free Care
10B SSS/SAU	3.6	4.3	98.5%	17.41%	4.06%	0	0	2	3	1	3	2	15.5%	1	8.3%	0	0	95.7%	1	100%
11A Gen Surg	3.5	3.3	100%	1.19%	1.13%	0	0	0	0	0	2	1	9.7%	1	7.3%	0	0	94.7%	0	100%
11B	3.2	2.6	87.5%	7.28%	5.66%	0	0	1	2	0	8	1	2.9%	7	36.8%	0	0	88.2%	0	100%
14A	4	2.8	90.9%	8.89%	0.67%	0	0	1	1	0	21	11	44.5%	10	44.7%	0	2	77.2%	1	100%
14B	2.4	3.1	75%	2.21%	12.19%	2	0	2	1	0	10	3	15%	7	27.2%	1	0	94.8%	1	96.55%
15A	3.8	3.1	88.9%	3.8%	6.59%	0	0	1	1	0	14	6	29.8%	8	36.1%	0	0	91.3%	0	100%
15B Stroke Unit	3.7	4	87.5%	2.03%	1.7%	0	0	0	0	0	6	3	20.5%	3	13.8%	0	1	97.8%	0	100%
7A	2.8	2.8	88.9%	22.8%	13.94%	0	0	0	0	0	16	9	48.3%	7	35.8%	0	0	89.3%	3	100%
7B Rehab	3.5	2.6	90.9%	9.55%	0.27%	0	0	0	0	0	15	7	38.1%	8	40%	0	0	81.7%	0	100%
9B	2.9	2.5	83.3%	13.5%	2.89%	0	0	0	0	0	13	4	22%	9	42.4%	0	0	91.7%	0	96.43%
ACU	N/A	N/A		NTR	NTR							0	NTR	0	0%			54.9%		
Critical Care	4.1	20.3		9.47%	1.7%	0	0	1	1	0	12	0	-3.8%	12	19.9%	0	1	80.7%	1	100%
EAU	3.3	4.3	94.4%	4.48%	1.31%	0	0	0	0	0	20	8	43.3%	12	50.5%	1	0	89.3%	0	100%
G Urology	5.2	6.4	87%	0.41%	5.03%	0	0	1	0	0	10	4	28.3%	6	25.1%	0	0	54%	0	100%
H - Ortho	6.2	12.2	100%	NTR	NTR	0	0	0	0	0	0	0	NTR	0	NTR	0	0	62.7%	0	100%
Maternity	5.4	22.6	96.7%	5.21%	3.1%	0	0	1	1	1	-1	-1	-0.5%	0	0.1%	0	0	101.8%	1	NTR
MDU			NTR			0	0	0	0	0	1					0	0	NTR	0	
NNU	0.4	11.3	NTR	29.75%	6.77%	0	0	0	0	0	1	0	6.6%	1	5%	0	0	99.1%	1	
OBS	3	5.7	93.8%	0%	3.36%	0	0	0	0	0	1	-1	-18%	2	18.1%	0	0	96.8%	0	100%
Paeds	3.7	9.4	91.1%	1.73%	4%	0	0	1	2	0	6	2	12%	4	11.5%	0	0	88.6%	1	
SIU	4.3	5.4	100%	2.55%	6.96%	0	0	0	0	0	14	2	5.5%	12	22.5%	0	1	90.8%	1	91.89%
SSU	2.8	2.6	64.3%	6.82%	2.22%	0	0	2	1	1	15	3	14.4%	12	58.1%	1	0	88.4%	0	100%
Theatres								0	0	0	3					0			0	
Treatment Centre			100%			0	0	0	0	0	4					0	0		0	

(NTR=nothing to report)

Southport and Ormskirk Hospital NHS Trust

TRUST BOARD

4 September 2019

Agenda Item	**TB149/19e**	**Report Title**	**CQC PREPERATION UPDATE**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Paul Jebb, Deputy Director of Nursing Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper provides Trust board with an update on 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.

The Committee are asked to note 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 and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

Linked to Regulation & Governance

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

Board of Directors to note the report and next steps

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

CQC PREPARATION UPDATE

1. PURPOSE OF REPORT

This paper provides the Quality & Safety 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 received notification from the CQC on Wednesday 10th April of the Provider Information Request (RPIR), this was submitted within deadline on 3 May 2019, since then the Trust has had two unannounced core service inspections (see section 6), the final part of the inspection, the Well Led review is scheduled for 20th – 22nd August.

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

The current progress against Must and Should do actions is outlined below, a review will take place following Well Led to incorporate any uncompleted actions and key themes from the recent inspections into the quality improvement plan.

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 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 Quality Improvement Delivery Group (QID) continues to meet weekly, chaired by the CEO, 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.

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 have also received coaching from a Regulatory Consultant and NHSE/I 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 Key Line Of Enquiry (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 relation to Infection Prevention and Control a service review led by external consultants has been planned for September 2019.

5. AREAS IDENTIFIED AS POTENTIAL KLOE

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.

Additional potential KLOE are added as we become aware of areas that he CQC will focus on.

6. CQC CORE SERVICE INSPECTIONS

The CQC carried out an unannounced visit on 9 – 11 July 2019. Within this review the inspection team reviewed four core services medicine, surgery, children and young people's services and urgent and emergency care. The team spoke to staff, patients, relatives and carers across the Trust.

Feedback from the inspection team was given on the 11 July and the CEO and DoN then led a feedback session to other key leaders across the Trust

General feedback included:

- Everyone the teams met were open, friendly, and happy to share experiences with them
- It was evident that staff across the organisation worked well as teams

Specific Core Service feedback was given and areas highlighted included:

Medicine

- The documentation relating to MCA/DoLS/DNACPR was not consistent
- Issues relating to privacy and dignity of patients was also raised
- Medical records storage was also highlighted as a concern
- Access and flow was well managed
- Discharge planning was good

Surgery

- Theatre night staffing levels
- Theatre culture
- Completion of WHO checklists
- Medicines management across the service
- Risks within the service were known

Urgent & Emergency Care
- Significant improvement have been made in areas highlighted in previous reports
- Medical records storage was highlighted
- Completion of risk assessments
- Medicines management within the Dept.
- Equipment checks not being completed

Children & Young people services

- Paediatric medical cover at weekend highlighted
- Management of equipment and specifically resuscitation equipment
- Complaints process had improved
- Safeguarding systems worked well

A second unannounced core services inspection took place between 30 July – 1 August, core services visited included Sexual Health, End of Life (EoL), Critical Care and Outpatients in Ormskirk Hospital.

General feedback included:
- Sharing details of the positive interactions CQC had encountered from the staff with them freely sharing information and discussing their work at the hospitals.

Sexual Health
- Staff Training
- Under 16 Pathways
- Internal Audits
- Escalation and Safeguarding
- Medicines Checks and Fridge Temperatures
- Culture

End of Life
- Governance & Contract Management for EoL Service
- Maintenance of Syringe Drivers and Training
- Recording of Incidents & Risks
- DNACPR Policy, Audits & Action Plans
- Patient / Family Feedback
- Documentation Audits
- EoL Transfers

Critical Care
- Staff Training
- Mixed Sex Breaches
- Delayed Discharges
- Therapy input
- Medicines Management

Outpatients in Ormskirk
- Safeguarding Policies, training, incidents
- Mandatory Training
- Life Support Training
- Treating vulnerable patients and children in adult clinic
- HEAT Audits & Cleanliness
- Equipment maintenance

- Patient feedback / Friend and Family Test
- RTT / overdue reviews / Lost to follow ups
- Complaints process / lessons learned
- Governance meetings / minutes
- Improvement projects eg Treatment Centre and GIRFT

Medicines Management

- Concerns raised following a pharmacy focus group regarding the management of discharge medicines in particular those that included controlled drugs.

From both Core Services Inspections we have now received written confirmation and feedback, this has been shared with Board members and since the 15 July the Trust received over 250 information requests, all submitted within the requested timescales.

7. WELL LED

On 8 August, the Trust received confirmation of the Interview Schedule for the Well Led Review due to take place between 20 – 22 August, all executives are to be interviewed along with the non-executive chairs of Quality & Safety Committee, Finance, Performance & Investment Committee and Audit Committee. Board members and senior managers have also received coaching from a Regulatory Consultant and NHSE/I as part of their preparation for the inspection and interviews.

8. MEDICINES MANAGEMENT

In response to the concerns raised during the core services inspections and feedback from the pharmacy focus group, the Trust commissioned an internal review on 11 July 2019, this was completed by 17 July 2019. In addition we held a quality meeting on 25 July 2019 with NHSE&I Regional Representatives for medicine, pharmacy, intensive support and national Deputy Pharmaceutical Officer for NHSE&I. The outcome of the review and NHSE&I meeting was the development of a Medicines Management Improvement Plan. The plan has actions across four timescales – immediate, 30 day,3 month and 9 months. The aim of these actions is to address the immediate concerns and also ensure the Trust is improving safety and quality on a sustainable basis. The plan was reviewed by the Regional Pharmacist and Deputy NHSE&I Chief Pharmaceutical Officer. Immediate actions have been completed and reviews are being undertaken to ensure ongoing compliance.

Immediate plan 26-30th July - All items identified in the CQC letter and via verbal communication identified and corrected, bar one remaining signature related to stock rotation of IV fluids.

30 day plan 26th July-25th August- The Medical Director as executive lead has met with the Medicines Management development team to develop the documentation which defines the individual work streams using project management support.

3 month plan 26-25th October- The work streams are- Storage and checks/ policies/record/training/ordering and delivery/TTOs/Audits/governance/sustainability

9 month plan 26th July- 25th April- The work streams are- Storage and checks/Policy and process alignment across Nursing and Pharmacy/ EPMA and records/training/ordering and delivery/TTOs/Audits/governance/sustainability/weekend working

In relation to the issue around dispensing TTOs containing CDs, the Trust has responded immediately to these concerns by instructing all staff to stop any practice which is not in line with the Trust Policy including the release of any TTO controlled drugs without the appropriate signature by a Doctor.

The Trust has also taken advice from the Regional Pharmacist, Deputy Pharmaceutical Officer for NHSE&I, Controlled Drugs Accountable Officer for NHSE&I and a national expert in Medicines Management. In line with the advice received the Trust has taken the following actions;

- Treat the matter as a serious incident and use the Serious Incident governance process
- Commissioning an external investigation (taking external advice on the terms of reference and an appropriate external investigator)
- Continue with the Medicines Management Improvement Plan

9. RECCOMENDATIONS

The Quality & Safety Committee is asked to note progress identified in this report as assurance that systems and processes are in place to deliver quality improvement.

Care Quality Commission
Cityate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Silas Nicholls
Chief Executive
Southport and Ormskirk Hospital NHS Trust
Town Lane
Kew
Southport
PR8 6PN

Date: 16 July 2019

Your account number: RVY
Our reference: INS2-6197305121

Dear Mr Nicholls

CQC inspection of Southport and Ormksirk Hospitals NHS Trust

Following your feedback meeting with Jonathan Driscoll and Deborah Lindley on 11 July 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 11 July 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

Urgent and emergency care – Southport and Formby District General Hospital

- We observed caring staff throughout the service.
- The privacy and dignity of patients had improved since the last inspection.
- We saw improvements since the last inspection in areas we said the trust must take action, including the environment, escalation processes, infection prevention and control, staffing and ambulance handover times.

- In some areas where we said the trust must take action issues further work was needed such as record keeping, risk assessments and medicines management, specifically out of date medicines.
- The service was not properly checking resuscitation trolleys, there were gaps in the checks and some equipment was out of date.
- The service told us Royal College of Emergency Medicine audit data had improved, we plan to add the new data if it is available before publication.
- Pathways and guidance had improved since the last inspection.
- We did not see issues with management of pain relief on site but audits indicated that this still needed improvement.
- The service was not fully meeting requirements of the Mental Capacity Act for every patient who lacked capacity.
- Performance standards were not being met, including the 4 hours standard. There were 12 hour breaches although the number of black breaches had improved.
- There were no issues with patient flow during the inspection, despite the day before being one of the department's busiest.
- Staff informed us that the culture amongst nursing staff had been challenged and there was still work to do. Medical staff were positive about the culture.
- The risk register had improved since the last inspection and leaders understood the risks.
- Staff reported that divisional leadership were very visible and 'hands on'.

Medicine - Southport and Formby District General Hospital

- We observed caring interactions between staff and patients but privacy and dignity was not always respected, for example on one ward we saw three patients during visiting hour in their underwear.
- Mandatory training levels were below trust targets (we would be requesting more up to date data).
- Records were not secure on every ward.
- We saw evidence of action not been taken when National Early Warning Scores indicated it should have been.
- We saw issues with medicines management including with self administration, medicines charts, thickener not securely stored on the stroke ward, out of date medicines and medicines unavailable.
- We saw hazardous substances not secured in dirty utility rooms on different wards.
- We saw issues with infection prevention and control on Ward 15A with side room doors open and no sink for washing equipment on the medical day unit.
- We saw issues with understanding and application of the Mental Capacity Act, including for patients lacking capacity with Do Not Attempt Cardio Pulmonary Resuscitation orders and Deprivation of Liberty Safeguards in place.
- We saw gaps in Malnutrition Universal Screening Tool and fluid balance charts

- The service was managing access and flow well and we saw examples of well managed discharge planning.
- We saw limited use of ‘this is me’ booklets and passports.
- We recognised there was a new management team. Staff said the divisional leadership were visible.
- Leaders were aware of issues and risks.
- Leaders told us about plans to change things and improve but we did not see evidence that they had been implemented or embedded yet.
- Staff reported mixed views about the culture. Some staff did not feel supported, although staff felt that they could speak up and challenge.

Surgery - Southport and Formby District General Hospital

- We observed good care of surgical patients.
- We had seen improvements in areas we said the service must take action.
- The theatre staffing at night time did not appear to be sufficient.
- We observed the World Health Organisation five steps to safer surgery checklist but saw that this was not fully completed as the surgeon was not present for sign out.
- We saw issues with medicines management including gaps in prescription chart and issues with disposing of drugs. We shared details of a controlled drugs cabinet which did not appear to meet requirements.
- We saw improvements to maintenance and use of equipment, including checking of resuscitation trolleys.
- Records were not secure on every ward.
- We saw issues with understanding and application of the Mental Capacity Act.
- The service had mixed outcomes in national audits
- Staff reported the recovery area being used for patients awaiting a bed. Staff told us they felt pressure to send patients to theatre without beds being available.
- Some theatre staff told us they felt they were not listened to and were concerned about pressures compromising standards. Staff told us they were expected to stay beyond hours. Culture amongst ward staff had improved.
- Leaders were cited about risks and issues which were recorded on the risk register.

Services for Children and Young People – Ormksirk District General Hospital

- We were concerned that there was not adequate paediatric medical cover at weekends. We were told that after 1pm there may be one ST7 doctor covering the paediatric ward, neonatals, maternity and the children’s emergency department. We would be requesting further information in relation to this.
- Concerns were raised with us that medical staff had not listened to nursing staff about deteriorating patients, we were given examples of two serious incidents.

- We saw equipment which was out of date and resuscitation and emergency trolleys were not properly checked or secure.
- We saw that the safeguarding systems were working well.
- We did not find any medicines issues although temperature checks for fridges were not consistently completed.
- Pathways appear to have improved since the last inspection.
- We observed good care and positive feedback from children and parents.
- The complaints process appears to have improved.
- Staff told us that leaders were generally approachable and were proud of staff.
- Staff told us about good teamwork between staff and the service “feeling like a family”.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS Improvement/NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

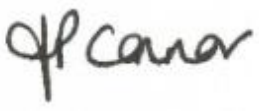
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Judith Connor

Head of Hospitals Inspection

c.c. Neil Masom, Chair
Marie Boles, NHS England/NHS NHS Improvement
David Fryer, CQC regional communications manager

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB150/19**	**Report Title**	**Medical Appraisal and Revalidation Annual Report 2018-19**
Executive Lead	Dr Terry Hankin, Executive Medical Director /Responsible Officer		
Lead Officer	Mr Kevin Thomas, Deputy Medical Director/Clinical Medical Appraisal Lead		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The purpose of this paper is to assure the Board that appropriate processes are in place to ensure that the Trust is compliant with its legal obligations in relation to medical appraisal and revalidation and continues to provide a robust medical appraisal and revalidation system.

All responsible officers have been requested to present an annual report to their Board, using '***The Framework of Quality Assurance for Responsible Officers and Revalidation'*** (FQA) which has been developed by NHS England and submit a ***'Statement of Compliance'*** to the Higher Level Responsible Officer at NHS England by 29th September 2019.

As at the end of the appraisal cycle on 31st March 2019, the Trust was the 'designated body' for 197 doctors (an increase of 11% on the previous year). 92.9% of doctors completed a medical appraisal in line with GMC requirements (3.3% above other designated bodies in the same sector). The reasons for incomplete or missed appraisals are as below:

	2018/19	2017/18
Appraisals completed on time	183 (92.90%)	164 (92.13%)
Approved missed or late appraisals - (sickness/maternity) - clinical commitments/other	6 (3.05%) 6 (3.05%)	3 (1.69%) 10 (5.62%)
Unapproved missed or late appraisal - (not completed by 31.3.19 and no prior approval sought from the RO for delay).	2 (1.00%)	1 (0.56%)
TOTAL	197	178

Recommendation:

The Board is asked to **approve** the contents of the report (by signing the Statement of Compliance) and be assured that the Trust has appropriate processes in place to ensure that doctors have high quality annual appraisals and that the Responsible Officer's revalidation recommendations are based on robust information about each doctor.

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 attached report and statement of compliance will be forwarded to the higher level responsible officer at NHSE.

Previously Presented at:

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

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of **SOUTHPORT AND ORMSKIRK NHS TRUST** can confirm that:

1. **The Annual Organisational Audit (AOA) for this year has been submitted.**

Date of AOA submission: **30.05.2019**
Action from last year: **N/A**
Comments: **92.9% of appraisals in 2018/19 were completed on time in accordance with category 1 of NHSE Annual Organisation Audit (AOA).**
Action for next year: **Continue with supportive and structured appraisal process and continue to improve % completion rate where possible.**

2. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Action from last year: **N/A**
Comments: **Dr Terry Hankin was appointed the Responsible Officer (RO) for the Trust on 07.01.2019 following the departure of the interim medical director and RO, Dr J Mahajan. Dr Hankin has undertaken the required RO training programme and has an annual appraisal undertaken by an external appraiser appointed by NHSE.**
Action for next year: **N/A**

3. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

Yes
Action from last year: **N/A**
Comments: **- the RO is supported by the Clinical Appraisal Lead (Mr Kevin Thomas) and the Appraisal and Revalidation Manager (Ann Higgin).**
Action for next year: **N/A**

4. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**

Action from last year: **N/A** Comments: **Reports received from HR are cross referenced with GMC Connect by the Appraisal and Revalidation Manager on a monthly basis to maintain an accurate record.** Action for next year: **Continue process**

5. **All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

Action from last year: **N/A** Comments: **The Appraisal and Revalidation Policy is due for review in Feb 2020.** Action for next year: **Review Policy and publish on intranet.**

6. **A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

Action from last year: **N/A** Comments**: A review was undertaken by Mersey Internal Audit in 2014 and a Higher Level Responsible Officer Quality Review with representatives from NHSE in November 2016. Feedback from both was positive.** Action for next year: **Consider any other appropriate reviews**

7. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from last year: **N/A** Comments: **All doctors holding a contract of employment are supported by the Trust and given the resources to undertake an annual appraisal regardless of whether they are employed as a locum or permanent doctor. The Risk Department provide information in relation to complaints, claims, incidents suis etc. for all doctors(whether or not from a different prescribed connection) to enable reflection.** Action for next year: **Continue to support doctors.**

Section 2 – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

Action from last year: **N/A** Comments: **All doctors are required to complete relevant declaration forms concerning participation in any outside work and include supporting information for their full scope of work in their appraisal.** **Information relating to complaints, claims, suis, and incidents is made available to all doctors to allow reflection. Where applicable clinical benchmarking data (currently using the Dr Foster system) is also provided.** Action for next year: **Continue process**

2. **Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Action from last year: **N/A** Comments: **N/A** Action for next year: **N/A**

3. **There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

Action from last year: **N/A** Comments: **MED STAFF 14 Medical Appraisal and Revalidation Policy is in place. The policy is due for review Feb 2020.** Action for next year: **Review and update as necessary**

4. **The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

Action from last year: **N/A** Comments: **There are currently 41 appraisers (32 Consultants and 9 SAS/AS doctors). 4 more consultants are attending training in October to cover appraiser turnover.** Action for next year: **Continue to review and train additional appraisers as necessary.**

5. **Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).**

Action from last year: **N/A** Comments: **Appraiser Support Groups are held twice a year to discuss topical issues, challenges and share best practice in a confidential environment.** **Following completion of their appraisal, doctors are requested to complete an appraisal feedback form. This information is anonymised and a summary report collated for each appraiser for them to include and reflect upon in their appraisal. Any concerns highlighted are discussed with the RO and the doctor and any relevant action taken (e.g. retraining).** Action for next year: **Continue**

6. **The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

Action from last year: N/A Comments**: Internal quality assurance measures including review of portfolios are in place.** **An Annual Board Report and Statement of Compliance are shared with the Board. Appraisal completion rates are published monthly.** Action for next year: **Continue**

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

1. **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Action from last year: **N/A** Comments**: All recommendations made to the GMC to date have been considered and submitted on time.** **Appraisal portfolios are reviewed for all doctors by the Appraisal & Revalidation Manager, Clinical Lead and/or RO before making a revalidation recommendation to the GMC to provide assurance that the outputs, declarations and supporting information provided meet the necessary requirements.** Action for next year: **Continue process**

2. **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from last year: **N/A** Comments: **Doctors are made aware of all revalidation recommendations prior to submission to the GMC. Any deferrals are discussed with the doctor and a plan of action agreed, documented and monitored.** Action for next year: **Continue process**

Section 4 – Medical governance

1. **This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from last year: **N/A** Comments: **There are clear effective systems in place for reporting and reviewing significant events, complaints and clinical performance. Openness and reporting of incidents is encouraged.** Action for next year: **Continue**

2. **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from last year: **N/A** Comments: **Doctors who have been involved in any complaints, claims, never events etc. are required to include a reflection of the incident in their annual appraisal portfolio. This information is provided to the Appraisal and Revalidation Manager by the Risk department and is uploaded into the doctor's appraisal portfolio prior to appraisal.** **'Dr Foster' clinical benchmarking data is provided where appropriate.** **Doctors also undertake a 360 patient and colleague feedback exercise at least once in each revalidation cycle.** Action for next year: **Continue**

3. **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from last year**: N/A** Comments**: The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS" (MHPS) is followed.** **The RO, Deputy Medical Director and HR Director meet on a monthly basis to discuss any issues.** **The RO attends a serious incident report group on a weekly basis to monitor overall response to serious incidents in the organisation** **Quarterly meetings are held between the RO and the GMC's employment Liaison Advisor to discuss any performance or revalidation issues.** Action for next year: **Continue to follow process**

4. **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].**

Action from last year: **N/A** Comments: **The RO in the organisation is responsible for managing any concerns raised regarding doctors and would involve HR/Senior Medical Management in the organisation as per policy.** **The RO is satisfied with the quality of management of concerns in the organisation** **Currently there are no MHPS cases.** Action for next year: **Continue**

5. **There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].**

Action from last year: **N/A** Comments: **Relevant RO to RO references are issued. Any immediate concerns are raised by the RO with any other relevant RO in a timely and appropriate manner.** Action for next year: **Continue**

6. **Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).**

Action from last year: **N/A** Comments: **The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS" (MHPS) and other relevant Trust policy are followed.** Action for next year: **Continue**

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. **A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

Action from last year: **N/A**
Comments: **The Trust has an appropriate procedure in place operated by the medical staffing department, for obtaining relevant information when entering into a contract of employment with doctors for the provision of services**
Action for next year: **Continue**

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of last year's actions:

Appointment of new Responsible Officer

92.9% completion appraisal rate - slight increase from previous year (92%)

Actions still outstanding

No actions outstanding

Current Issues

No current issues

New Actions:

Appraisal and Revalidation Policy review Feb 2020.

Overall conclusion:

Engagement in medical appraisal continues to be very positive.

Additional Note: QUEENSCOURT HOSPICE

Although Queenscourt Hospice is now a designated body in its own right the Trust continues to provide a responsible officer for the hospice given the small number of doctors employed (3). The hospice is provided with a separate board report and AOA and the Trust provides appraisal support for the hospice under a formal SLA. Two doctors at Queenscourt have been trained as appraisers and act as appraisers for the Trust.

Section 7 – Statement of Compliance:

The Board of **SOUTHPORT AND ORMSKIKR NHS TRUST** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman

Official name of designated body: **SOUTHPORT AND ORMSKIRK NHS TRUST**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB151/19**	**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.

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

Strategic Objective(s) and Principal Risks(s)

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

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

Previously Presented at:

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

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Integrated Performance Report

Trust Board September 2019

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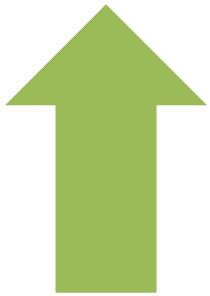
Steve Christian
Chief Operating Officer

IPR Overview

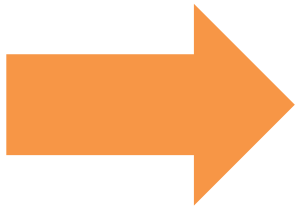
Reporting month: July 2019

IPR Performance Summary – Month on Month



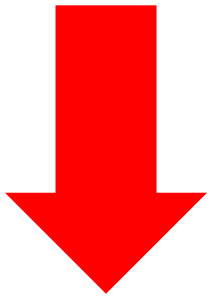
30 indicators have improved

Safe	2
Effective	5
Caring	1
Responsive	6
Well-Led	6
Efficiency	10



8 indicators have remained the same

Safe	3
Effective	1
Caring	1
Responsive	3
Well-Led	0
Efficiency	0



22 indicators have deteriorated

Safe	4
Effective	1
Caring	1
Responsive	4
Well-Led	11
Efficiency	1

Most significant Deteriorating Indicators

Fractured Neck of Femur

Performance deteriorated in July to 47.37% due to an increase in demand over a concentrated period - an extra trauma list was arranged to help reduce the waiting times

Length of Stay

Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 7.3 days in July. The increase is primarily down to longer length of stay patient being discharged in-month

Vacancy Rates

Vacancy rates remain high for both medical and nursing vacancies. Time to recruit has a focus and is the Workforce Improvement Group (accountable to the Hospital Improvement Board) is focused on further improvements. KPIs are set which shows positive improvements in *Time to Shortlist* and *Time to Approve Vacancy Request*

Referral to Treatment

Whilst the trust continues to meet the 18 week standard, there is a continued deterioration in performance to 92.72% . In the first quarter alone there has been an increase in the PTL of 3.5% however long waiters are being managed with no risk to 52 week wait breaches. The Trust currently has medical resource shortages in the majority of specialties.

Personal Development Reviews (PDR)

PDR compliance remains fairly static now at 72.4% for July 2019. Data validation identified a technical issue preventing the recording of completed PDRs

Most Significant Improving Indicators

HSMR	HSMR see further consecutive improvement and is now at 94.8
Ambulance Handovers	Performance has significantly improved compared to the previous year - 54.66% of ambulance handovers were completed within 15 minutes of arrival in July 2019 compared to 38.12% in July 2018
Stroke 90% Ward Stay	Performance in July improved significantly in month and achieved above target.
Mandatory Training	Mandatory training has remained above the Trust target of 85% since Feb 2019 and continues to improve
Theatre Utilisation	Theatre utilisation continues to improve at both sites
Stranded Patient	The number of patients with a LoS > 7 days occupying an inpatient stay reduced to 169 patients which delivered trajectory

Activity Summary – July 2019

Southport and Ormskirk Hospital NHS Trust

Indicator Name	July 2018	June 2019	July 2019	Trend (month on month)
Overall Trust Attendances	9,866	9,912	10,891	▲
SDGH A&E Attendances	4,538	4,738	5,208	▲
ODGH A&E Attendances	2,231	2,308	2,448	▲
SDGH Full Admissions Actual	918	973	1,057	▲
Stranded Patients AVG	183	178	169	▼
Super Stranded Patients AVG	69	69	66	▼
MOFD Avg Patients Per Day	53	68	60	▼
Elective Admissions	196	199	204	▲
Daycase Admissions	1,863	1,704	1,951	▲
Outpatient Seen	21,144	21,053	24,039	▲
Theatre Cases	644	589	626	▲
In Hospital Deaths	78	48	60	▲

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Under the Spotlight One:
Theatre Improvement Programme

- The Golden Patient - starting on time or early for the first patient on the list.
- On The Day Cancellations – decreasing avoidable cancellations.
- Scheduling – adequate scheduling processes to maximise existing available theatre time.

The Golden Patient

- Identifying the Golden (First) and Silver (Second) patient on a list.
- Ward able to plan arrivals and admissions in that order to be ready for surgeon and anaesthetic review.
- Golden Patient entering anaesthetic room at 9am for an AM or all day elective list.
- T+O – both elective and trauma lists – commenced in July
- Ophthalmic – Commenced in August.
- Urology – Commences officially in September.
- Other specialties to happen with haste post September.
- It is happening organically as the language of Golden Patient becomes business as usual.

On The Day Cancellations

- 6 week review identified 60% of cancellations avoidable.
- 48 Hour TCI Call pilot performed – 1 week in July.
- For that weeks patients we had zero on the day avoidable cancellations.
- Ormskirk Wards have been directed to present plan to implement.

Scheduling

- Work continues to embed 6-4-2 scheduling processes.
- Ensures scheduling of theatres to 85% utilisation.
- Clinical Ownership of lists.
- Clinical ordering of lists (to assist Golden Patient).
- Over time to develop short notice cancellation waiting lists (to work in conjunction with 48 Hour TCI call).
- Starting on time – finishing on time.
- Reduced overruns and underruns.

Results So Far

The Golden Patient	% On Time or Early Starts (Jan 19-Jun 19)	% On Time or Early Starts (Jul 19)
T+O	44.93%	50%
All Specialties	41.28%	57.6%

Cancellations	Jan 19 – Jun 19	Jul 19
All Specialties	9.63%	8.72%

Utilisation	In Session Utilisation (Jan 19 – Jun 19)	In Session Utilisation (Jul 19)
T+O	72.75%	74.23%
All Specialties	70.98%	75.7%

The Challenge –

Planned Sessions Cancellations due to Lack of Anaesthetic Cover

Specialty	Cancelled session due to "Lack of Anaesthetic Cover"	% against total planned sessions
ENT	1	2.2%
Gynae	3	4.1%
Gen Surg	9	6.9%
Ophthalmology	4	4.5%
T&O	17	13.1%
Urology	4	4.4%

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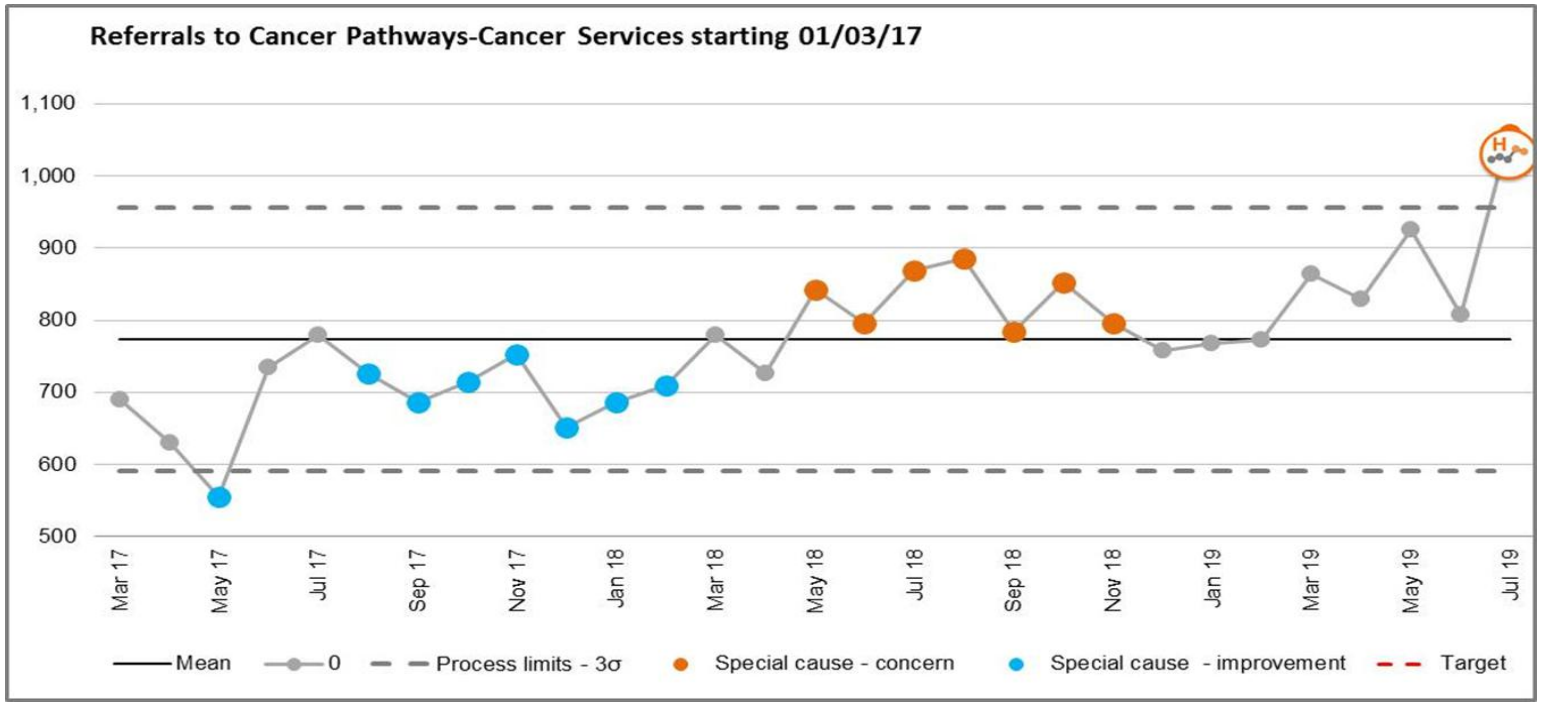
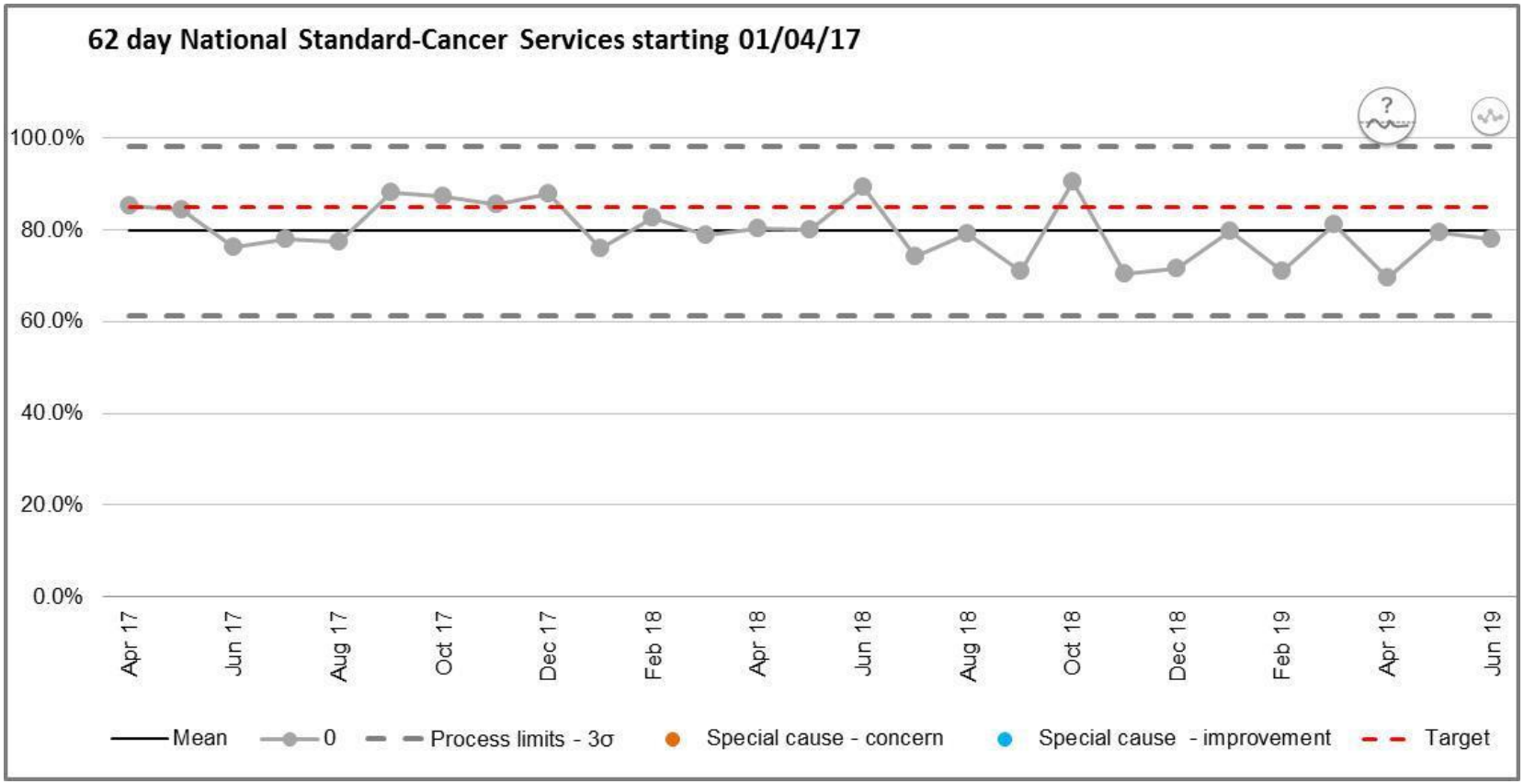
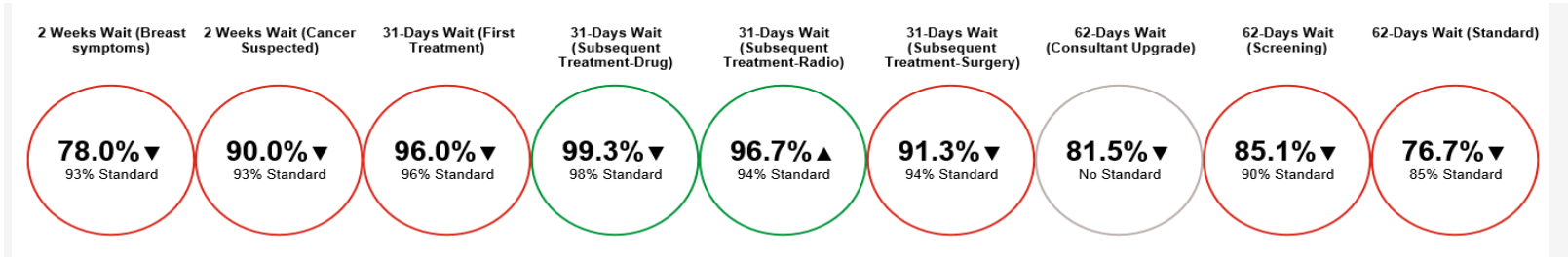
Under the Spotlight Two:
Cancer Performance



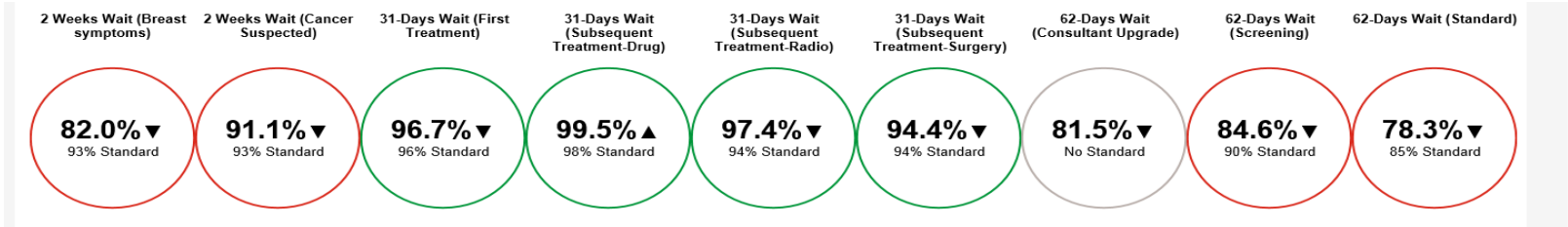
National 62 day Cancer Standard (S&O)



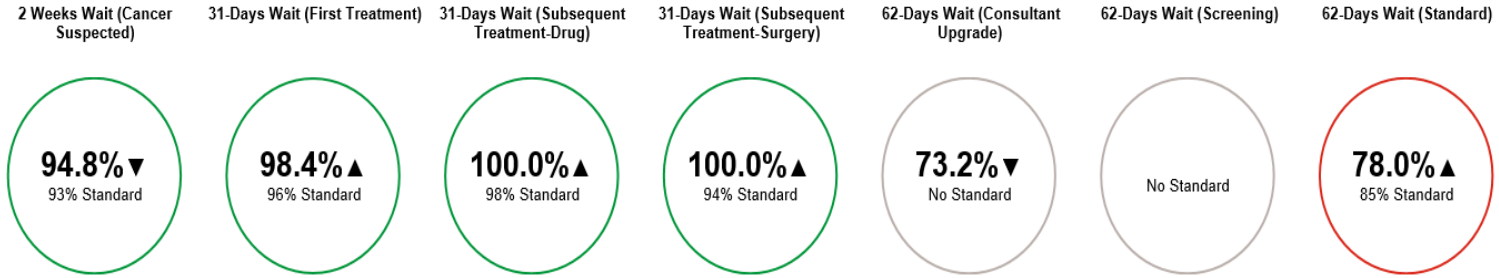
National Performance JUNE 2019



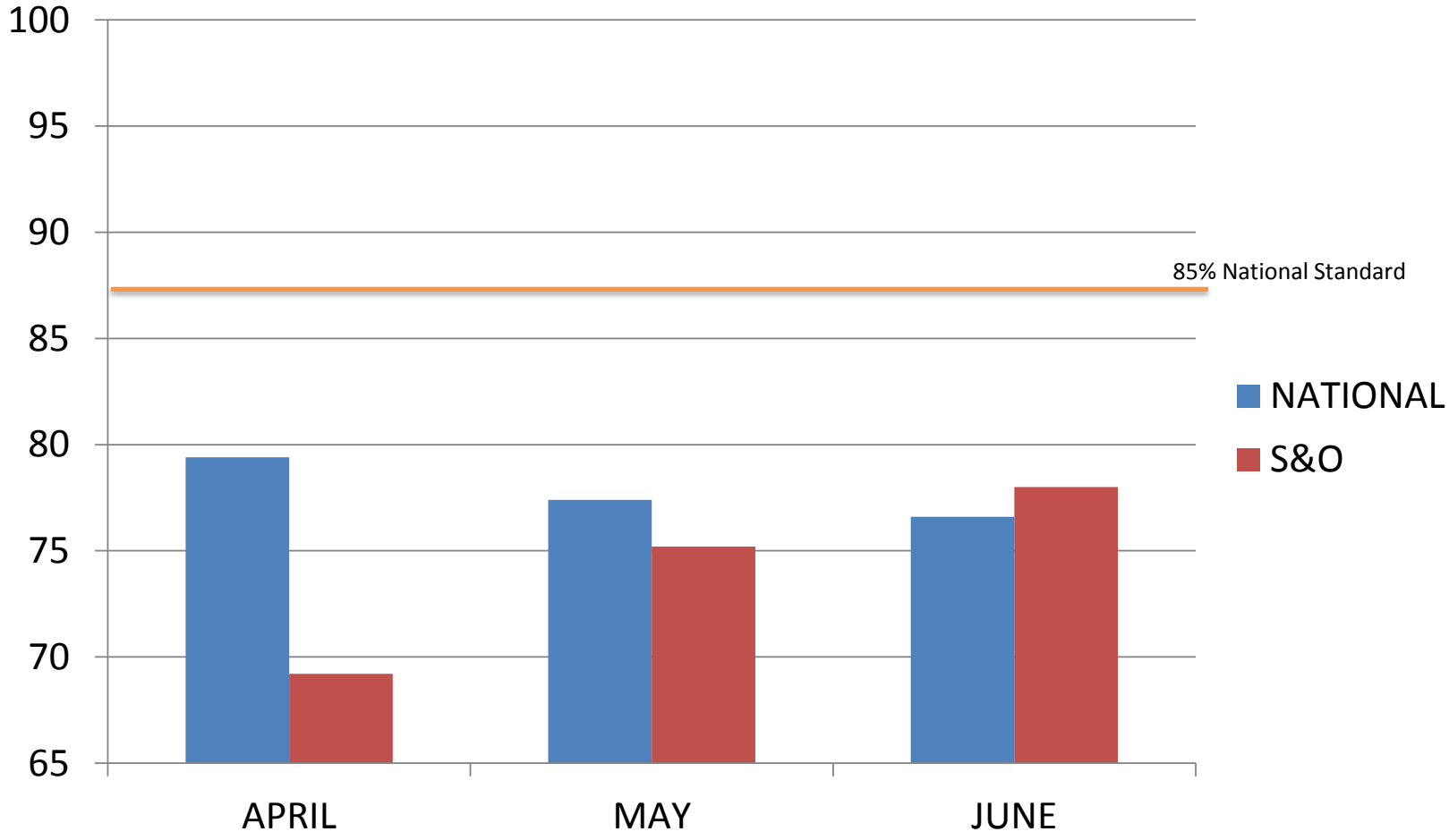
Regional Performance JUNE 2019



Southport & Ormskirk Performance JUNE 2019



S&O position against National figures



	APRIL	MAY	JUNE
S&O position in country	138/154	100/154	78/154

Initial Key Improvements in July

- Introduction of robust RCA process for all breaches
  - Over time will give a clearer view of RCA themes both internal and external to organisation
- Daily point of contact between tracking and operational team
  - Ensuring all issues discussed and dealt with in timely manner
- Embedded escalation process
  - Robust escalation process that allows to movement on potential “breaches” to “saves”
  - Oversight of themes to breaches now at more senior level (SOLT meeting)

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Board Report - July 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	0	0	0			
C-Diff	3	2	10	2			
Never Events	0	0	1	0			
VTE Prophylaxis Assessments	95%	96.9%	97.5%	147			
Harm Free (Safety Thermometer)	95%	98.6%	97.6%	5			
Falls - Moderate/Severe/Death	1	3	8	3			
Patient Safety Incidents - Low, Near Miss or No Harm		717	3194	717			
Safe Staffing	90%	88.3%	91.9%	N/A			
Fractured Neck of Femur	90%	47.4%	70.7%	9			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Percentage of Deaths Screened	100%	54.2%	38.5%	22			
SHMI (Summary Hospital-level Mortality Indicator)	100	111.1		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	94.8	94.8	N/A			
WHO Checklist	100%	100%	100%	0			
Stroke - 90% Stay on Stroke Ward	80%	88%	67.2%	3			
Sepsis - Timely Identification	90%	94.6%	97.1%	N/A			
Sepsis - Timely Treatment	90%	82.9%	82%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	14	97	14			
Written Complaints	35	18	85	18			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	92.9%	94%	52			

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%	88.8%	88.6%	1214			
Accident & Emergency - 12+ Hour trolley waits	1	4	30	4			
Ambulance Handovers <=15 Mins	99%	54.7%	52.2%	695			
Diagnostic waits	1.01%	4.1%	4.1%	149			
14 day GP referral to Outpatients	93%	94.8%	94.8%	42			
31 day treatment	96%	98.4%	98.2%	1			
31 day treatment (Surgery)	94%	100%	100%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	78%	74%	0.22			
62 day GP referral to treatment	85%	78%	75.9%	10			
Referral to treatment: on-going	92%	92.7%	93.7%	813			
Bed Occupancy - SDGH	93%	93%	94%	N/A			
Bed Occupancy - ODGH	60%	47.3%	46.6%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	100%	96.2%	0			
Duty of Candour - Evidence of Letter	100%	100%	96.2%	0			
I&E surplus or deficit/total revenue	-1%	-8.4%	-19%	N/A			
Liquidity	-106	-109	-109	N/A			
Distance from Control Total	0%	-0.9%	-7.9%	N/A			
Capital Service Capacity	0.21	-0.644	-3.559	N/A			
% Agency Staff (cost)	5.45%	8.1%	8%	N/A			
Use of Resources (Finance) Score	3	4	3	N/A			
Distance from Agency Spend Cap	0%	124%	124%	N/A			
Staff Turnover	0.76%	1%	6.8%	N/A			
Staff Turnover (Rolling)	10%	11.3%		N/A			
Vacancy Rate - Medical	5%	13.4%		N/A			
Vacancy Rate - Nursing	8%	17.4%		N/A			
Sickness Rate	5%	5.3%	5%	N/A			
Personal Development Review	85%	72.4%	72.2%	N/A			
Mandatory Training	85%	87.1%	86.7%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.7	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	60	62	60			
DTOC - Number of Beds lost per month		181		181			
Length Of Stay	6.5	7.3	7.3	N/A			
New:Follow Up	2.64	2.3	2.4	N/A			
DNA (Did Not Attend) rate	8%	7.1%	7.1%	1769			
Cancelled Ops	0.61%	0.1%	0.3%	3			
Theatre Utilisation - SDGH	80%	70%	59.4%	N/A			
Theatre Utilisation - ODGH	90%	74.5%	68.1%	N/A			
Stranded Patients (>6 Days LOS)	170	169	733	169			
Super Stranded Patients (>20 Days LOS)	58	65	285	65			
Southport A&E Conversion Rate	20%	19.7%		1053			

Reporting Frequency is monthly except for SHMI which is quarterly.

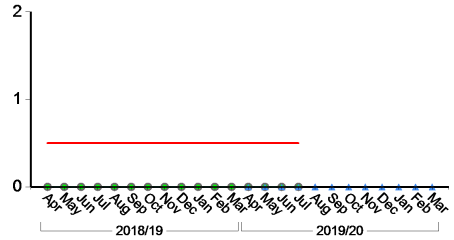
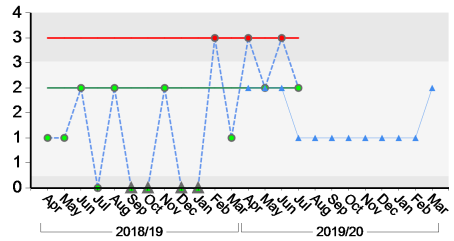
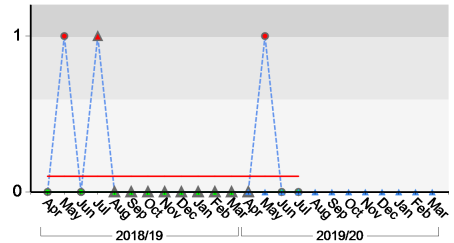
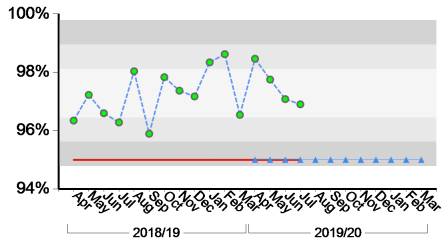
Southport and Ormskirk Hospital
NHS Trust

KPI Graphs and Update

Board Report - July 2019

NHS Southport and Ormskirk Hospital NHS Trust

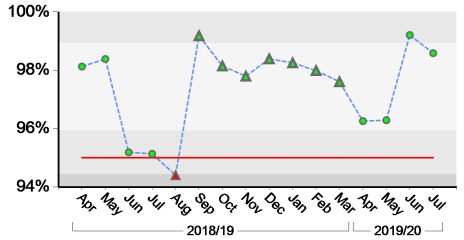
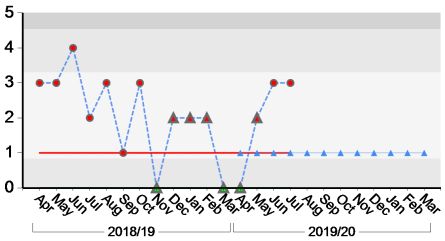
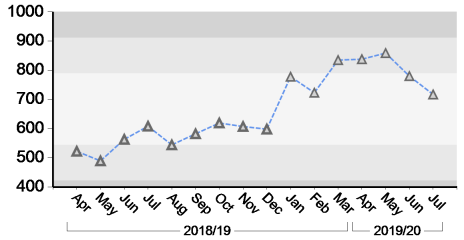
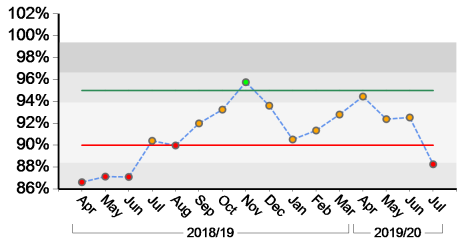
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	Continued excellent results with no MRSA bacteraemia to report since September 2017 - All patients attending for invasive elective surgery are screened for MRSA and where possible prior to surgery are prescribed suppression treatment if found to be positive, similarly emergency admissions are screened for MRSA and if found positive are isolated and suppression treatment initiated. Screens that are missed (5% in July) are identified by the IPC team and if the patient is still an in-patient the screen is requested to be completed by the ward. The IPC team are also auditing cannula care plans to verify these are being properly monitored and maintained.	
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.	2 C diff cases in July - small increase in cases so far this year which is also evident in neighbouring trusts. - 2 cases of C. diff. attributed to the Trust; one on 14B and the other a community onset healthcare associated infection from a GP requested sample from a patient who had been an in-patient within the last 28 days. The community onset case is appealable together 3-4 cases from earlier in the year which will bring the Trust back on target.	
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.	The Trust reported 1 never event in the last 12 months - in May 2019. - There were no never events in July Ongoing training and monitoring of processes continue	
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	The percentage of assessments has slightly deteriorated month on month for the last four months but remains within the normal range for the trust - The trust maintains compliance	

Board Report - July 2019

NHS Southport and Ormskirk Hospital NHS Trust

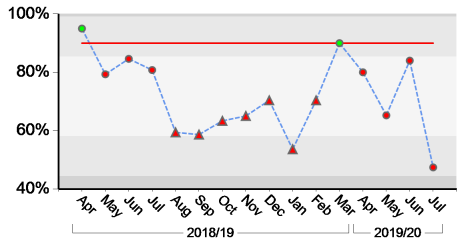
Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance for July remains ahead of target - Patient harms reported as part of monthly Harm free care audit continues to be above target. During census day in July 2019 the Trust reported 5 patient harms which were; 3 x category 2 pressures ulcers on NWRSIU 1 x low harm fall on 9b 1 x moderate harm fall on 14b. Local investigation for each of the reported harms is the responsibility of the relevant CBU	
Falls - Moderate/Severe/Death	The total number of falls within the Trust were the severity of the harm was either moderate, severe or resulted in death. Threshold:0	Performance demonstrating a static picture as the roll out plan progresses and remains on track. - The roll out of the falls assessment and care planning bundle is expected to be completed on the acute wards at SDGH by the end of August with the whole Trust by the middle of September. Staff are completing an e-learning module to enhance education and knowledge. The post-falls assessment is being reviewed and is expected to be ready to test in September following feedback on a first draft. The falls this month of which three were moderate/severe harm were all moderate harm on RCA. The success of the work is interdependent on the roll out of the enhanced supervision policy which will commence roll out by the end of August and a full roll-out plan will be established, this will be rolled out rapidly, although the action to provide a bay tag or 1-1 supervision will be limited if staff are not available and therefore will result in the number of falls remaining at the current level.	
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.	There were 711 lower level incidents reported in July a decrease from 780 last month - In July there were 711 lower level incidents reported - 31 Near miss incidents, 619 No harm and 84 Low harm incidents. 82 of these were DoL's applications , 53 safeguarding . The other categories with the highest reported incidents relate to Bed management issues such as delay in transfer to the ward -44 reported , same sex breaches 14 reported and patients nursed in the corridor in A&E -20 reported , the other category relates to patient falls where 63 incidents , themes -20 delay in treatment , 23 unexpected admission to NNU .	
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 remains stable and above national compliance 90% with all trust actions supportive to outcomes. - The trusts ongoing plan to deliver improvements is supported through the Trusts investment to nursing establishments. Band 5 and HCA recruitment events throughout August.	

Board Report - July 2019

NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance deteriorated in July to 47.37% - A high number of fractured neck of femur patients were all admitted within the space of a few days in mid July, therefore theatre lists were unable to cope with this extra workload, so an extra trauma list was arranged to help reduce the waiting times.	

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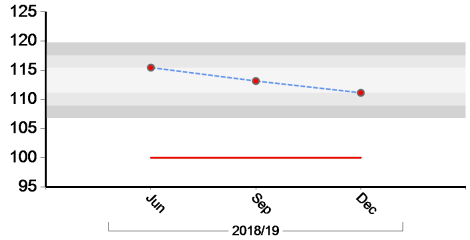
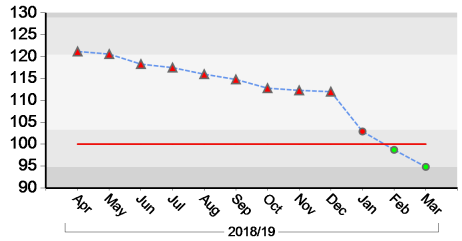
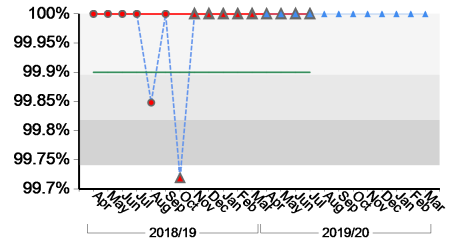
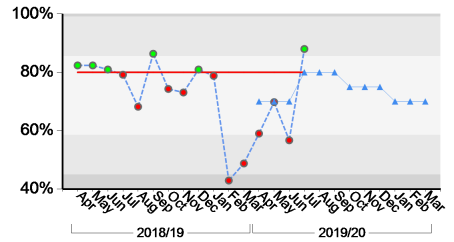
NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly (rolling 12 months) and is 6 months behind due to when Dr Foster publish the data.	Performance within tolerance - The SHMI release is quarterly Actions are as per 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. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data.	Performance is within accepted tolerance - The priority is to continue the ongoing work to identify and mitigate risks to patient safety, encourage learning and embedding of lessons learned into practice. The process of reviewing and improving pathways of care - both clinical and organisational - should continue as usual business.	
WHO Checklist	WHO Checklist.	Continued compliance of 100% was reported in July 2019 - Reports from the checklist audits will supplement this performance update in future reports to validate this	
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 in July improved significantly in month. The trust achieved above the 80% target at 88% - Stroke - 90% stay on ASU - Performance remains below both target and trajectory - The deterioration has been driven by:- 1. Increased number of Stroke admissions which has affected patient flow on ASU 2. The lack of protected Stroke Beds on ASU not being available due high occupancy on the Southport site Action taken (for July): The COO has reinforced and reinvigorated a focus at daily site meetings to ensure a stroke bed is available at all times with escalation in place	

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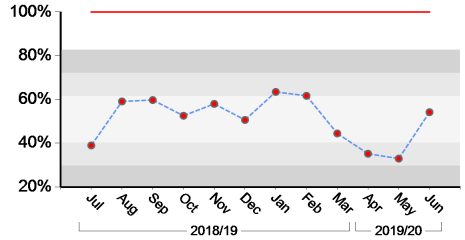
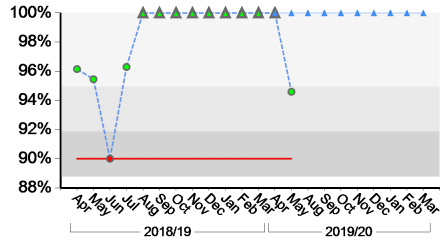
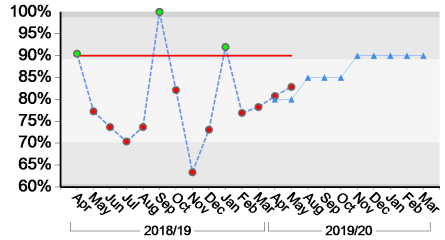
NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
Percentage of Deaths Screened	Percentage of Deaths Screened - DATIX	Return to baseline - Performance has returned to previous average. this is prior to the implementation of the iPAD system and the reminder posters. The impact of this will be evidenced in the July data.	
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.	Performance remains above target - 35 out of 37 patients had their NEWS score recorded within the timeframe in May 2019	
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.	Timely administration of antibiotics continues to improve in A&E for the fourth month in a row - This equates to 29 out of 35 patients	

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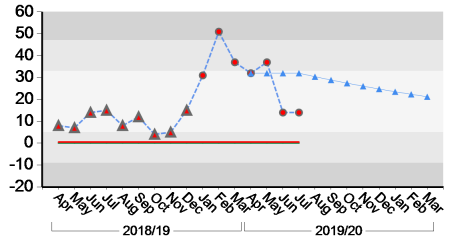
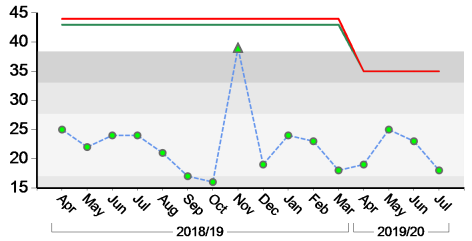
NHS Southport and Ormskirk Hospital NHS Trust

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.	Performance improved in June and was sustained in July - The majority of breaches are in HDU and Obs ward. All delays have a datix completed ; There is a review of all patients for stepdown from critical care at all bed meetings and the plan is dependent on the overall Trust position; The Critical Care Manager now attends the 13:30 bed meeting daily; obs ward to monitor mixed sex breaches	
Written Complaints	The total number of complaints received. A lower number is good.	There were 18 complaints in July which is a lower number than June (5) however this remains within normal range - The themes are as follows 1. staff attitude/behaviour 2. clinical treatment issues 3. lack of support after discharge 4. discharge issues – support after discharge/discharge destination. Also communication issues. The number of complaints received suggests that patients are aware of the complaints procedure. the complaints continue to be reported into the Quality and Safety reports for each Clinical Business Unit and in the integrated Governance Report presented at Q&S Committee for complaints analysis such as trends, themes and responsiveness.	

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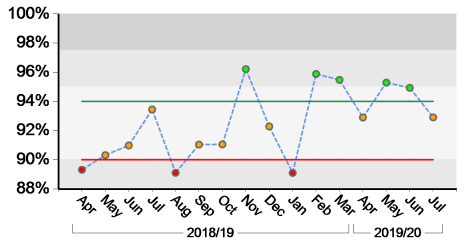
NHS Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
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 deteriorated compared to the previous months results at 92.91% but remains within tolerance. - Response rates although slightly increased, continue to be low. Trust Overall response rate- has increased from 7.04% to 7.42% Planned Overall response rate- has decreased to 16.28% from 17.34% Those that would recommend has decreased slightly to 97.95% from 98.17% Urgent Overall response rate- has increased to 6.21% from 5.62% Those that would recommend has decreased to 87.22% from 93.21% Maternity Overall response rate- has increased to 14.25% from 10.13% Those that would recommend has decreased to 96.72% from 97.62% Paediatrics Overall response rate- has decreased to 4.13% from 4.76% (Children's Ward 32.71% and A&E 1.39%) Those that would recommend has increased to 91.09% from 89.81% A&E Southport response rate has decreased to 1.57% from 2.62% The 'would recommend' has decreased to 86.67% from 97.18% A&E Ormskirk response rate has decreased to 1.39% from 3.58% The 'would recommend' has increased to 90.32% from 89.04% Themes taken from the FFT comments for July -19 of those unlikely to recommend: - Use of chest drain room on 14B as escalation area. - Experience of extreme heat on wards - particularly ward 9a (SSU) - Waiting times and location of the sexual health clinic St Hughs Bootle. These themes have been escalated to the senior nursing teams for these areas and will be monitored in future FFT responses/concerns and complaints. Funding has been secured for twelve months of digital enhancement of FFT in the Trust which will use a blended approach to increase response rates/comments to direct improvements in the right areas. A trial of I-PADS on the paediatric ward has demonstrated a 17.43% increase in response rates on the previous month. Response rates and % that would recommend continue to be monitored monthly.	

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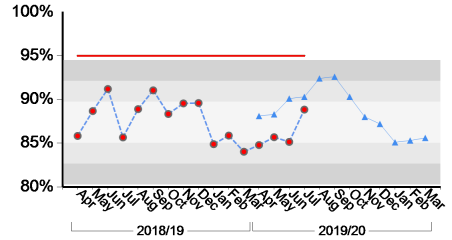
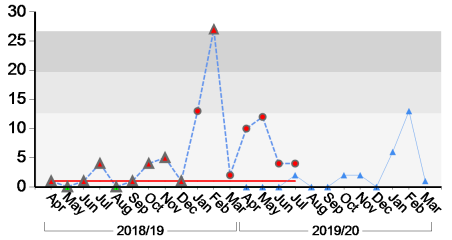
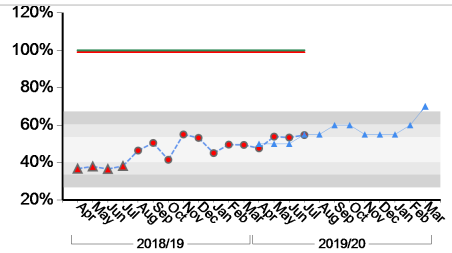
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	The Trust attained 88.6% against the 4 hour standard for patients attending AED - missing its performance trajectory (90.3%) by 1.7% in July and was 3.3% down on July last year. The Trust was ranked 47 of 123 Trusts (much improved national ranking position against previous month). The Trust ranked 21 best in region out of 44 acute Trusts. Issue: For the month of July 2019 ED attendances were up by 10% against July 2018. 9 of the 10 dates are in the 2019 with 4 dates in July 2019. Whilst the Trust conversion rate for an inpatient bed has stayed at around 20% the increased volume of patients presenting to Southport ED has meant more patients are requiring admission. Therefore we have a greater demand for beds due to increased demand. The focus remains on reducing LoS to help manage this increased demand and in testament to our system we perform better than the national median (which we didn't do 12 months ago) however this itself isn't enough at this stage. In addition the Trust has experienced a 30% increase (July 2019 against July 2018) in the number of Medically Optimised for Discharge (MOFD) patients occupying an inpatient bed that no longer need to be in hospital if the services were in place across the community and primary care tiers. Action: The Trust continues to focus on internal improvement opportunities and has an established Patient Flow Improvement Programme (PFIP) that oversee the improvement plan – however this alone will not drive 4 hour improvement and significant reduction in LoS / bed days. The Trust is engaging with the system on wider health and care economy actions and proposals given the increased demand and worsened position on MOFDs. The Venn work is coming to its end with final results being published at the end of August. The initial finding suggests capacity shortages in the intermediate care tier (both step up / down) across bedded and non-bedded services. All partners agreed from the outset the findings would be the priority of the system to support winter and this must be followed through to support continued improvement of the system UEC system.	
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.	Performance improved in June and was sustained in July at 4 patients - There were 4 reported 12 hour breaches across the month of July. Clinical timelines have been completed and shared with the CCG. All patients had input from the relevant clinical teams whilst in ED with management plans and diagnostic tests completed.	
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.	Performance has significantly improved compared to the previous year - 54.66% of ambulance handovers were completed within 15 minutes of arrival in July 2019 compared to 38.12% in July 2018 (In terms of patient numbers, 235 more patients were handed over within 15 minutes, demonstrating that the ED estates work continues to ensure that our NWAS colleagues can be released to attend patients waiting in the community. Overall 89% of handovers were completed within 30 minutes compared to 73.5% last July. Action:The Trust is working with NWAS to develop front door streaming in order that patients can bypass EDD and transfer directly to assessment units. This will support flow out of the department and support reduction in overall occupancy in the department to help maintain good patient flow.	

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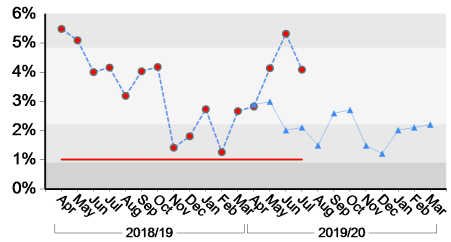
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower.	Diagnostic waits reduced to 4.09% in July - Breaches are as follows: Cardiology - Echo 2 patients 0.6% - due to limited capacity. Requesting extension of 2 locums for 3 months Colonoscopy 35 pts 18.5% 5 breaches are due to patients not attending within the 6 week period. 30 due to capacity with the decrease in WLI sessions Cystoscopy 15pts 12.4% 5 patient choice 5 lack of theatre capacity due to the increase in demand for Target/Urgent cases. 5 consultant capacity Gastroscopy 1pt 0.5% 1 - DNA Computed Tomography 4pts 1.1% Patient choice/cancellation/unable to contact patient Dexa Scan 8pts 4.2% Patient choice/unable to contact patients MRI 11pts 1.9% Patient cancellations/unable to contact patients Non Obs Ultrasound 63 pts 4.8% 31 next available musculoskeletal scan appointment. 5 patient choice, 7 difficulty in contacting the patient and 20 hospital cancellation Urodynamics (treatment centre) 2 pts 12.5% - DNAs. Both Urology nurses now back in post after sickness, Urology training nurse post commenced in June Urodynamics (Gyn) 6pts 16.2% Capacity Video Urodynamics (Urol) 2pts 20.0% Reduced consultant activity The two key service lines that are impacting upon performance for Diagnostics are: Radiology - Issue: National shortages within both the Radiologist and Radiographic workforce are having impacts on the delivery of diagnostics within the Trust. The Radiology team are currently at 40% vacancy (10 ET). Of the positions filled only 5 of the 6 are substantive with 1 locum. This has resulted in delays for decisions to treat and hence delayed discharge back into the community. A performance improvement plan is in place. Action: Recruitment is obviously high on the agenda with continuing sourcing of high cost locums to fill as many vacant sessions as possible. To support recover and maintain resilience the Trust has in place SLAs with another local provider and a private provider within the framework (PDS)to support outsourcing to support delivery of activity. Endoscopy - Issue: Due to recent national government briefings regarding Consultant contracts (tax rebate and pension allowances) the Trust has lost capacity within the service to manage demand (and further compounding this at a time when demand has increased). Action: The Trust has been undertaking significant work in improving endoscopy performance which includes organisational change to allow for increased availability of endoscopy sessions from a nursing workforce point of view. There Trust has commenced in-house training of nursing staff to be able to perform endoscopy. The Trust has also engaged with external providers to assist medical staffing of endoscopy sessions through insourcing. The Trust has significant workforce constraints within radiology and Endoscopy. the recent changes to the tax rebate has further impacted on the Trust - as it has up and down the country. The trust has improvement plans in place to address the issues however the fundamental issue is a necessary overreliance on temporary workforce solutions	

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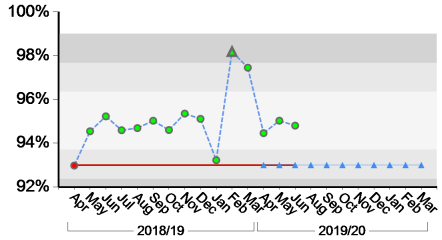
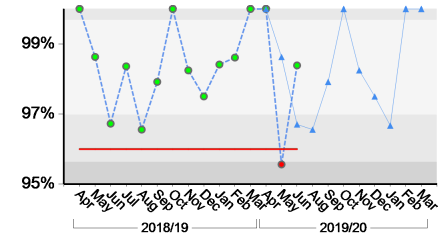
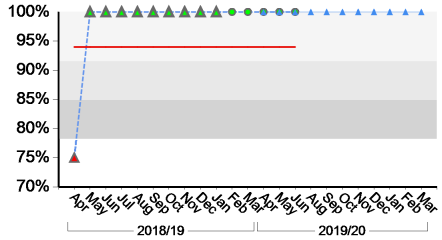
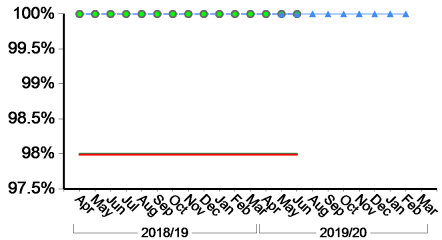
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher.	Slight improvement in compliance against target - Trust is aiming to move to 7 days for first appointment in order to reduce the overall wait for patients and to ensure first appointment cancellations are rebooked swiftly. SCR/Medway link is live but there are still teething issues that are being addressed by IT and Somerset. Most, but not all, patients are pulled through to be tracked from day one.	
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.	Trust back on track ad target met - There was only one patient over target this month. This was a colorectal patient, for whom there was not enough capacity.	
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').	Compliance against standard maintained. - The Trust continues to comfortably maintain standard.	
31 day treatment (Anti-cancer drugs)	Percentage of patients receiving first definitive anti-cancer drug treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Trust maintains compliance against target - 4 patients received drugs as a subsequent cancer treatment. All were within 31 days.	

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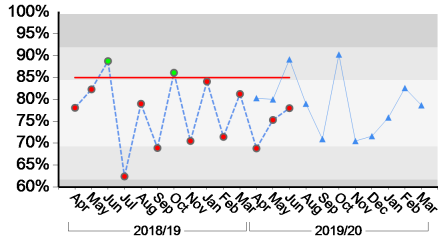
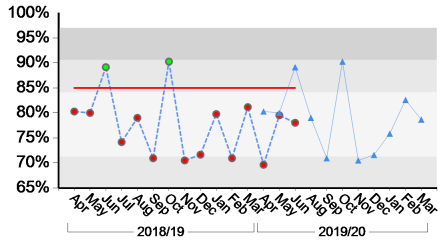
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Performance for June against 62 day standard closed at 78% - Trust closed at 78% for this target, a slight improvement from last month. The Trust treated 45.5 accountable patients, with 10 breaches; 37 of those patients were treated 'in house'	
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.	Performance remains similar to the previous month at 78.02% - Trajectory for the coming months and year ahead is difficult to accurately predict due to variable numbers of both potential cancer referrals and acute cancer diagnosis for several reasons: 1. Unpredictable number of referrals to S&O 2. An increase in number of referrals puts added pressures on already stretched diagnostics services 3. A decrease in number of referrals reduces the overall denominator which means we can carry fewer breaches 4. Multiple tertiary centre referrals often increases the pressure to have full diagnostics required prior to the tertiary transfer 5. New breach reallocation policy now means we are at danger of carrying the bigger proportion of breaches due to delayed tertiary transfers Progress to date: • Cancer Improvement plans with deliverable KPIs for each area that has a direct impact on the cancer patient's pathway have been completed. • RCAs on all 62 day National Cancer Waiting Times Standard breaches • Daily Priority Tracking List (PTL) meetings have been tested in some tumor sites and these are now substantiated in Lung, Gynaecology, Haematology and Head & Neck, allowing both operational teams and cancer navigators a robust process to escalate issues and unblock barriers at earliest opportunity. • The Cancer Improvement Group meets twice monthly with oversight of all the improvement to improve compliance against the Cancer Standard • A weekly highlight report sent to the senior operational team (SOLT) updates on directorate issues, action plans and blockages which affect patient specific pathways. The senior operational team pro-actively manages any blockages.	

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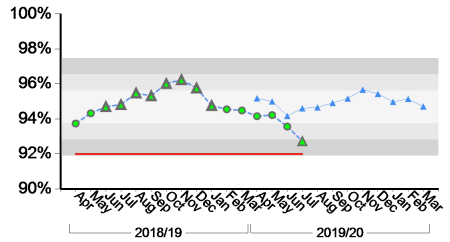
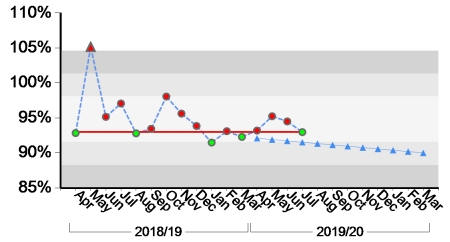
NHS Southport and Ormskirk Hospital NHS Trust

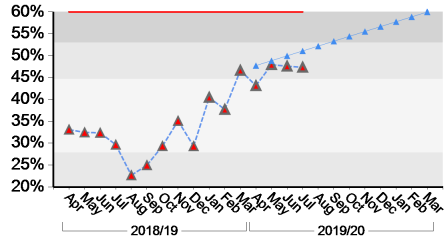
Responsive

Indicator Name	Description	Narrative	Month Trend
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher.	Whilts the trust continues to meet the 18 week standard, there is a contined deterioration in performance to 92.72% - The Trust currently has medical resource shortages in the majority of specialties. There are a few of particular note: Issue: Medical workforce shortages Anaesthetics – currently the Trust has an unprecedented shortage of anaesthetists with a vacancy rate in excess of 40%. This is due to a number of factors most notably difficulty to recruit to positions and a severe national shortage. This is having an obvious knock on effect on planned care due to the requirement to cancel surgical sessions due to a lack of anaesthetic medical cover. In recent months the Trust has cancelled 38 theatre sessions due to that lack of cover. It has only been through goodwill of our medical staff and obviously financial incentives such as WLIs that we have been able to keep cancellations to that level. The Trust are attempting to recruit but also going through the process to future proof the service with an approved business case to transform the workforce via demand and skill-mix recruitment initiatives. Community Pediatrics – the service sits outside of PBR and is for West Lancashire residents only. The service has been under funded historically and performance has seen gradual deterioration for the last 2 years as demand into the service has significantly increased. The CCG has recognised the funding gap and has approved the funding for an additional 0.6 WTE Pediatric Community Pediatrician. The Trust is underway in recruiting and in the interim continues to manage the service through its single handed Consultant. Action: Internally the Trust is undertaking numerous improvement programmes such as: • Patient Flow Improvement Board • Cancer Target Improvement Board • Outpatients Improvement Board • Theatre Improvement Board • Endoscopy Improvement Board. The Trust is also currently engaging with a number of external organisations and programmes such as: • NHSI/ GIRFT Theatre Efficiency Programme – designed to improve throughput of theatres. • Surgical Ambulatory Emergency Care Network – which is designed to improve performance of same day treatment and potentially discharge within the Trust.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	July saw a reduction in occupancy for Southport site - target level was achieved - Bed occupancy reduced by 2% in July. Daily bed occupancy is monitored through the escalation meetings and improvement work to reduce occupancy being undertaken and monitored via the Patient Flow Improvement Group	

Board Report - July 2019

NHS Southport and Ormskirk Hospital NHS Trust

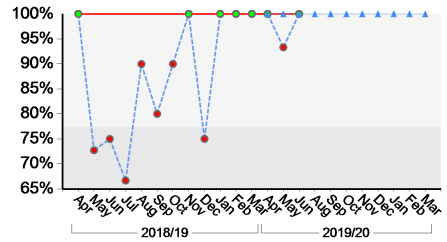
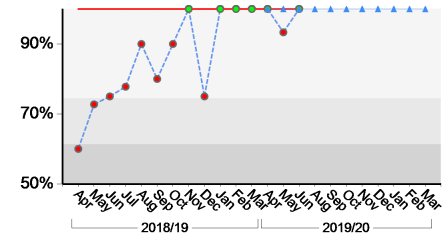
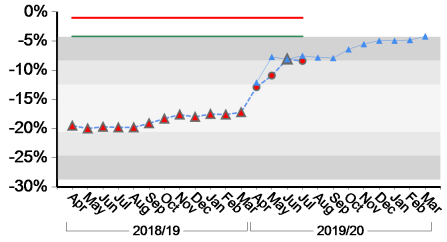
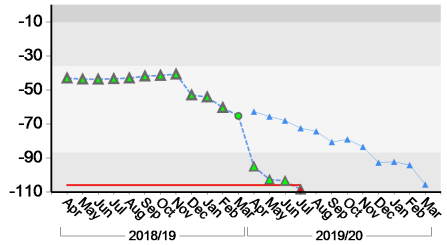
Responsive

Indicator Name	Description	Narrative	Month Trend
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site, based on open beds. A lower percentage is good. Threshold is 93%.	Occupancy remains stable at 47%. - Activity at ODGH continues to be impacted by the shortages of anaesthetists, with 22 theatre lists lost during July.	

Board Report - July 2019

NHS Southport and Ormskirk Hospital NHS Trust

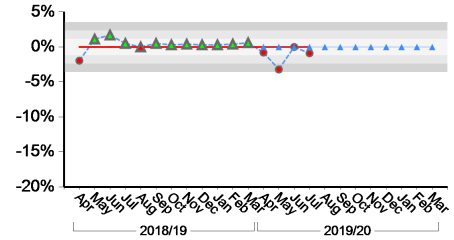
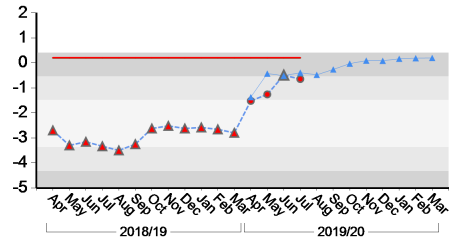
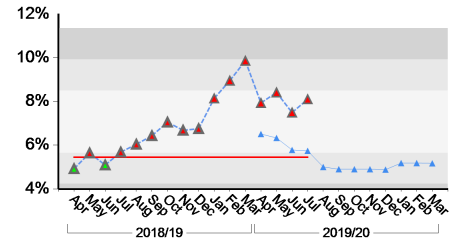
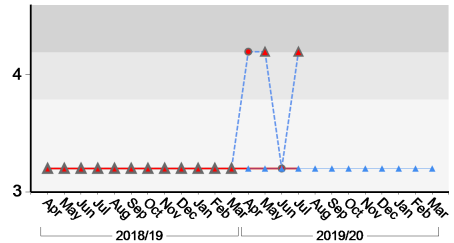
Well-Led

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 achieved compliance in June - This amounts to 7 patients	
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 achieved compliance in June - This amounts to 7 patients	
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Deterioration from last month - The target is an I&E margin of -7.5% and the Trust achieved -8.4%. The Trust needs to get a tight grip on expenditure to ensure that it gets back on track. If it doesn't then there is a risk that the Trust will fail this target in Quarter 2 (July to September) and therefore it will not receive non-recurrent Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) monies of £3.654 million. This in turn will mean a failure to achieve its control total.	
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.	

Board Report - July 2019

NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Control Total	Distance from Control Total.	Slight deterioration in performance from last month - The Trust is away from plan in July 2019. Expenditure levels incurred in the first four months of the year are consistent but rising steadily. In Quarter 1 these levels could be mitigated non recurrently. There are currently no further mitigations available and, therefore, the Trust will not deliver its 2019/20 control total if expenditure levels cannot be reduced.	
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.	Slight deterioration in performance from last month - Although there is a deterioration in month to this metric the table does show a step-change improvement from 18/19. This 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 from a use of resources rating perspective. Performance needs to be a positive 1.25 to achieve a use of resources score of 3 for this aspect. A plan is being developed to move the Trust into a surplus position	
% 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 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)	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Performance deterioratied in July - As the Trust is away from its July's financial target the I&E margin: distance from financial plan metric has deteriorated from a 1 to a 2. As all the other metrics are 4s - Capital service cover, Liquidity, I&E margin and agency rating this has had the consequence of making the overall use of resources score a 4 (last month 3).	

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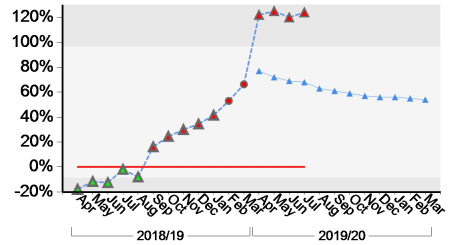
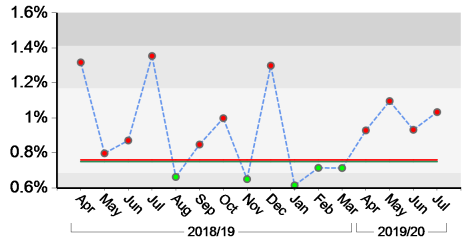
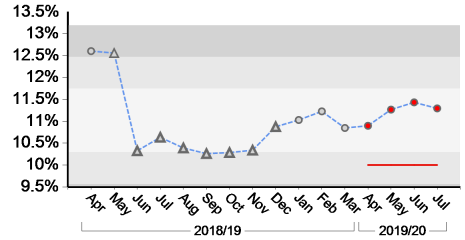
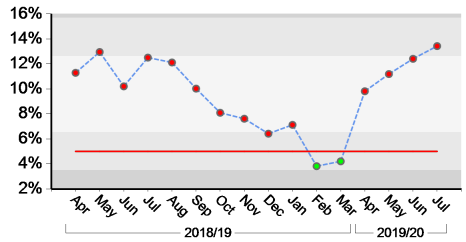
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Material overspend against the cap - Quarter 4 18/19 agency spend has continued into Quarter 1 19/20. Recruitment isn't keeping pace with the number of leavers, particularly in medical and nursing staff.	
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 remains relatively stable and only marginally higher than the monthly target at 1.03% - There was a slight increase in month with 31 in leavers in July compared to 28 in June this can be attributed to a number of medics that were employed to cover training gaps of the 18/19 Foundation rotation. 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 and recruitment plans and strategies.	
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.	The rolling staff turnover has decreased this month for 11.3% from 11.43% last month. - There was a slight increase in month with 31 in leavers in July compared to 28 in June this can be attributed to a number of medics that were employed to cover training gaps of the 18/19 Foundation rotation. 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 and recruitment plans and strategies.	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	Recruitment to hard to fill specialities remains challenging. - Medical vacancies are supported by the utilisation of medical locums. Whilst this causes financial challenges decisions are made taking in to account quality and patient safety. The Trust is actively recruiting to medical vacancies and has implemented a wider scope of advertising to attract candidates to our vacancies. The Trust is engaging with framework recruitment agencies to source candidates for long term and hard to fill vacancies.	

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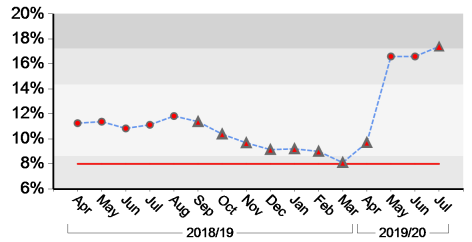
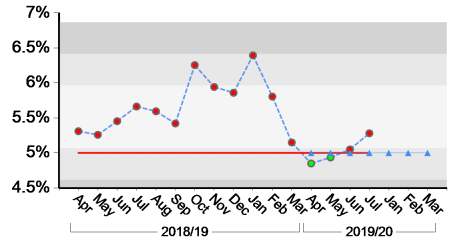
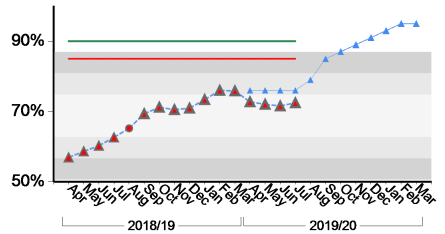
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Vacancy reporting is reflective of the trusts investment to nursing establishments approved in May 2019 - Nursing vacancy rate is reflective of the trusts investment to its nursing establishment from May 2019 with additional 52 RN posts and 57 HCA posts aligned to establishments. Recruitment events have commenced.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	July 2019's sickness absence rate has increased in month to 5.28% - This is the fourth increase in a row. the monthly increase can be attributed to a significant increase in the Corporate Services sickness absence rate to 6.61% the highest rate since October 2018. However the rolling year to date sickness absence rate highlights progress made to date and that there has been a month on month reduction of the Trust's sickness absence rate since December 2018: Dec-18 - 5.95% Jan-19 - 5.89% Feb-19 - 5.82% Mar-19 - 5.76 Apr-19 - 5.72% May-19 - 5.70% Jun-19 - 5.65% Jul-19 - 5.61% The Trust continues to monitor levels closely and continue the focused work around improving and support staff's attendance to work. There are a number of on-going 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. A 6 month review of the policy will take place in the coming months in partnership with staff side and key stakeholders within the Trust.	
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance increased slightly in month to 72.44%. - PDR compliance is now at 72.44% for July 2019 which is a slight increase from last month. All CBU's have revised their PDR improvement which will be presented to August's Performance Development Review. Additionally support is being provided from the PMO team and Information team in supporting a data cleanse and getting the message out as to how to record a PDR when it has been undertaken. Initial indications confirm that PDR's are taking place but that the dates are not being recorded on ESR.	

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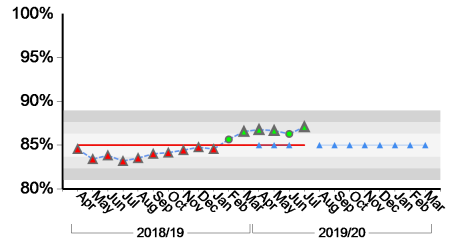
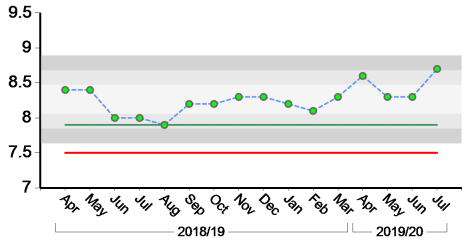
NHS Southport and Ormskirk Hospital NHS Trust

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 has remained above the Trust target of 85% since Feb 2019 and continues to improve - Concerted effort from managers & staff to deliver on a steady but sustained improvement in mandatory training compliance Approval for hand hygiene and local fire safety to form part of a role specific training report is being sought as these are local training requirements not national. This will support an increase in core mandatory training and allow clearer reporting of the role specific training.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Slight deterioration in reporting in month - Ongoing analysis of areas reporting into the trusts overall CHpPD reflective of outlier areas in specialists services and planned care. BI supporting trust analysis over the next month to further identify calculation behind trusts overall reportable figure and assurance against CHpPD criteria (acute inpatient settings).	

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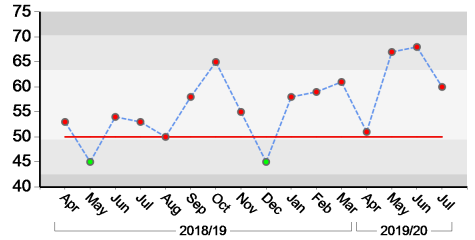
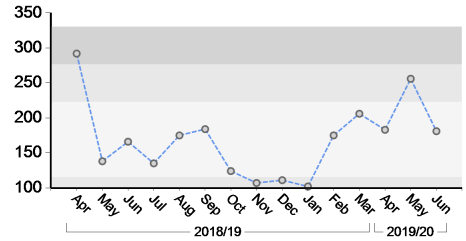
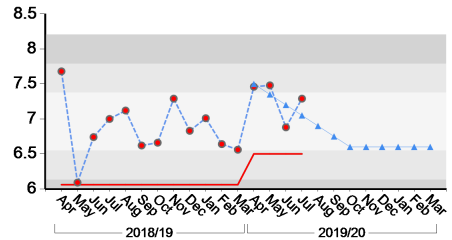
NHS Southport and Ormskirk Hospital NHS Trust

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.	July saw a downward trend - Downward trend for July. The Trust continues to cooperate with partners to deliver the safe and sustainable models required to improve performance. The Trust will play as an active partner in the required improvements however performance is reliant on community and CCG partners. The Trust has supported the system by submitting a daily delays report which highlights the services that have identified patient delays. In addition, the Trust hosts daily face to face huddles with partners to discuss individual patients to help accelerate and expedite decisions for discharge.	
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).	The number of beds lost in June was reduced (181) compared to May (256) - but remains within the normal range	
Length Of Stay	The average amount of time in days that patients spent as an inpatient from an emergency admission. Excludes ZERO Length of Stay.	Average Length of Stay was slightly increased in June to 7.29 days but remains within the normal range for the Trust - The COO has re-set the Patient Flow Improvement Programme (PFIP) and has established two work streams within that group. One work stream is focusing on AED and the triage process to ensure patients are streamed to the appropriate place and the second work stream is looking at reducing LoS by 0.5 days. Further to these work streams there have been QI projects running alongside these which will support in the delivery of the project. Actions taken • Fortnightly work stream meetings take place for the project groups with support from PMO • Away for SAFER engagement day and further ward visits planned to present always events in relation to discharge • Establishing ward level leadership for the management of patient discharges – to embrace and bring together the clinical leadership and full MDT. • “Right ward first time” – and an emphasis on reducing the number of patient outliers on wards that don’t necessary specialise in patient’s condition, through effective bed allocation that will be monitored through the bed meetings, thereby reducing LoS and additional bed days added to patients stay when on the wrong ward. • Plan for every ward to have at least two discharges per day, one before lunch, and to monitor through the bed management and manager of the day each wards progress against expectations – tracking and acknowledging successes and supporting wards that ae struggling within the day. • Publicising “What you need when you come into hospital” – too many patients don’t have the correct clothes to prevent PJ paralysis while on the wards or be ready to go to the discharge lounge in their own clothes, as these things often delay discharge.	

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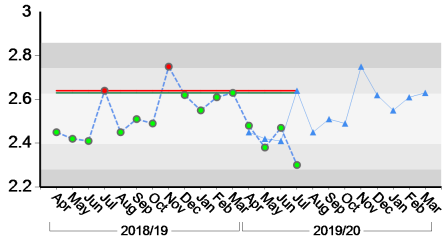
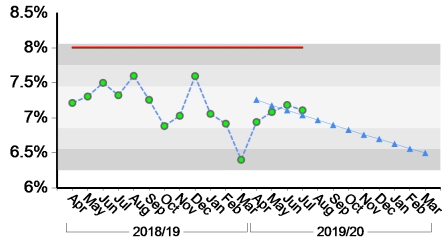
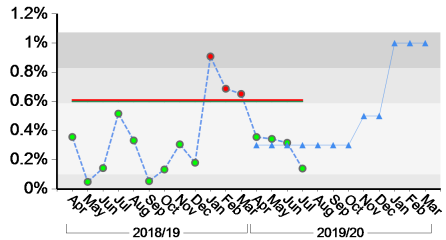
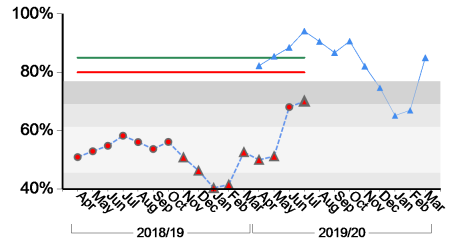
NHS Southport and Ormskirk Hospital NHS Trust

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.	The Trust continues to see month on month improvement -	
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.	A slight dip seen in month. - Whilst the trust continue to perform better than the national target, this remains a focus. - DNA rate performs better than the national median. The current performance on Model Hospital is Q4 which has the Trust at 6.84% against 7.7% for peers. The Trust has introduced and interactive SMS Reminder service and 48 hour pre-consultation phone calls. The Trust is currently introducing the concept of virtual clinics	
Cancelled Ops	Percentage of Operations Cancelled.	The trust remains compliant for the fourth month in a row - returning back to performance within the normal range for the trust at 0.14% - 3 operations out of 2148 were cancelled at short notice in July	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Continued improvement seen in utilisation. - Ophthalmology commenced on 5th August 2019. In July Orthopaedics improved from average of 44.93% starting on time or early to 50% of sessions. Across the board this has increased from 41.28% of sessions starting on time or early from Jan-Jun to 57.6% of sessions. Along with on time starts and decreased cancellations there has been a commensurate increase in utilisation. Rollout continues with other specialties - will be formal but happening just through knowledge and discussion of Golden Patient.	

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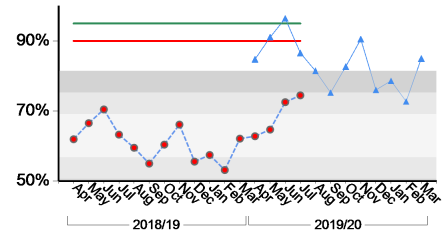
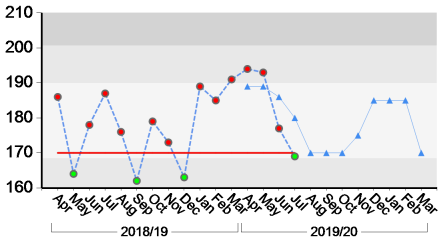
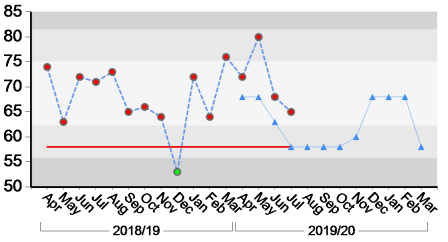
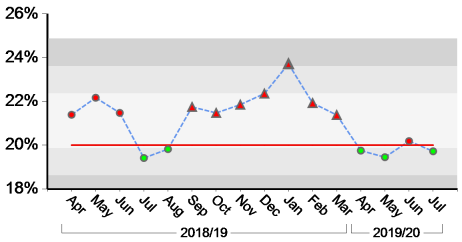
NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Theatre performance continues to improve - Ophthalmology commenced on 5th August 2019. In July Orthopaedics improved from average of 44.93% starting on time or early to 50% of sessions. Across the board this has increased from 41.28% of sessions starting on time or early from Jan-Jun to 57.6% of sessions. Along with on time starts and decreased cancellations there has been a commensurate increase in utilisation.	
Stranded Patients (>6 Days LOS)	Patients who spend 7 days or more as an inpatient.	July saw a reduction to 169 patients - Reporting is through the Patient Flow Improvement Programme Board to board level in relation to length of stay; The SAFER roll out has been reviewed and although red2green compliance has improved it is recognised that more work is required to support SAFER. Quality Improvement PDSA cycles are being done on 11b to support clinical engagement. 'Away for SAFER' delivered at an engagement event in July highlighting 'always events'; The roll out of 'away for SAFER' at ward level is throughout August; engagement events with CD and medical staff; red2green monitoring is improving and weekly audits identify areas for additional support. The next steps are to develop flow activity reports for wards	
Super Stranded Patients (>20 Days LOS)	Patients who spend 21 days or more as an inpatient.	There was a reduction in month for superstranded to 65 patients - There remains on-going work with #longstaytuesday with the community and LA at ward level and continued progress through the Patient Flow Improvement programme, including the review of current process at ward level for SAFER, engagement events with MDT and clinicians to promote SAFER, acute working to support complex discharges into community beds	
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 remains compliant at 19.7% - The Trust has worked hard to ensure conversion rate remains under 20% to ensure patients who do not require hospital admission can be offered safe alternatives. The delivery of this is through the development of "same day emergency care" models through the newly established CDU, SAU and ACU. The models are in line with best practice and have been designed in conjunction with ECIST (national in-house NHS expert consultancy for UEC). The development of the pathways and models have supported the recent improvement in conversion rate. The next step is ensuring the units can be accessed for extended period and most notably out of hours (in particular the evening and weekend periods). This is predicated on a successful recruitment campaign of approved business cases and advertisements are out to the market.	

NHS
Southport and Ormskirk Hospital
NHS Trust

Executive Assurance

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

Overview

Constitutional standards

- See IPR dashboard under Responsive for performance overview and in-month narrative.

Is assured

Theatre Utilization (efficiency)

The theatre efficiency group meets fortnightly and chaired by Steve Christian. The aim of the programme is to deliver 85% utilization by 31st March 2020, showing month on month improvement. The progress is positive and overall utilization has improved by 5.7% against baseline.

Three Main Focuses:

- The Golden Patient - starting on time or early for the first patient on the list.
- On The Day Cancellations – decreasing avoidable cancellations.
- Scheduling – adequate scheduling processes to maximise existing available theatre time.

DNA rate (efficiency)

Whilst the Trust continues to perform better than the national target, this remains a focus. - DNA rate performs better than the national median. The current performance on Model Hospital is Q4 which has the Trust at 6.84% against 7.7% for peers. The Trust has introduced and interactive SMS Reminder service and 48 hour pre-consultation phone calls. The Trust is currently introducing the concept of virtual clinics.

Ambulance handover

Performance has significantly improved compared to the previous year - 54.66% of ambulance handovers were completed within 15 minutes of arrival in July 2019 compared to 38.12% in July 2018 (in terms of patient numbers, 235 more patients were handed over within 15 minutes, demonstrating that the new ED processes continue to ensure that our NWAS colleagues can be released to attend patients waiting in the community. Overall 89% of handovers were completed within 30 minutes compared to 73.5% last July.

The Trust is working with NWAS to develop front door streaming in order that patients can bypass EDD and transfer directly to assessment units.
This will support flow out of the department and support reduction in overall occupancy in the department to help maintain good patient flow.

Not Assured/Most Deteriorated

18 week RTT (Responsive)

Whilst the trust continues to meet the 18 week standard, there is a continued deterioration in performance to 92.72% . In the first quarter alone there has been an increase in the PTL of 3.5% however long waiters are being managed with no risk to 52 week wait breaches. The Trust currently has medical resource shortages in the majority of specialties. There are a few of particular note:

- **Anaesthetics** – currently the Trust has an unprecedented shortage of anaesthetists with a vacancy rate in excess of 40%. This is due to a number of factors most notably difficulty to recruit to positions and a severe national shortage. This is having an obvious knock on effect on planned care due to the requirement to cancel surgical sessions due to a lack of anaesthetic medical cover. In recent months the Trust has cancelled 38 theatre sessions due to that lack of cover. It has only been through goodwill of our medical staff and obviously financial incentives such as WLIs that we have been able to keep cancellations to that level. The Trust are attempting to recruit but also going through the process to future proof the service with an approved business case to transform the workforce via demand and skill-mix recruitment initiatives.
- **Community Paediatrics** – the service sits outside of PBR and is for West Lancashire residents only. The service has been under funded historically and performance has seen gradual deterioration for the last 2 years as demand into the service has significantly increased. The CCG has recognised the funding gap and has approved the funding for an additional 0.6 WTE Community Paediatrician. The Trust is underway in recruiting and in the interim continues to manage the service through its single handed Consultant

4 hour standard (Responsive)

The Trust attained 88.6% against the 4 hour standard for patients attending AED - missing its performance trajectory (90.3%) by 1.7% in July and was 3.3% down on July last year. The Trust was ranked 47 of 123 Trusts (much improved national ranking position against previous month). The Trust ranked 21 best in the North region out of 44 acute Trusts.

Issue: For the month of July 2019 Southport ED attendances were up by 10% against July 2018. 9 of the 10 highest ever Southport ED attendance days dates are in the 2019 with 4 dates in July 2019. Whilst the Trust conversion rate for an inpatient bed (excluding assessment units) has stayed at around 20% the increased volume of patients presenting to Southport ED has meant more patients are requiring admission. Therefore we have a greater demand for beds due to increased demand. The focus remains on reducing LoS to help manage this increased demand and in testament to our system we perform better than the national median (which we didn't do 12 months ago) however this itself isn't enough at this stage. In addition the Trust has experienced a 30% increase (July 2019 against July 2018) in the number of Medically Optimised for Discharge (MOFD) patients occupying an inpatient bed that no longer need to be in hospital if the services were in place across the community and primary care tiers.

Action: The Trust continues to focus on internal improvement opportunities and has an established Patient Flow Improvement Programme (PFIP) that oversee the improvement plan – however this alone will not drive 4 hour improvement and significant reduction in LoS / bed days. The Trust is engaging with the system on wider health and care economy actions and proposals given the increased demand and worsened position on MOFDs. The Venn work is coming to its end with final results being published at the end of August. The initial finding suggests capacity shortages in the intermediate care tier (both step up / down) across bedded and non-bedded services. All partners agreed from the outset the findings would be the priority of the system to support winter and this must be followed through to support continued improvement of the system UEC system. The Chief Executive has requested the system wide winter plan from the CCG in the response to delivering the Venn recommendations.

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

Overview

Month 4

The Quarter 1 position after PSF and FRF was a deficit of £3.886 million against a plan of £3.914 million (£27,000 better than plan). This was only achieved after the assistance of non-recurrent income and expenditure (£1.3 million).

The month 4 YTD position after PSF and FRF is a deficit of £5.431 million against a plan of £4.889 million, £543,000 worse than plan.

Assured/Most Improved

Not Assured/Most Deteriorated

Liquidity

Downward trend continues as our 3 year revenue loans become due. These loans are been rolled over for 12 months and the debt is being reclassified as current

Condition of revenue loan is that the Trust retain cash balance of £1.0million; Rolling 13 week cash flow forecasts submitted to NHSE/I

Distance from Control Total

The Trust is away from plan in July 2019; Expenditure levels incurred in the first four months of the year are consistent but rising steadily. In Quarter 1, this had been mitigated non recurrently. There are currently no further mitigations available and, therefore, the Trust will not deliver its 2019/20 control total if expenditure levels cannot be reduced.

Capital Service Capacity

Slight deterioration in performance from last month; The step-change improvement from 2018/19 is because of the planned deficit for 2019/20 is supported by non-recurrent funding of £18.271m for PSF (Provider Sustainability Fund) and FRF (Financial Recovery Fund).

% Agency Staff (cost)

Agency spend in month was £966,000 (June £865,000), 8.1% of total pay bill. Model Hospital benchmark value is 5.5%
In month spend Medical £563,000, Nursing £303,000 and other £100,000.
The 2019/20 improvement programme focuses on the following priorities: Time to recruit; Agency costs (regional protocol).

Distance from Agency Spend Cap

The Trust agency cap for 2019/20 is £4.891 million which the Trust's Operational Plan highlighted could not be achieved is forecast to be breeched in month 6.
Material overspend against the cap - Quarter 4 2018/19 agency spend has continued into Quarter 1

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

Overview

Vision 2020

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

2a – Quality & Safety Plan
Infection Prevention – ongoing work and operational group continues to meet. Spinal center continues to be monitored and support gained from PHE to carry our peer review
Quality Improvement Delivery Group – weekly meetings set up to review progress against the Completing and embedding any outstanding CQC Must any Should do Actions ,addressing and closing down any Key Lines of Enquiry (KLOES) identified during the recent PIR, preparing for Use of Resources, CQC unannounced core services and Well Led Reviews
CQC Inspection process continued with the well led competed on 22nd August. Report expected in Autumn 2019.
Southport & Ormskirk Nursing Assessment & Accreditation System (SONAAS) – roll out started and feedback positive

Safeguarding –
MCA/DoLS – work continued to streamline the documentation and referral process to ensure that every referral is also sent to the safeguarding team, and this is linked to the CCG work around the quality of the reporting. MCA training programme also being reviewed by the team to review effectiveness and access

Older Persons Care – work stream continue to progress. Interviews for admiral nurse take place week commencing 27th August. Dementia strategy approved and launched this links education and practice as well as carer involvement. Discharge pathways continue to be reviewed in conjunction with CCG colleagues.

Continence group has been established

2b – QI Methodology
QI celebration events planned in September

2c – Safe Staffing
Trust vacancy rate for Registered Nurses has increased in month reflective of commencement to the establishment uplifts and natural attrition in month.

For the month of July 2019 the Trust reports safe staffing against the national average (90%) at 88.25%.
2d – Medical Workforce Engagement

Medical Engagement Survey improvement plan in development

Operational Overview:
Safe Staffing is compliant with national average and further improved slightly in April 2019 (94.5%).
Performance in Harm Free Care (Safety Thermometer) remains above target at 97.6%
VTE remains above target at 96.9%

Assured/Most Improved

Duty of Candour again reporting 100% in for documentation of the discussion and letter.
Written complaints have reduced to 18

Not Assured/Most Deteriorated

Three incidents were referred to StEIS in July 2019
Delivering single sex accommodation breached (14) remains due to waits for beds from critical care environments
There has been two C. Diff. infections reported against a trajectory of two per month.
Friends & Family Test (FFT) response rate continues to be low, however the likely to recommend in July 2019 was 92.9%
Continued expenditure in nurse Bank & Agency due to vacancies, sickness and additional capacity across the Trust. Vacancy rate within nursing has increased due to the addition of posts highlighted as part f the establishment review

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

Overview

Vision 2020

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

Meet or exceed the national standards for patient mortality.

SHMI & HSMR: Trust is actively working to reduce both HSMR and SHMI values to bring them within acceptable parameters by 2020.
The rolling HSMR shows a successive fall, down to 94.8 for March 2019.
The SHMI is down to 1.02 for March 2019.
Crude Hospital death rates since April 2018 remain below target.
Varies between 16 and 30.1 (January – June).
Acute Kidney Injury (AKI) pathway to improve quality of care has been rolled out.
Structured Judgement reviews methodology for Learning from deaths is now being used across CBUs.
Root cause analysis finished and shared with families and CCG.
Work streams under the Reducing Avoidable Mortality 2 project are being progressed.
Critical care outreach team started in April.
Screening rates improving.

Assured/Most Improved

High SHMI and HSMR remains a risk for the trust. Action plans are in place to improve care and reduce SHMI & HSMR . The actions are being monitored at the board level via the Quality Safety Committee and monthly Reducing Avoidable Mortality report to the board.
A full report on Mortality is presented to the board monthly by the Medical Director.

The reducing mortality action plan has been reviewed and organized across three principal domains for improvement over the coming year.
Mortality for respiratory diseases continues to improve.
In hospital deaths fell in June to 48, below the target of 77.
Fractured neck of femur performance remains variable, it is closely monitored by the Medical Director.

Not Assured/Most Deteriorated

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

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

Overview

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 in month has slightly increased in July to 5.283% although this is a deterioration compared to last month. Sickness absence YTD has consistently reduced since December 2018. The Trust rolled out a new Supporting Attendance Policy at the end of January 2019 and is in the process of reviewing this policy with staff side colleagues and key stakeholders within the Trust. A training programme has been continuously rolled out since the policy was implemented.

Core Mandatory Training

Mandatory training rates have consistently exceeded the Trust target of 85% since Feb 2019 – the Trust compliance is now 87.08% as at 31/07/2019. Work is ongoing to support managers to ensure rates are monitored and staff encouraged and given the opportunity to undertake mandatory training. The Training Department are undertaking a project to realise the benefits of the NW Streamlining Project by reducing repetition of mandatory training at Corporate Induction for transferring staff by Jan 2020.

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 on date has been a 71% drop in usage on 14A and a 24% drop in usage on 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 however this work has been impacted by the removal of project support funding and is therefore delayed in its delivery with medical agency delivery now expected in December 2019.

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

Recruitment Service

The recruitment service and time to hire has been identified as a priority project for the QI programme which commenced in June. The Recruitment team 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 per stage

- Time to shortlist 7.5 days average (July 19) delivering an improvement of 18.6 days (26.1 Q4 average)
- Time to check references 3 days average (July 19) delivering an improvement of 8.2 days compared to Q4.

The advert for 2x WTE Band 3 12 month contracts within the Recruitment Team went out on 22nd August 2019. The posts' will deal with the volume of recruitment along with the backlog of activity that transferred from St Helen's and Knowsley.

Occupational Health and Wellbeing

Sickness Absence

- Management referrals – key performance indicators 10 days (2 days for managers to receive the report) 100% compliance.
- Training and support being given to theatre staff re: improving quality of management referrals, understanding the OH report, understanding their role and responsibilities and why and how we complete return to work interviews. One session completed, three further sessions booked.
- Supporting the Equality and Diversity Lead in developing a 'disability passport'.
- Vocational counselling now being offered to staff, this provides up to nine months support for staff, this is a free service funded by the government and delivered by Remploy, the vocational counsellor attends every three weeks.

Pre-employment – reducing time to hire

Pre-employment – key performance indicators 2 days for paper screen and 5 days for appointment, 100% compliance. Any delays have been with the prospective candidate not being able to attend or rescheduling appointments. Current opening hours being reviewed to enable us to offer appointments before 08:30 and after 17:00, the aim being to establish if this has a positive impact on reducing the delays by the prospective candidate.

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

Health & Wellbeing (reducing sickness absence) NHSI project

Review and update of the action plan completed, three areas identified that would benefit from some targeted support based on high sickness rates and high agency spend. Meetings to be scheduled with managers in these areas.

Quality Improvement Project

QI project focussing on Ward 7a, aim of project to improve attendance and reduce agency spend. Project Lead, Head of HR supported by Assistant Director of Health and Wellbeing.

Health and Wellbeing Strategy

Review and development of strategy being undertaken to ensure that the strategy aligns with workforce and OD plans; and it wholly supports our aim of a culture of health and wellbeing. First draft sent for consultation to members of the Valuing Our People steering group. Final document to be submitted to the Workforce Committee in September.

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). Monthly reports are being developed to circulate to senior leaders & managers so that staff feedback is actioned at a local level. Longer term engagement activities will be actioned by the OD Team with regards to leadership & management development, coaching & mentoring, team development etc. 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 signed off by the board (July 2019). The engagement strategy has been shared with the organisation via Trust News and Facebook. References to the SO Proud conversations & staff engagement strategy will be linked so staff recognise that actions are being taken based on the themes of their feedback.

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

NHSi commenced a programme of QI training in June to over 45 project leads, team leaders and executive sponsors. There are 17 focussed projects which are being supported and coached by NHSi and the internal PMO team. A celebration event will be held in September.

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 at Workforce Committee in September 2019. This will be underpinned by an in-house coaching service and an online coaching resource accessible 24/7.

Leadership and Talent Management (TM)

The Shadow Board programme is rescheduled for September 2019, 10 delegates are confirmed to date. The programme will be delivered by the ILN Team and evaluated in conjunction with the NHS Leadership Academy.

The Trust is part of the early adopter group to test the new NHS Leadership Academy's Talent Management Online Self-Diagnostic Tool (Sept 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.

Four leadership programmes are in the scoping phase currently:

- Southport & Ormskirk Way Managers Programme – for new managers and existing managers who want to improve their skills
- L.E.A.P – Leaders Engaging in Action Programme – for leaders wanting to further develop their skills & deliver a service improvement project (in conjunction with an external provider)
- Triumvirate Development Programme – based on a team coaching approach (NHS Elect)
- New Consultant Programme – in conjunction with key medical staff and FMLM

Not Assured/Most Deteriorated

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

Personal Development Reviews

PDR compliance is now at 72.44% for July 2019 which is a slight increase from last month. All CBU's have revised their PDR improvement which will be presented to August's Performance Review meeting. Additionally support is being provided from the PMO team and Information team in supporting a data cleanse and getting the message out as to how to record a PDR when it has been undertaken. Initial indications confirm that PDR's are taking place but that the dates are not being recorded on ESR.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
4 September 2019

Agenda Item	TB 152/19	Report Title	Financial Position at Month 4
Executive Lead	Steve Shanahan Director of Finance		
Lead Officer	Kevin Walsh Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ☑ To Receive

Executive Summary

This report contains the month 4 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 which consists of Provider Sustainability Funding (PSF) of £3.464 million and Financial Recovery Fund (FRF) of £14.807 million.

The quarter 1 financial position was achieved after the assistance of non recurrent income and expenditure (£1.3 million).

The month 4 positon after PSF and FRF is a deficit of £1.543 million against a plan of £975,000 resulting in £569,000 worse than plan. The month 4 YTD position is a deficit of £5.431 million against a plan of £4.889 million resulting in £543,000 worse than plan.

All contracts have now been agreed following the arbitration decision in respect of the West Lancashire CCG contract. The income budget is currently being achieved but expenditure levels remain too high.

Expenditure levels incurred in the first four months of the year are consistent but rising and currently there are no further mitigations available and, therefore, the Trust will not deliver its 2019/20 control total if expenditure levels cannot be reduced.

The 2019/20 CIP programme is £257,000 behind plan at month 4, a significant improvement on the Quarter 1 positon; the forecast outturn is £5.057 million leaving an unidentified gap of £1.276 million.

The Use of Resources metric has worsened from a 3 to a 4 as the Trust financial performance is worse than plan.

The Board is asked to note the content of the report.

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

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

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

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

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

Director of Finance Report – Month 4 2019/20

1. Purpose

1.1. This report provides the Board Committee with the financial position for Month 4 - the financial period ending 31st July 2019, against the plan submitted to NHSI on 4 April 2019.

1.2. The report also includes an update on the 2019/20 contract arbitration decision with West Lancashire CCG.

2. Executive Summary

2.1. 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).

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. All contracts have now been agreed following the arbitration decision in respect of the West Lancashire CCG contract.

2.4. The quarter 1 financial position was achieved after the assistance of non recurrent income and expenditure (£1.3 million).

2.5. After PSF and FRF the month 4 positon is a deficit of £1.543 million against a plan of £975,000, £569,000 worse than plan and the YTD position is a deficit of £5.431 million against a plan of £4.889 million £543,000 worse than plan.

2.6. The income budget is currently being achieved but expenditure levels remain too high. The month 4 expenditure overspend could not be mitigated resulting in the adverse I&E position.

2.7. The 2019/20 CIP programme is £257,000 behind plan at month 4 which is a significant improvement on the Quarter 1 positon; the forecast outturn is £5.0 million leaving an unidentified gap of £1.3 million.

2.8. Expenditure levels incurred in the first four months of the year are consistent but rising steadily. In Quarter 1 these levels could be mitigated non recurrently. There are currently no further mitigations available and, therefore, the Trust will not deliver its 2019/20 control total if expenditure levels cannot be reduced.

2.9. There are a number of risks emerging, some of which have already been built into the month 4 position; CQUIN performance is assumed to be neutral in the YTD position but will have a clearer position in month 5; we are awaiting a formal response from CCG's regarding Quarter 1 performance.

2.10. As the Trust is now away from plan the Use of Resources metric has worsened from a 3 last month to a 4 in July. Last month all the metrics in the Use of Resources were a 4 except for the I&E margin: distance from plan which was a 1. This rounded to give the Trust a score of 3 last month, however, now the distance from plan has increased to a 2 this has the impact of rounding the overall Use of Resources score to a 4.

2.11. The table below is the I&E statement for July:

I&E (Including R&D)	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
INCOME							
Commissioning Income	165,216	55,917	55,739	(178)	13,681	13,643	(38)
PP, Overseas & RTA	1,090	363	270	(93)	91	72	(19)
Other Income	11,731	3,906	4,372	466	1,034	1,149	114
PSF & FRF	18,271	3,959	3,959	0	1,218	1,218	0
Total Operating Income	**196,307**	**64,146**	**64,340**	194	**16,024**	**16,082**	57
PAY	(139,762)	(47,195)	(47,546)	(351)	(11,594)	(11,924)	(330)
NON PAY	(52,726)	(17,768)	(18,153)	(385)	(4,404)	(4,678)	(274)
Total Operating Expenditure	**(192,488)**	**(64,964)**	**(65,699)**	**(736)**	**(15,998)**	**(16,602)**	**(604)**
EBITDA	**3,820**	**(818)**	**(1,359)**	**(542)**	**26**	**(520)**	**(547)**
Net Financing Costs	(12,149)	(4,083)	(4,081)	2	(1,003)	(1,002)	1
Retained Surplus/Deficit	**(8,329)**	**(4,900)**	**(5,440)**	**(540)**	**(976)**	**(1,522)**	**(546)**
Technical Adjustments	33	12	9	(3)	2	(21)	(23)
Break Even Surplus/(Deficit)	**(8,296)**	**(4,889)**	**(5,431)**	**(543)**	**(975)**	**(1,543)**	**(569)**
Less PSF/FRF Funding	(18,271)	(3,959)	(3,959)	0	(1,218)	(1,218)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(8,848)**	**(9,390)**	**(543)**	**(2,193)**	**(2,761)**	**(569)**

3. 2019/20 Contract Position

3.1. The only outstanding contract issue was the outcome of the arbitration process with West Lancashire CCG.

3.2. Arbitration has now been concluded and for 2019/20 gives the Trust a non recurrent income shortfall of £0.4 million; this needs to be confirmed with West Lancashire CCG.

3.3. The 2019/20 contract with West Lancashire CCG is a PbR contract with additional funding secured for "non PbR" services but not all of the arbitration issues are effective from 1 April 2019:

- Additional funding for some non PbR services will be payable from 1 April 2020.
- The PbR charge for CDU will only be payable from 1 October 2019.

3.4. In the table above the commissioning income annual budget for West Lancashire CCG is £51.0 million and has not been adjusted for the outcome of the arbitration.

4. Income

4.1. The Trust is currently underperforming against a number of areas which mainly fall within the "conditional income" section of the Southport & Formby CCG contract and these are:

- Elective performance; activity is 6% below plan year to date
- Best Practice Tariffs above 2018/19 levels
- Repatriation of elective work

- Business cases not implemented
- Contingency not incurred to date

4.2. The Trust's commissioning income in the month 4 YTD position assumes the following:

- Southport & Formby CCG will pay up to the month 4 value of the contract (full year £74.9 million).
- West Lancashire CCG will pay in accordance with the arbitration outcomes; this results in achievement of the West Lancashire CCG income budget at month 4 YTD.

4.3. Provision of £49,000 has been made in month 4 towards 2018/19 contract settlement issues (South Sefton CCG and NCA's); full year risk is £392,000.

4.4. Main issue for elective activity being 6% lower than plan is vacancies in Anaesthetics.

4.5. A&E attendances are 5% above plan year to date with non-elective income is significantly over performing against plan.

4.6. Income from Specialised Commissioning and NHSE is lower than plan due to chemotherapy and dental services activity, caused by vacancies in medical staff.

4.7. Other income is over performing due to funding received from NHSI in quality as well as non recurrent technical adjustments in month 3 (VAT recovery for salary sacrifice).

5. Expenditure

5.1. Expenditure levels in month 4 are consistent with previous months and continue at the high levels experienced in Quarter 4 of 2018/19 and with no further mitigations available it is too high to achieve the year end control total.

5.2. Monthly pay expenditure has continued at the levels experienced in Quarter 4 of 2018/19.

5.3. After removing non recurrent adjustments the expenditure run rate is rising steadily.

6. Bank/agency spend

6.1. Year to date Month 4 agency spend is £3.795 million; spend has increased in July; total spend in month was £966,000, 8.1% of total pay (Medical £563,000, Nursing £303,000 and other £100,000).

6.2. The Trust agency cap for 2019/20 is £4.891 million which the Trust's Operational Plan highlighted could not be achieved is forecast to be breeched in month 6.

6.3. Bank spend in month 4 is £942,000 (7.9% total pay), the same as June; Year to date spend is £3.698 million.

6.4. There is evidence that nurse agency (and total nurse expenditure) is reducing. Medical agency costs remain high. Bank and agency expenditure is key area of focus for the Trust to improve its financial position..

6.5. Bank and agency expenditure is key area of focus for the Trust to improve its financial position.

7. Cost Improvement Plan (CIP)

7.1. The Trust's plan assumes a £6.3 million CIP would be delivered from both increased income and reduced expenditure.

7.2. Following contract discussions the plan will now mainly be dependent on expenditure reduction.

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

	Annual Plan £000	Annual Budget £000	Month 4 Budget £000	Month 4 Actual £000	Month 4 Var £000	YTD Budget £000	YTD Actual £000	YTD Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	205	511	306	1,033	616	(417)	1,241	937
19/20 Plan - Expenditure (non pay)	1,724	1,724	123	308	185	437	511	74	1,133	969
19/20 Plan - Income (other op income)	325	325	3	165	162	9	175	166	272	8
19/20 Plan - Income (BPT)	1,800	300	173	0	(173)	80	0	(80)	0	0
19/20 Plan - Total	**6,314**	**6,314**	**504**	**984**	**480**	**1,559**	**1,302**	**(257)**	**2,646**	**1,914**

7.4. The forecast outturn finance risk adjusted CIP is £5.057 million leaving an unidentified gap of £1.276 million.

8. Risks

8.1. With West Lancashire CCG on a PbR contract there is a risk that the full 1.25% CQUIN will not be achieved/received.

8.2. There is no risk regarding the Southport & Formby element.

8.3. NHSE have confirmed achievement of Q1 targets. However, whilst the spinal unit remains closed to new referrals, due to the Klebsiella infection, Quarter 2 will not be achieved

9. Capital

9.1. Actual spend YTD is £737,000 (planned spend YTD £1.9 million) with a further £857,000 committed expenditure.

9.2. Comparing this against the annual plan, £5.103 million excluding donated and GE radiology assets, then the Trust has committed 31.2% of the plan at the end of July 2019.

9.3. The Southport ward upgrade project is due to start on 2nd September 2019 with a finish date for 6 of the wards before Christmas.

9.4. It is managed with a monthly Project Board together with a weekly technical and operational meeting involving all key members including the contractor. Wards 10a and 10b works are being deferred until April 2020 and will be built into the 2020/21 capital plan.

9.5. This is to manage the final costs of the scheme, £840,000 for 2019/20 and £150,000 in 2020/21.

9.6. The original scheme budget for the ward upgrades is £600,000 plus £100,000 for replacement of the nurse call system.

9.7. To bridge the gap the Trust will be using charity monies (£21,000), and deferring the spinal ramp and lifts (£85,000) and fire compartmentation (£100,000).

9.8. The emergency bathroom refurbishments in the Spinal Injury Unit to address the Klebsiella infection risk is being funded out of capital contingency.

9.9. IT has the highest level of commitments mostly connected with the Windows 10 rollout.

10. Cash

10.1. A cash flow is attached as an appendix, showing actual cash flows from April 2019 to July

2019 and forecast cash flows from August 2019 to March 2020.

10.2. The Trust continues to require loans from the Department of Health & Social Care (DHSC) as it is trading with a deficit each month.

10.3. The loans are interest-bearing repayable in full at the end of 3 years and the conditions include a minimum month-end cash balance of £1.0 million, and as the Trust has agreed its control total, interest is charged at a rate of 1.5%.

10.4. Rolling 13 week cash forecast is updated monthly and sent to NHS Improvement (NHSI), usually in the second working week of the month; this forms the basis of any cash draw downs in the following month.

10.5. July's cash flow was submitted to NHSI on 12th June 2019 and the loan request for July 2019 was £2.179 million.

10.6. Performance against the cash target in July was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	**1,000**	**1,100**	
Cash inflows	16,940	17,861	Additional monies received from West Lancs and Southport & Formby CCGs
Cash outflows	-16,940	-17,487	Non NHS payment runs £300k more than in the plan.
Closing balance	**1,000**	**1,474**	

10.7. The Trust is working with the main commissioners to try and settle debts on both sides and in July the receipts received from both West Lancashire CCG (£315,000 higher than the forecast contract payment) and Southport & Formby CCG (£162,000 higher) was more than planned.

10.8. Agreement has now been reached on the contract values for all the CCGs and cash support to reduce interest payments is being provided by Southport & Formby and South Sefton CCGs.

10.9. The cash support is an additional monthly contract payment in August 2019 and will start to be clawed back from October 2019 and will mean that no new DHSC loans will be required until November 2019.

10.10. The loan in November 2019 will include a £3.0 million working capital request to settle prior-year CCG invoices

10.11. The timing of this is likely to be flexible; it is possible this will be requested nearer to March 2020.

11. Recommendations

11.1. The Board is asked to note the content of the report.

List of Appendices

1. **Activity run rate by month**
2. **Statement of Comprehensive Income (Income & Expenditure Account)**
3. **Expenditure run rate by month**
4. **Statement of Financial Position (Balance Sheet)**
5. **Capital Expenditure**
6. **Cashflow Forecast**

1. Activity run rate by month

	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	Month 3	Month 4
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	7,446	7,162	7,602
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	1,706	1,605	1,808
Elective	199	227	194	178	221	179	212	189	138	180	175	179	144	187	183	177
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	2,505	2,343	2,670
Non Elective Non Emergency	211	226	237	255	261	273	239	233	285	241	254	262	75	78	167	206
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	15,615	14,366	16,629

2. Statement of Comprehensive Income (Income & Expenditure Account)

I&E (Including R&D)	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioning Income	165,216	55,917	55,739	(178)	13,681	13,643	(38)
PP, Overseas & RTA	1,090	363	270	(93)	91	72	(19)
Other Income	11,731	3,906	4,372	466	1,034	1,149	114
PSF & FRF	18,271	3,959	3,959	0	1,218	1,218	0
Total Operating Income	**196,307**	**64,146**	**64,340**	**194**	**16,024**	**16,082**	**57**
PAY	(139,762)	(47,195)	(47,546)	(351)	(11,594)	(11,924)	(330)
NON PAY	(52,726)	(17,768)	(18,153)	(385)	(4,404)	(4,678)	(274)
Total Operating Expenditure	**(192,488)**	**(64,964)**	**(65,699)**	**(736)**	**(15,998)**	**(16,602)**	**(604)**
EBITDA	**3,820**	**(818)**	**(1,359)**	**(542)**	**26**	**(520)**	**(547)**
Net Financing Costs	(12,149)	(4,083)	(4,081)	2	(1,003)	(1,002)	1
Retained Surplus/Deficit	**(8,329)**	**(4,900)**	**(5,440)**	**(540)**	**(976)**	**(1,522)**	**(546)**
Technical Adjustments	33	12	9	(3)	2	(21)	(23)
Break Even Surplus/(Deficit)	**(8,296)**	**(4,889)**	**(5,431)**	**(543)**	**(975)**	**(1,543)**	**(569)**
Less PSF/FRF Funding	(18,271)	(18,271)	(18,271)	0	(1,218)	(1,218)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(23,160)**	**(23,702)**	**(543)**	**(2,193)**	**(2,761)**	**(569)**

3. Expenditure run rate by month

Class	STAFF GROUP	STAFF TYPE	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
PAY	Consultants	Substantive	(1,346)	(1,258)	(1,346)	(1,319)	(1,299)	(1,319)	(1,395)	(1,324)	(1,118)	(1,238)	(1,239)	(1,234)	(1,321)
		Bank	(106)	(63)	(70)	(50)	(40)	(70)	(101)	(78)	(104)	(98)	(70)	(65)	(112)
		Agency	(69)	(96)	(109)	(110)	(154)	(187)	(179)	(206)	(272)	(279)	(279)	(201)	(275)
	Consultants Total		(1,521)	(1,417)	(1,525)	(1,479)	(1,494)	(1,577)	(1,675)	(1,608)	(1,494)	(1,615)	(1,587)	(1,500)	(1,708)
	Other Medical	Substantive	(1,114)	(1,220)	(1,165)	(1,243)	(1,202)	(1,263)	(1,319)	(1,307)	(1,256)	(1,337)	(1,305)	(1,327)	(1,297)
		Bank	(136)	(157)	(129)	(129)	(163)	(142)	(137)	(115)	(167)	(165)	(167)	(195)	(155)
		Agency	(318)	(279)	(240)	(226)	(217)	(208)	(244)	(273)	(316)	(256)	(257)	(277)	(288)
	Other Medical Total		(1,568)	(1,656)	(1,534)	(1,597)	(1,581)	(1,612)	(1,699)	(1,695)	(1,739)	(1,758)	(1,730)	(1,799)	(1,740)
	Nurses & Midwives	Substantive	(3,588)	(3,879)	(3,600)	(3,628)	(3,604)	(3,571)	(3,704)	(3,672)	(3,388)	(3,954)	(3,818)	(3,797)	(3,745)
		Bank	(494)	(660)	(544)	(529)	(565)	(543)	(595)	(588)	(684)	(609)	(637)	(645)	(632)
		Agency	(191)	(250)	(291)	(367)	(294)	(262)	(427)	(415)	(436)	(372)	(397)	(319)	(303)
	Nurses & Midwives Total		(4,273)	(4,789)	(4,435)	(4,524)	(4,463)	(4,375)	(4,726)	(4,675)	(4,508)	(4,935)	(4,852)	(4,761)	(4,680)
	Scientific, Technical &	Substantive	(1,272)	(1,375)	(1,320)	(1,331)	(1,330)	(1,307)	(1,320)	(1,319)	(1,260)	(1,437)	(1,349)	(1,329)	(1,323)
		Bank	(13)	(16)	(12)	(11)	(13)	(12)	(9)	(12)	(12)	(7)	(7)	(7)	(8)
		Agency	(22)	(17)	(17)	(16)	(20)	(15)	(12)	(8)	(14)	(4)	(8)	(20)	(35)
	Scientific, Technical & Theraputic Total		(1,307)	(1,408)	(1,349)	(1,358)	(1,363)	(1,334)	(1,341)	(1,339)	(1,286)	(1,448)	(1,364)	(1,355)	(1,366)
	Other Staff	Substantive	(1,962)	(2,183)	(1,989)	(2,010)	(2,040)	(1,981)	(1,965)	(2,008)	(1,731)	(2,284)	(2,156)	(2,147)	(2,090)
		Bank	(34)	(37)	(24)	(31)	(7)	(28)	(27)	(19)	(34)	(38)	(17)	(27)	(34)
		Agency	(16)	(46)	(48)	(63)	(51)	(58)	(59)	(50)	(54)	(59)	(54)	(48)	(64)
	Other Staff Total		(2,013)	(2,267)	(2,060)	(2,105)	(2,098)	(2,067)	(2,051)	(2,077)	(1,818)	(2,381)	(2,227)	(2,223)	(2,188)
	Pay Reserves	Substantive	(125)	199	0	0	35	184	232	798	(176)	(57)	(56)	149	(191)
	Pay Reserves Total		(125)	199	0	0	35	184	232	798	(176)	(57)	(56)	149	(191)
	Pay CIP	Substantive	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pay CIP Total		0	0	0	0	0	0	0	0	0	0	0	0	0
	Apprenticeship Levy	Substantive	(38)	(40)	(38)	(39)	(44)	(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)
	Apprenticeship Levy Total		(38)	(40)	(38)	(39)	(44)	(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)
PAY Total			(10,843)	(11,378)	(10,941)	(11,102)	(11,008)	(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)
NON-PAY	Supplies & Services Clinical		(2,140)	(2,290)	(2,260)	(2,317)	(2,290)	(2,228)	(2,249)	(2,227)	(2,413)	(2,263)	(2,325)	(2,259)	(2,420)
	Supplies & Services General		(183)	(182)	(222)	(204)	(214)	(200)	(203)	(199)	(212)	(186)	(172)	(173)	(164)
	Non-Executive Directors											(6)	(6)	(6)	(8)
	Establishment Expenses		(230)	(273)	(291)	(288)	(352)	(295)	(298)	(292)	(268)	(191)	(226)	(232)	(221)
	Premises & Fixed Plant		(1,002)	(830)	(936)	(990)	(943)	(993)	(953)	(917)	(775)	(1,018)	(1,035)	(991)	(985)
	Miscellaneous		(656)	(637)	(625)	(616)	(632)	(659)	(638)	(654)	(595)	(717)	(720)	(716)	(735)
	Services From Other NHS Bodies		(280)	(251)	(269)	(279)	(293)	(209)	(287)	(253)	(328)	(103)	(61)	(69)	(145)
	Non Pay Reserve		0	0	0	0	0	0	0	0	0	(7)	7	0	0
	Non Pay CIP		0	0	0	0	0	0	0	0	0	0	0	0	0
NON-PAY Total			(4,492)	(4,463)	(4,603)	(4,695)	(4,725)	(4,583)	(4,628)	(4,543)	(4,590)	(4,491)	(4,538)	(4,446)	(4,678)
NON-OPERATING EXPENDITURE			(938)	(934)	(959)	(920)	(939)	(942)	(939)	(940)	(479)	(1,031)	(1,023)	(1,037)	(1,006)
Grand Total			**(16,274)**	**(16,775)**	**(16,503)**	**(16,717)**	**(16,672)**	**(16,346)**	**(16,868)**	**(16,119)**	**(16,137)**	**(17,761)**	**(17,418)**	**(17,009)**	**(17,608)**

4. Statement of Financial Position (Balance Sheet)

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	31/07/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	121,443	(1,624)	(292)
Other assets	966	1,204	238	31
TOTAL NON CURRENT ASSETS	**124,033**	**122,647**	**(1,386)**	**(261)**
CURRENT ASSETS				
Inventories	2,382	2,352	(30)	143
Trade and other receivables	11,678	14,456	2,778	(1,175)
Cash and cash equivalents	1,042	1,474	432	374
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**18,282**	**3,180**	**(658)**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(22,696)	75	1,499
Provisions	(199)	(226)	(27)	(26)
PFI/Finance lease liabilities	(1,153)	(1,153)	0	0
DH revenue loans	(20,487)	(49,015)	(28,528)	(3,335)
DH Capital loan	(411)	(400)	11	0
Other liabilities	(1,025)	(899)	126	30
TOTAL CURRENT LIABILITIES	**(46,046)**	**(74,389)**	**(28,343)**	**(1,832)**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(56,107)	(25,163)	**(2,490)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**66,540**	**(26,549)**	**(2,751)**
NON CURRENT LIABILITIES				
Provisions	(207)	(180)	27	16
DH revenue loans	(82,953)	(62,299)	20,654	1,156
PFI/Finance lease liabilities	(13,831)	(13,601)	230	57
DH Capital loan	(1,000)	(800)	200	0
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(76,880)**	**21,111**	**1,229**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(10,340)**	**(5,438)**	**(1,522)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,214	0	0
Retained earnings	(112,432)	(117,870)	(5,438)	(1,522)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(10,340)**	**(5,438)**	**(1,522)**

5. Capital

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M4 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0090	1,000	50	170	(120)	14		1,000	184	816
	Pharmacy Robots	G0060									
	Sub total MEDICAL DEVICES		**1,000**	**50**	**170**	**(120)**	**14**		**1,000**	**184**	**816**
IM&T	Electronic Patient Record Bluespier	G0100	111	55		55			111		111
	Electronic Patient Record PDS	G0101	69	23		23			69		69
	Electronic Patient Record Careflow	G0102	149	38		38	277		149	277	(128)
	Vitalpac	G0007	10		17	(17)			10	17	(7)
	Patient Service Signposting	G0103	184	92	106	(14)			184	106	78
	eDMS Evolve	F6447	80	20	43	(23)			80	43	37
	Windows 10 Project	G0104	318		127	(127)	289		318	416	(98)
	Telephony System Replacement	G0059	50						50		50
	Baby Tagging	G0105	50						50		50
	Cyber Security	G0071	80	40	11	29	8		80	19	61
	Fixed Network Infrastructure	F6498	120	40		40			120		120
	PAS Replacement	F6409			6	(6)				6	(6)
	Data Storage Infrastructure	G0106	25						25		25
	Wireless Network Upgrade	G0073			2	(2)				2	(2)
	IM&T Contingency	G0107	450	115		115	38		450	38	412
	Sub total IM&T		**1,696**	**423**	**312**	**111**	**612**		**1,696**	**924**	**772**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	350						350		350
	6 Facet Survey	G0150	90	90		90			90		90
	Nurse Call System	G0151	100						100		100
	Upgrade Ventilation Plants	G0152	100						100		100
	Fire compartmentation	G0052	100						100		100
	Fire Precautions - Fire Doors	G0019	100						100		100
	Legionella Prevention	G0153	50						50		50
	Spinal Lift & Ramp	G0154	85						85		85
	Spinal isolation works	G0099	150	150	120	30	22	1	150	143	7
	SDGH Ward Upgrades	G0155	600	300		300	6		600	6	594
	Library Extension	G0156	145	145		145			145		145
	Capital Team	F6305	160	52	55	(3)			160	55	105
	CCTV	G0157	50	30		30			50		50

Capital ..

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M4 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
ESTATES	UPS Theatre	G0053			15	(15)				15	(15)
	Southport A&E	G0068			13	(13)				13	(13)
	Sexual Health Accomodation	G0079			(1)	1				(1)	1
	Car Parking Scheme										
	Waste Management	G0080									
	EBME Lift										
	Endoscopy both sites										
	Spinal Ward Bathrooms	G0158									
	HR Move - Further Alterations to LRC	F6301			(2)	2				(2)	2
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,080**	**767**	**200**	**567**	**28**	**1**	**2,080**	**229**	**1,851**
FACILITIES	Catering equipment	G0026	75	50	18	32			75	18	57
	Vehicle Replacement	G0145	50						50		50
	Sub total FACILITIES		**125**	**50**	**18**	**32**			**125**	**18**	**107**
	CONTINGENCY	**F6301**	**202**	**41**	**(4)**	**45**	**15**		**202**	**11**	**191**
	Capital plan excluding donations and IFRIC 12		**5,103**	**1,331**	**696**	**635**	**669**	**1**	**5,103**	**1,366**	**3,737**
OTHER	Donated assets	000000	100	25	41	(16)			100	41	59
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,214	544		544			1,214		1,214
	Sub total Donations and IFRIC 12		**1,314**	**569**	**41**	**528**			**1,314**	**41**	**1,273**
	TOTAL CAPITAL SPEND		**6,417**	**1,900**	**737**	**1,163**	**669**	**1**	**6,417**	**1,407**	**5,010**

	SUMMARY % SPEND (excl. donations and IFRIC 12)	%
	ACTUAL SPEND AGAINST YTD PLAN	52.3%
	SPEND AGAINST 19/20 PLAN	13.6%
	SPEND AGAINST REVISED 19/20 PLAN	13.6%
	SPEND AGAINST 19/20 PLAN INCL. COMMITMENTS	26.8%
	SPEND v. REVISED 19/20 PLAN INCL. COMMITMENTS	26.8%

6. Cashflow Forecast

	Actual Apr-19 £'000s	Actual May-19 £'000s	Actual Jun-19 £'000s	Actual Jul-19 £'000s	Plan Aug-19 £'000s	Plan Sep-19 £'000s	Plan Oct-19 £'000s	Plan Nov-19 £'000s	Plan Dec-19 £'000s	Plan Jan-20 £'000s	Plan Feb-20 £'000s	Plan Mar-20 £'000s	Total £'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(1,593)	(1,005)	(26)	(1,093)	(907)	(788)	827	386	(185)	516	(111)	814	(3,165)
Income recognised in respect of capital donations	(9)	1	0	(34)	0	(8)	0	0	(25)	0	0	(25)	(100)
Depreciation and Amortisation	594	593	601	571	573	573	580	581	580	595	596	596	7,033
Impairments and Reversals	0	0	0	0									0
(Increase) in Inventories	59	(86)	200	(143)									30
(Increase) in Trade and Other Receivables	(949)	(2,096)	(1,115)	1,143	5,143	1,384	(3,049)	(3,049)	605	(3,353)	(3,353)	2,294	(6,395)
Increase in Trade and Other Payables	3,517	(1,123)	(1,871)	(1,887)	1,307	1,891	(896)	(3,225)	938	(731)	129	(415)	(2,366)
Increase in Provisions	1	(8)	(3)	10									0
Net Cash Inflow/(Outflow) from Operating Activities	1,620	(3,724)	(2,214)	(1,433)	6,116	3,052	(2,538)	(5,307)	1,913	(2,973)	(2,739)	3,264	(4,963)
Cash Flows from Investing Activities													
Interest Received	3	4	5	5	4	4	4	4	4	4	4	3	48
(Payments) for Intangible Assets	(57)	0	(2)	(152)	(56)	(58)	(47)	(67)	(85)	(58)	(55)	(53)	(690)
(Payments) for PPE and investment property	(190)	(117)	(186)	40	(515)	(602)	(565)	(481)	(660)	(471)	(381)	(972)	(5,100)
Receipts from disposal of fixed assets	0	0	0	0									0
Receipt of cash donations to purchase capital assets	9	(1)	0	34		8			25			25	100
Net Cash Inflow/(Outflow) from Investing Activities	(235)	(114)	(183)	(73)	(567)	(648)	(608)	(544)	(716)	(525)	(432)	(997)	(5,642)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0									0
Public dividend capital repaid	0	0	0	0									0
Loans received from DH	2,456	1,458	2,386	2,179				6,186	3,042	3,800	3,900	4,160	29,567
Loans repaid to DH	(200)	0	0	0			(2,941)		(3,654)			(5,481)	(12,276)
Capital element of finance leases	(8)	(8)	(8)	(8)		(24)	(588)		(24)		(240)	(24)	(932)
Capital element of PFI, LIFT	(16)	(15)	(118)	(16)	(15)	(119)	(15)	(16)	(118)	(16)	(15)	(119)	(598)
Interest Paid	(190)	(234)	(225)	(195)	(228)	(546)	(195)	(238)	(234)	(205)	(236)	(551)	(3,277)
Interest element of finance lease	0	0	0	0		(240)					(158)		(398)
Interest element of PFI, LIFT	(80)	(81)	(209)	(80)	(80)	(210)	(80)	(81)	(209)	(81)	(80)	(210)	(1,481)
PDC dividend (paid)/refunded	0	0	0	0									0
Net Cash Inflow/(Outflow) from Financing Activities	1,962	1,120	1,826	1,880	(323)	(1,139)	(3,819)	5,851	(1,197)	3,498	3,171	(2,225)	10,605
NET INCREASE/(DECREASE) IN CASH	**3,347**	**(2,718)**	**(571)**	**374**	**5,226**	**1,265**	**(6,965)**	**0**	**0**	**0**	**0**	**42**	**0**
Cash - Beginning of the Period	1,042	4,389	1,671	1,100	1,474	6,700	7,965	1,000	1,000	1,000	1,000	1,000	1,042
Cash - End of the Period	**4,389**	**1,671**	**1,100**	**1,474**	**6,700**	**7,965**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,042**	**1,042**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB153/19**	**Report Title**	**Emergency Preparedness, Resilience and Response (EPRR Annual Report 1 April 2018 – 31 March 2019)**
Executive Lead	Steve Christian, Chief Operating Officer		
Lead Officer	Chris Pilkington, Emergency Preparedness Manager		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be brought before Trust Board to assure them that the organisation is meeting its obligations. This is the Annual Report for the year April 2018 to March 2019.

Recommendation

The Board is asked to formally **approve** the EPRR Annual Report 2018-19.

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

Southport, Formby and West Lancashire	*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

Southport and Ormskirk Hospital NHS Trust

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

ANNUAL REPORT 1 APRIL 2018 – 31 MARCH 2019

1 EXECUTIVE SUMMARY

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be brought before Trust Board to assure them that the organisation is meeting its obligations. This is the Annual Report for the year April 18 to March 19.

Responsibility for Resilience within the UK sits with the Civil Secretariat. Failure to meet the set out obligations can lead to prosecution via relevant government agency. NHS England oversees the arrangements within NHS England organisations and provides assurance to the Local Resilience Forum via the Local Health Resilience Partnership. This body of work is known as Emergency Preparedness, Resilience and Response (EPRR).

The Trust must be able to continue to deliver key services during times of disruption as part of the wider health economy. In doing so it must ensure patient and staff safety and take into account stakeholder considerations. This report is to update the Board on annual progress in this matter and sets out how the Trust meets its obligations. The Trust is required to have an up-to-date Major Incident Plan and Business Continuity Plan. These must be updated in the event of major incidents, exercises and/or other learning.

The responsibility for Emergency Preparedness, Resilience and Response sits within the portfolio of the Chief Operating Officer (COO). The work is managed on a daily basis by the Emergency Preparedness Manager and supported by an Associate Specialist from the Emergency Department. The work programme is managed through the Resilience Group, which the COO chairs. The Resilience Group meets monthly with representatives from across the organisation and reports directly via the AAA report into Quality and Safety Committee.

2 LEGAL OBLIGATIONS

As a Category 1 responder, the Trust has the following legal obligations:

a) Co-operation with other responders
b) Risk Assessment
c) Emergency Planning
d) Communicating with the public
e) Sharing information
f) Business Continuity Management

a) Co-operation with other responders

Throughout the year, the Trust has been represented at the Local Health Resilience Partnership (LHRP) Strategic and Practitioners meetings and relevant sub groups by Steven Christian and Chris Pilkington. The Trust participated with multi agency partners, including NHS England, provider Trusts, commissioners and other partners including the Police, Fire Service and NWAS in various exercises and workshops. Other areas of co-operation with partner agencies such as Sefton Council have included involvement in preparing for events held locally such as the Southport Air Show July 2018, Southport Flower Show August 2018, British Musical Firework Championship September 2018 and the Christmas Lights Switch On November 2018.

b) Risk Assessment

The Trust risk assessment has been completed in line with National and Community Risk Registers and is reflected in the Trust Major Incident Plan. It should be noted that Pandemic Influenza and Cyber Attacks remain the highest risks on the National Registers. Any items of concern or risk will be received at the Resilience Group (RG) meeting and added to the Trust Risk Register if required.

c) Emergency Planning

The Major Incident Plan and the Business Continuity Management Plan require Board approval and all other emergency plans are reviewed and approved at the Resilience Group. Emergency Plans are reviewed three yearly as a minimum, and shared with multi agency partners. Once developed, plans are exercised to ensure they are fit for purpose. The revision of the Major Incident Plan (V8) has been completed and updates have incorporated the relocation of the Major Incident Control Room at SDGH, Trust Executive changes, removal of Government Office North West, update of hospital maps etc. Our resilience has been further strengthened by the introduction of a monthly On-Call Forum which is designed for those members of staff who participate on the 1st and 2nd On-Call rota to share experiences and learning from their colleagues.

d) Communicating with the public

The Trust continues to explore ways of communicating with the public. Social media has great potential to help the NHS reach patients and service users who do not use traditional communications and engagement channels. During the year the Trust has used a range of methods to communicate with the public, including local radio, local TV, local press, Facebook, Twitter. The Trusts new website is now operational and the Resilience Group will support developing appropriate EPRR tools and communications within this.

e) Sharing information

Under CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of cooperation. The Trust receive alerts from an online private network called Resilience Direct, which is run by the Cabinet Office and enables civil protection practitioners to work together, across geographical and organisational boundaries, during the preparation, response and recovery phases of an event or emergency. The network helps organisations fulfil their obligations under the Civil Contingencies Act to co-operate and share information to ensure that action is coordinated.

f) Business Continuity Management

The Trust Business Continuity Management Plan is updated as a minimum every three years. The Plan sets out the framework that the Trust should follow when responding to disruption in line with legal obligations and EPRR guidance. Wards and departments are responsible for developing their own plans and updating them as a minimum every two years or sooner in the event of an incident or change of service.

The Trust experiences disruption to its Business Continuity through various incidents such as power outages, imaging equipment failures, IT downtime and is continually looking at ways to minimize the impact these incidents have. These incidents provide ways to learn from what has happened and we hold debriefs to enable action plans to be drawn up to address the issues raised. Incidents are discussed at the Resilience Group meetings and actions taken as appropriate.

The Trust implemented its Business Continuity Plans (BCPs) on a number of occasions when planned downtimes were requested and agreed via the Resilience Group. These outages affected a number of areas and on occasions were affecting both Southport and Ormskirk hospital sites. E.g. IT Core Switch Upgrade; Telephony Upgrade; Medway Upgrade; Evolve Upgrade; VitalPac Upgrade; Wi-Fi Upgrade.

3 TRUST OPEN DAY SEPTEMBER 2018 AT SOUTHPORT HOSPITAL

As part of the Trust Open Day in September 2018, the decontamination tent was erected in the Spinal Gym and appropriate members of staff were on hand to discuss with the public, the role the Trust would play in the event of chemical related incident in the area. There was also a Powered Respirator Protective Suit (PRPS) on display for people to examine.

4 BREXIT PREPARATIONS TO LEAVE THE EU ON 31 MARCH 2019

The Trust appointed the Deputy Director of Nursing to lead on the preparations for a no deal exit from the EU. The Trust sent a member of staff to represent the organisation at one of the regional EU Exit events where the 9 main work streams for organisations to focus on were highlighted. These were, Supply of Medicines; Clinical Trials; Supply of Medical Devices and Consumables; Supply of Non-Clinical Consumables; Blood and Transplant; Workforce; Reciprocal Healthcare; Data Sharing; Processing and Access. Weekly EU Exit meetings were set up with representation across all CBU's and the outcome from each meeting, in the form of an action plan was fed into the Executive meetings and Trust Board, to provide assurance the Trust was EU Exit ready in the event of a 'no deal'.

5 TRAINING

Training and awareness sessions have been held with various groups across the Trust including staff who cover on-call at Tactical and Operational levels. Awareness sessions and training has been provided through the monthly On-Call Forum meetings.

To check Chemical, Biological, Radiological, Nuclear and explosive (CBRNe) Preparedness, awareness sessions were held in July 2018 with appropriate members of staff to check their level of knowledge and the reliability of the decontamination equipment. A Preventative Programme of Maintenance (PPM) is in place to highlight any equipment which requires replacing/repairing. The PPM was completed at ODGH in July 2018 and at SDGH in September 2018.

Action Counters Terrorism (ACT) Training is an initiative led by Merseyside Police Counter Terrorism Support Agency (CTSA). A training session was delivered to Trust staff in November

2018 by the CTSA.

6 EXERCISES

NHS England EPRR guidance sets out the following requirements for training:

- Internal Communications Exercise: Minimum frequency – every six months
- Table Top Exercise: Minimum frequency – every twelve months
- Live Exercise: Minimum frequency – every three years

A requirement of the NHS England Emergency Preparedness, Resilience and Response Core Standards requires Acute Trusts to participate in planned exercises with external partner organisations. The Trust participated in the following exercises this financial year:

- June 2018 Exercise Golden Eagle - which was a mass casualties exercise in real time with simulated casualties
- November 2018 Hospital Fire Evacuation Workshop - which was jointly delivered by NHS England and Merseyside Fire and Rescue Service (MFRS)
- December 2018 Exercise Ferranti - which was an opportunity to identify and discuss sector interdependencies to develop a greater understanding of the impacts and local response required to improve resilience during a long-term power outage

Our internal Major Incident communications cascade was tested in June 2018 as part of the Golden Eagle Exercise and in November 2018 an out of hours communication cascade took place as an additional check to test the resilience of our plans and processes out of hours.

A Table Top Exercise was held in December 2018 and was designed to test the Escalation Policy. The learning from the Table Top enabled the policy to be reviewed and updated. Following consultation, the Patient Flow and Escalation Policy was uploaded onto the Trust Intranet.

7 GOVERNANCE AND OVERSIGHT

The workplan for EPRR is managed through the Resilience Group which reports progress, through the AAA reporting system to the Quality and Safety Committee. The workplan and actions are managed on a monthly basis.

As a Category 1 responder the Trust must report progress and assurance for emergency planning to Trust Board.

8 COMPLIANCE WITH STATUTORY AND NON-STATUTORY REGULATION

The Trust is required to complete an annual EPRR Core Standards self-assessment for NHS England and submit a statement of compliance to the Trust Board. Compliance levels are *Full, Substantial, Partial* and *Non-compliant*. In the submission for 2018/19 the Trust was rated Substantial. In comparison with other Trusts in Merseyside, there were 14 Trusts rated Substantial, 4 rated Full, 1 rated Partial. An Improvement Plan was developed and agreed with the Accountable Emergency Officer and presented to the Trust Board.

9 RECOMMENDATION

In line with the legal obligations as a Category 1 responder to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place, Trust Board is asked to approve this Annual Report on Emergency Preparedness, Resilience and Response (EPRR). The arrangements the Trust has in place as outline in this Annual Report are in line with

our legal obligations as set out in Civil Contingencies Act 2004 and NHS England EPRR guidance.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**PB154/19**	**Report Title**	**Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Interim Head of Risk 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, three new risks have been added onto the risk register.

- **1977** – Paediatric Dietetics. Risk escalated due to the insufficient clinic capacity impacting the ability to see patients in a timely manner.
- **2021** – In Hospital Mortality. This risk has been escalated onto this risk register due to the risk of increased in hospital mortality due to potential inadequate escalation and senior review.
- **2056** – Missing Patient appointments/admissions. Risk added following the identification of issues with the process for Outpatient clinic and ward outcomes which has resulted in patient harm.

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

There are currently 9 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
- **2056** - Missing Patient appointments/admissions
- **2021** - In Hospital Mortality
- **1977** - Paediatric Dietetics Band 6

Before the next meeting, a new risk will be added relating to 'Fragile Services' within the Trust. This will amalgamate all relevant specialities and will lead to the closure of risks 1688, 1987 and 1977.
There is also a planned review of risk 1862 to look at the current vacancy levels against the

Nurse Establishment Review with a view to potentially downgrading the risk.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

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

AUGUST 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 22/08/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
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	20↑	=20
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↘	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	12↓	=12	=12	=12	9↓
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	=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	=16	=16
2056	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards	Missing Patient appointments/admissions	Chief Operating Officer						!16
2021	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 SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	In Hospital Mortality	Executive Medical Director					!15	=15
1977	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	Peadiatric Dietetics Band 6	Director of Nursing & Quality					!15	=15

TRUST RISK PROFILE AS AT 22/08/2019

	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** **1977 – Paediatric Dietetics Band 6**	**1688 - Inadequate Staffing Levels in Anaesthetic Department** **2056 – Missing Patient appointments/admissions**
Possible (3)					**2021 – In Hospital Mortality**
Unlikely (2)					
Rare (1)					

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards			Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**		
27/06/2019	2056	Chief Operating Officer	Helen Baythorpe	Missing Patient appointments/admissions		
Description	If we fail to have a robust process in place to manage Outpatient Clinic and Ward outcomes then there is a risk we will cause harm to patients due to not providing appropriate treatment in a timely manner.					
Controls	SOP's in place for management of clinic outcomes Patient's given advice and contact number to call if not heard within a certain period within Urology GP letters alerting to loss to follow up				**Gaps in Controls**	No audit of process in place for booking appointments and listing patients for procedures Paper based process which is fragmented Lack of electronic system Logistical issues of clinics being held across sites causing issues transferring paper forms in various modes RTT Validator in place for 18 week target and Cancer pathway only, not patients on a non-active RTT pathway Clinic outcome sheets not retained The process puts the onus on the patient GP's may not alert the loss to follow up in all cases.

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	13/08/2019	10/09/2019

Assurance	Highlighted to the Board. Patients lost to follow-up reported when identified via Datix	**Gaps in Assurance**	Likely to have a significant delay prior to gaining the right solution As at 11/07/19 - 12 SI's reported relating to Urology and Ophthalmology
Action Plan	To review the current process for the management of outpatient clinic outcomes, booking appointments and listing patients for procedures to identify failings and solutions. To review the management structure and role of the RTT team to enable the ability to track and monitor both RTT and non-RTT patients. The processes identified from review will require staff training, implementation and audit Review the process for retaining clinical outcome sheets To validate non RTT pathways to identify potential patients that have been lost to follow up. To identify the numbers and specialties where patients could have been lost to follow-up. Board to clarify Risk appetite	**Action Plan Due Date**	30/09/2019 10/12/2019 30/09/2019 30/09/2019 31/12/2019 31/08/2019 26/07/2019
		Action Plan Rating	Moderate Progress Made Moderate Progress Made Little or No Progress Made Moderate Progress Made Little or No Progress Made Moderate

					Progress Made Completed
Latest Month Progress	The COO has commissioned a weekly Outpatient Risk Meeting chaired by the ADO Planned Care. This is attended by the COO or other Exec member on a fortnightly basis and reports into SOLT. The CCG have also been invited to attend. An overarching action plan has been collated from existing StEIS incidents relating to lost to follow-ups and failure to track non-RTT pathways. This action plan has been discussed with the CCG. A 3 month solution has been approved to recruit trackers to review Ophthalmology and Urology open referrals in the first instance. The CBU's have requested to review with Clinical Directors and prioritise those patient cohorts at greater risk of harm if lost to follow-up.				

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	Carol Fowler	Maintaining safe quality nursing care with current level of nursing & HCA vacancies				
Description	If levels of Nurse & HCA staffing remains below funded establishment due to vacancies then patients may experience poor quality of care (safety & patient experience).							
Controls	Safe Care monitored daily M-Fri Daily staffing huddles with Matrons & Senior nurse Review Health roster Policy & compliance ratified July 2019 NHSP contract Nursing establishments ratified 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 Retention group with a focus on Recruitment, supported by NHSI						**Gaps in Controls**	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 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	15/08/2019	15/09/2019

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 E-Roster policy CQC inspection Monthly staffing report mandatory training Complaints Incident reporting Quality and safety reports Bi annual staffing reports	**Gaps in Assurance**	Workforce Plan (including Retention & Recruitment) Updated E roster policy Matrons dashboard/Clinical metrics needs to be developed further Mandatory training not being at Trust required standard Managing Performance Framework process

Action Plan	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 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	**Action Plan Due Date**	27/12/2019 27/12/2019 31/12/2020 31/12/2020 31/12/2020 29/06/2018 31/01/2019 29/03/2019 31/05/2019	**Action Plan Rating**	Completed Moderate Progress Made Completed Moderate Progress Made Moderate Progress Made Completed Completed Completed Completed

	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				
Latest Month Progress	Currently only 2 HealthRoster templates require alignment with the Nurse Establishment Review (NER), this will be completed by the end of August. PAG agreement to extend temporary fixed term post until Nov 2019 against the Identified HR support to enable proactive recruitment of the vacancies within the NER. Recruitment Events planned across the year to support delivery against the NER. The e-roster policy has been ratified and a QI Programme for e-roster delivery has commenced.				

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	15/08/2019	15/09/2019

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 First unannounced inspection w/c 08.07.19 Second unannounced inspection w/c 30.07.19 Well led preparation is underway Medicines management improvement plan developed & agreed with NHS E & I & shared with CQC	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. CQC Inspection July identified issues with Medicines Management, MCA / DoLs and other areas for further improvement

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	17/07/2019 30/09/2019 28/06/2019 22/09/2019	Completed Moderate Progress Made Completed

	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.		29/11/2019		Actions Almost Completed Moderate Progress Made
Latest Month Progress	The Well-Led review has been completed, this brings to an end of the formal CQC inspection. Follow-up work includes ensuring all information requests are sent in a timely manner and it has been agreed that the Trust will send a follow-up letter providing more information on identified KLOE's in anticipation of the reports being formalized by the CQC in October. Following receipt of this report, a revised risk will be recorded on the risk register.				

Strategic Objective	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Link to BAF	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
06/03/2019	1987	Executive Medical Director	Dr David Snow	Haem / Oncology, reduction in medical capacity following resignation of consultant

Description	If a replacement Consultant haematologist cannot be found then the current haematology service cannot be maintained. This will result in loss of income and significant impact on patient experience.

Controls	- Service will begin an risk assessment in terms of the impact of the resignation on the service continuity and organisational reputation of any loss of local provision. Consideration of Southport to attempt to recruit locum consultant Consideration of Aintree to recruit a locum on behalf of Southport Or - collaboration including Clatterbridge to bring forward the longer term plans for haematology - oncology for the region.	Gaps in Controls	- There is no written / formal SLA between the respective organisations, other than then remuneration of the cost of the clinicians. - Aintree are currently carrying 2wte vacancies for haematologists for the past 18 months and consequently are unable to support the historical arrangements to provide alternative at the end of the Consultants contact (in 6 weeks' time) tertiary caseload of patients from Preston area as there is a limited provision within the present area

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	20	16	Extreme risk	4	Moderate risk	15/08/2019	10/09/2019

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	14/10/2019 16/09/2019 27/03/2019	Action Plan Rating	Moderate Progress Made Moderate Progress Made Completed

Latest Month Progress	Recruitment to the vacant consultant post for a 12 month fixed term post had no applicants. The Directorate Manager has spoken with assistant Clinical Business Manager from Aintree who has advised that post will now go out to permanent post in the hopes of attracting a suitable applicant. Aintree continue to source a locum consultant, there is a provisional plan in place for 2 consultants to work split site with SOHT with a provisional start date of 2nd September (will be 2 locums who will split the role to provide 5 day cover). Awaiting confirmation from UHA regarding clinic templates and then will set up clinics from September for 6 months. Discussions at CEO level involving S&O, Aintree, Clatterbridge and the CCGs are ongoing to produce a long term plan.

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	Red2Green rolled out - Therapy developing a competency and training for staff to be equipped to chair and challenge in a consistent way sustaining te 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 in-reaching - 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.	**Gaps in Controls**	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 eg 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	16/08/2019	16/09/2019

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**	07/10/2019 07/10/2019 07/10/2019 31/12/2019 30/09/2019 28/10/2019	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made Moderate Progress Made Actions Almost Completed Moderate Progress Made Moderate Progress Made
Latest Month Progress	Plan to roll out Mouth Care care plan on at least 1 ward by the end of September with regular meetings now set up. New falls documentation including risk assessment and multifactorial further assessment and care plan is now on 10 wards and increasing by 2 wards weekly, this will be complete across the Trust by mid-September. A blueprint for resource boxes has been created specifically for patients with cognitive impairment; this is currently being costed before generating charitable funds bid. Revised nutritional screening policy has been rolled out on Ward 10B with demonstrable improvement. The Frailty Practitioner is working on developing best practice recommendations to incorporate into education, care pathways/plans and provision of products related to continence. The first training programme for Care of Older People has been delivered to excellent feedback, with 170 people booked to undertake by the end of 2019.				

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 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
26/04/2019	2021	Executive Medical Director	Christopher Goddard	In Hospital Mortality

Description	Risk of increased in-hospital mortality due to inadequate escalation and senior review

Controls	Outreach service 24/7 Smart Boards NEWS2	Gaps in Controls	Lack of Robust system for Shared learning ? Mortality and Morbidity Meeting Staffing deficits

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	08/08/2019	30/09/2019

Assurance	Structured Judgement Reviews in place with link to SI process Mortality Operational Group (MOG)	Gaps in Assurance	

Action Plan	To be escalated to the RAM Project 'Senior Ownership' work stream. Track and Trigger Policy to be rolled out across wards either by adding training onto ESR or training to be rolled out systematically by Ward Link Nurses. Awareness of the role of the CCOT to be included as part of this training as well as a communications exercise Identify workforce gaps in medical staffing of the acute specialties and aim to close this. Diversify staffing to utilise skills offered by non-medical personnel. Continue the rollout of electronic observations to the emergency department. Complete the trial of the SmartBoards and roll out with the ward reconfiguration programme. Review and formalise handover between day medical teams and on-call medical teams.	Action Plan Due Date	30/09/2019 31/07/2020 30/07/2020 30/08/2019 31/03/2020 28/02/2020 30/09/2019	Action Plan Rating	Moderate Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made

Latest Month Progress	The Trust has a 'Recognition and Care of the Deteriorating Patient' Programme to reduce the risk of avoidable mortality. The pilot trial of the Electronic Consultant Board Round (to support senior ownership) is continuing on Ward 10B; with a final evaluation scheduled for the end of September. As part of the NHSI Introduction to Quality Improvement Programme, a PDSA cycle is being trialed on the Short Stay Unit to increase compliance of timely observations against the new Trust NEWS2 / Track and Trigger Policy. The Trust is continuing to work in association with the Advancing Quality Alliance (AQUA) to identify best practice for AKI, Sepsis and Pneumonia through attendance at biannual Collaborative and as part of the regional Mortality Improvement Collaborative.

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	15/08/2019	15/09/2019
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 Update 01.07.19 - still awaiting final sign off - back to HMB Business case approved and all adverts will go out.						**Action Plan Due Date**	18/12/2017 05/12/2019	**Action Plan Rating**	Completed Moderate Progress Made
Latest Month Progress	Candidates appointed to posts and due commence in August have withdrawn due to a change in circumstances - 3 more vacancies now outstanding - 7 Consultant level and 3 Sp Doctor. JD's all approved by the Royal College and will put all posts out to advert pending final approval. Business case approved and all posts out to advert, PAA (x4) and 1 x Sp Dr post have all been recruited to and pre-employment checks have commenced.								

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Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
18/02/2019	1977	Director of Nursing & Quality	Nicola Ivanovic	Paediatric Dietetics Band 6				
Description	If we do not provide the additional unfunded 0.40 WTE band 6 paediatric dietician, then clinics will be cut from 5/week to 3/week. There are then insufficient clinic slots for number of referrals / on-going patient reviews that need to be seen at correct time. High risk group (premature babies, babies with allergies, infants/ children on tube feeds who need to be seen in a timely way).							
Controls	Monitoring waiting list Clinical triage Peer support to current band 6 post holder Stop in-patient work as low risk and children safe MSK admin to try and support booking of clinics and picking up messages						**Gaps in Controls**	No funding for this service
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	12	16	Extreme risk	6	Moderate risk	06/08/2019	30/09/2019
Assurance	Clinical Effectiveness CBU HON CCG / contracting						**Gaps in Assurance**		
Action Plan	Dietetic Tam Leader and OSM to determine activity 12 months and monthly JC ADO to discuss with SC COO regarding notice to CCG's related to not accepting any community referrals						**Action Plan Due Date**	03/06/2019 30/09/2019	**Action Plan Rating**	Completed Moderate Progress Made
Latest Month Progress	Contract discussions are being used to review the funding associated with this service - however, with sickness in the team there is no one to support the on-going delivery. Waiting lists are now being compiled with a view to discussion with CCGs to suspend the service.									

Strategic Objective		SO3 - Efficiently and productively provide care within agreed financial limits						Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
15/01/2019	1942	Director of Finance	Steve Shanahan	Eradicating the Trust's deficit by 2023/24					
Description	If the Trust does not reconfigure services and invest in its infrastructure then it will not make significant financial improvements against the current deficit. It will then be unable to comply with NHS Operational Planning and Contracting Guidance 2019/20 which states that all Trust deficits should be eradicated by 2023/24.								
Controls	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						**Gaps in Controls**	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	
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	22/07/2019	16/09/2019
Assurance	Acute Sustainability Programme Board-currently fortnightly Finance Performance & Investment Committee and Trust Board-monthly Hospital Management Board-monthly Performance Review Board-monthly						**Gaps in Assurance**	Agency spend/vacancy rates	
Action Plan	Review of Model Hospital data to ensure its accuracy and relevance in driving Trust efficiency improvements Update 20/8/19 fortnightly MH meetings in train, with key efficiency programmes aligned with leads identified across the Trust to test the assumptions and take forward recommendations. as a result some data cleansing has taken place, specifically in procurement and ESR Finance team to model the impact of the proposed change to the finance architecture to assess the improvement to the Trust's underlying financial deficit. Trust and CCG to work together to establish a financial model for the revised Frailty pathway; this could then be used to roll out for other services that have an element of service provision outside the Trust.						**Action Plan Due Date**	30/09/2019 31/01/2019 30/09/2019	**Action Plan Rating**	Actions Almost Completed Completed Moderate Progress Made
Latest Month Progress	A Model Hospital Group has been established which meets fortnightly. This is supporting the validation of data and embedding processes in the Trust. A financial model has been built as part of the acute sustainability programme and data is currently being verified by the Finance department to ensure mapping to specialty is correct. The workforce modelling is also underway.								

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 September 2019

Agenda Item	**TB155/19**	**Report Title**	**Leadership Strategy**
Executive Lead	Jane Royds, Director of HR & OD		
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 aims to inform the Board of the Trust's new Leadership Strategy (2019-2022). This strategy was initially presented to Workforce Committee in July 2019 and was approved following minor aesthetic amendments included here.

The Leadership Strategy sets out the Trust's approach to leadership development over the course of the next 3 years to deliver compassionate & inclusive leadership to 'create a healthy culture' (Workforce & OD Strategy – Pillar One).

The strategy and leadership framework (Appendix A) start the Trust's journey towards the implementation of talent management (TM) at all levels. The Board are asked to note that the Trust is an early adopter of the NHS Leadership Academy's Talent Management Diagnostic Assessment Tool (report due Autumn 2019), a tool used to better understand the Trust's current state vs future state around TM.

Recommendation
The Board is asked to **approve** the Trust's Leadership 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
x	Engagement and Communication	☐	Quality & Safety
☐	Equality	☐	Risk
☐	Finance	x	Workforce

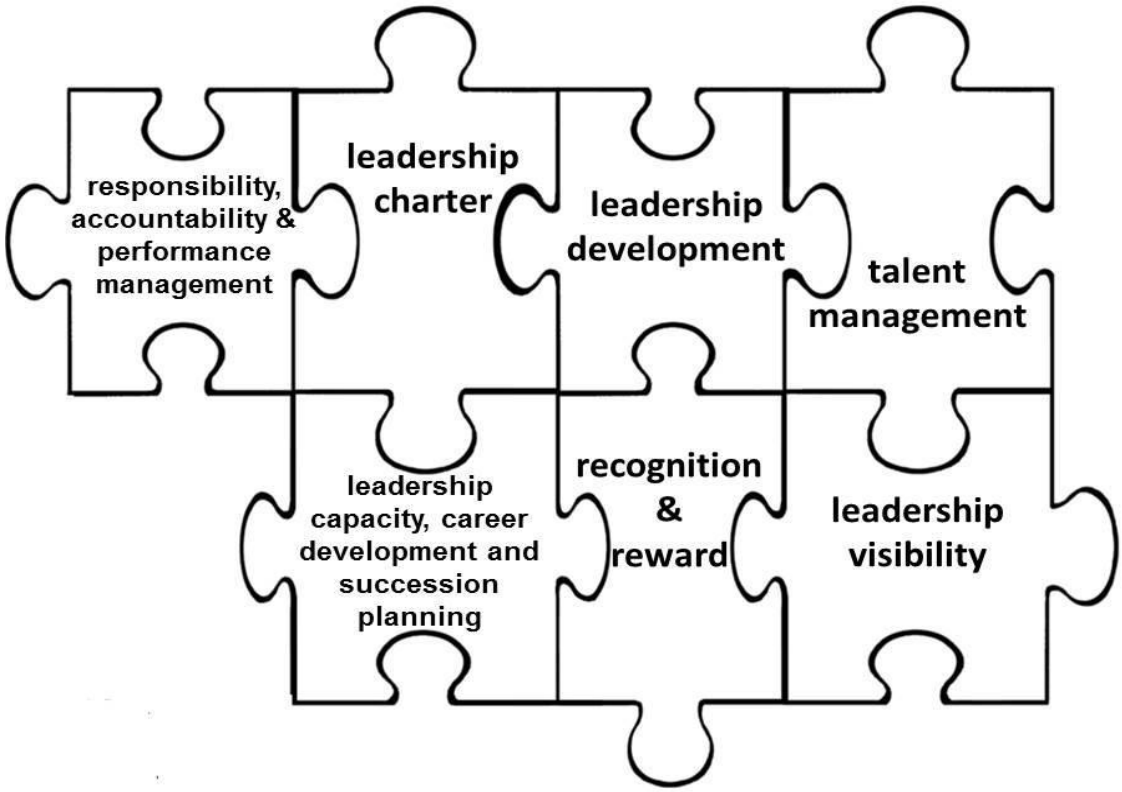
Equality Impact Assessment If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)		
	☐	Policy
	☐	Service Change
	☐	Strategy

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*
Board approval for follow up by Tracy Gunn, Head of E,T&OD

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

Leadership Strategy



2019 - 2022

Compassionate & inclusive leadership

Contents

1. Introduction

Southport & Ormskirk NHS Trust (SOHT) is a complex and diverse organisation which exists to serve the needs of its local population. At the heart of our organisation are our people who are fundamental to ensuring we can deliver on the expectations of those we serve.

To achieve our Vision 2020, the Trust must achieve such standards that mean our people feel valued, supported, empowered and accountable. Above all, they must be well led. It is often said that some leaders are born, but given the value we place on our people; we must also develop and nurture our own. The future success and sustainability of our Trust is in the hands of our current and future leaders, in every area and at every level of our organisation.

This strategy is the key to unlocking that potential, it is essential to developing our leaders and it is vital to a future where our people are sometimes managed but always well led.

Strong, compassionate leadership will be the key defining factor in ensuring that our trust delivers on its strategic aim to deliver a safe and effective healthcare service to all of our communities. We have identified the need for a patient focussed and engaged workforce to deliver that aim and developing our leadership skills and behaviours will be instrumental in ensuring our staff are well led, well supported and empowered to achieve their full potential and in turn, enabled to provide the best possible care to our patients. This ambitious Leadership Strategy sets out how we will identify and develop our leaders across all areas of the Service and enhance the health, wellbeing and engagement of all of our people.

Silas Nicholls
Chief Executive Officer

Jane Royds
Director of HR & OD

2. Background

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three.
However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients.

The need for investment into leadership both nationally and locally in the NHS is of paramount importance for its sustainability and transformation of the NHS health economy. For Southport & Ormskirk NHS Trust (SOHT), the need has never been greater and is integral to its staff providing high quality patient care across all communities we serve in Southport, Formby & West Lancashire

Effective leadership is well evidenced as being a key factor in the success of organisations; '*the way we do things around here'* shapes the behaviour of everyone in the organisation and directly affects the quality of care they provide. Research shows the most powerful factor influencing culture is leadership. Leaders who model compassion, inclusion and dedication to improvement in all their interactions are the key to creating cultures of continuous improvement in health and care. There is also significant evidence that good leadership in NHS organisations has direct links to important organisational outcomes including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, recruitment and retention, staff turnover, absenteeism and overall quality of care. *(The King's Fund)*

This Leadership Strategy is aligned to and underpins the Workforce & OD Strategy. It clearly outlines the need to develop effective leadership at all levels of the organisation in order to support the achievement of the Trust vision:

'To provide safe, high quality services for you and with you'

The Trust has identified five key strategic pillars underpinned by six strategic objectives to support our organisational delivery over the next two years.

Whilst effective leadership is essential to achieving the whole vision and all strategic priorities, the two strategic priorities most relevant to the Leadership Strategy are:

- *To develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated*
- *To enable all staff to be patient centred leaders building on an open and honest culture and the delivery of the Trust values*

This is strengthened by the three strategic pillars of the Workforce & OD Strategy:

1. *Create a healthy culture* - develop a leadership culture where our staff feel values and respected in an environment where they can deliver great care
2. *Build a responsive workforce* – attract and retain a cost effective workforce that is in the right place, at the right time, to meet the needs of our patients
3. *Develop a skilled workforce* – create an environment in which the workforce continually develops and shares its knowledge and learning from others to ensure we deliver best practice

In order to deliver this, we must ensure that our people are supported by compassionate and inclusive

leadership. This is not unique to SOHT and is a recognised leadership shift that is required across the NHS.

This leadership strategy represents a shift not only in how SOHT thinks, behaves and leads but also in the actions we take going forward to make this leadership strategy become 'the way we do things around here'. Cultural change takes time and this strategy includes the steps we can take over the next two years to support Vision 2020.

3. Our leadership approach

Organisations depend upon capable leadership to guide them through unprecedented changes. It is widely appreciated that leadership can be from anywhere, at any level, from any role, not just at a senior or executive level. We believe that in SOHT everyone is a leader and our approach to leadership development will not focus solely on people in management positions but will enable and empower every SOHT employee to be a leader in their own right. It is not simply the number or quality of individual leaders that determines organisational success, but the ability of formal and informal leaders to pull together in support of organisational goals that ultimately makes the difference.

Effective leadership has clearly been proven to have a positive impact upon the following:

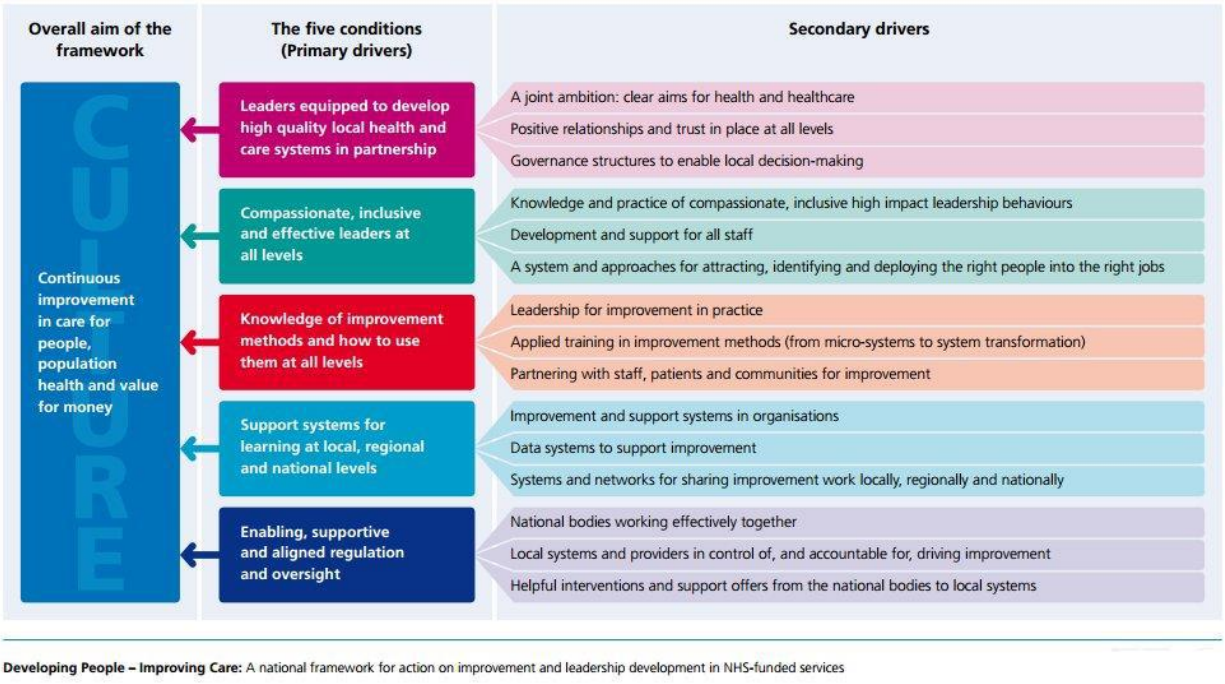
4. Developing people – improving care

The national framework for leadership development 'Developing People – Improving Care' identifies five conditions common to high quality systems that interact to produce a culture of continuous learning and improvements.

The framework explains that to become a successful and sustainable organisation, they must develop the following critical capabilities:

1. Systems leadership skills – to build trusting relationships with our health and social care partners and collaborate across boundaries
2. Improvement skills – to establish and embed quality improvement methods across the organisation
3. Compassionate, inclusive leadership skills – across all levels, paying attention to all the people you lead and challenging power imbalances
4. Talent management – to plan for the future and fill senior roles with diverse, appropriately developed people.

Our leadership strategy sets out our leadership aims and describes what leadership behaviours we support and reward and how our leaders will demonstrate the Trust's vision, values and behaviours to deliver an NHS organisation that is fit for the future.



Developing People – Improving Care – A national framework for action on improvement and leadership development in NHS funded services, December 2016

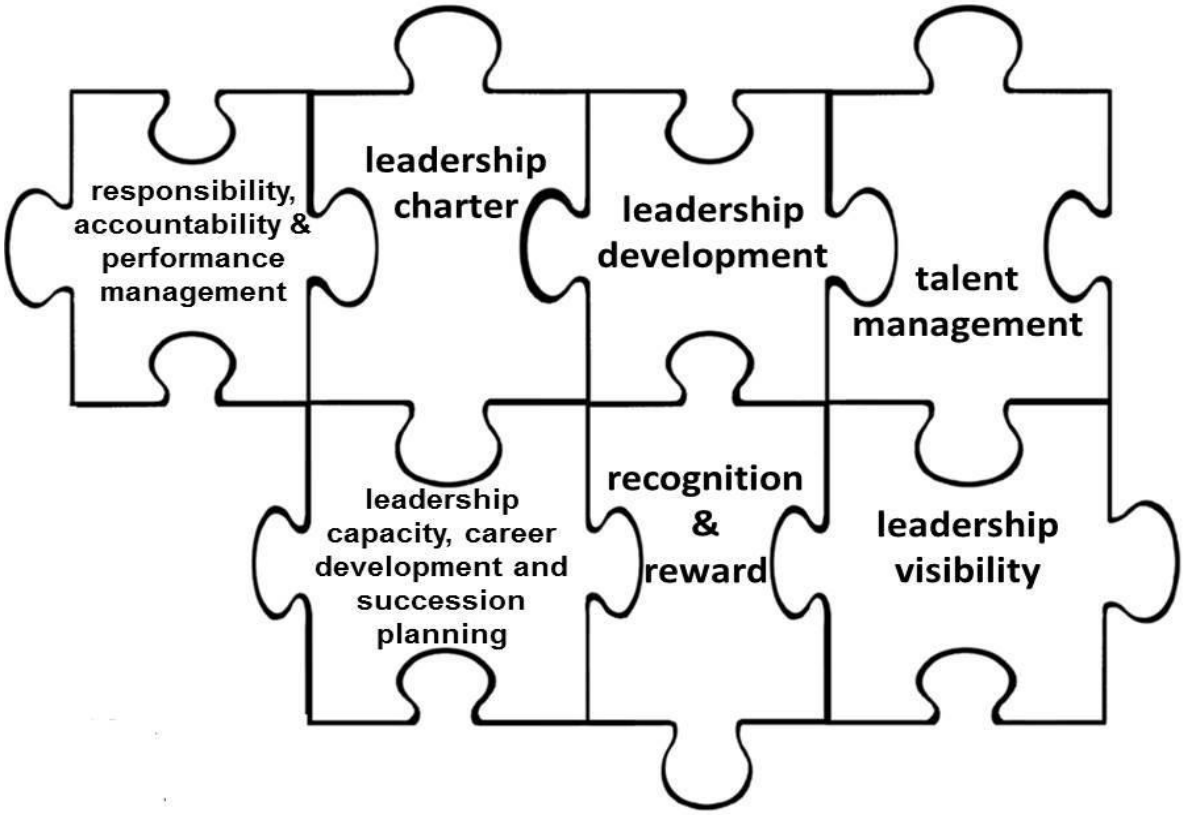
5. Trust vision, values & behaviours

Gone are the days of a command and control or hierarchical approach to leadership. Instead, our people value a transformational leadership style that seeks to work collectively and collaboratively with all stakeholders both internal and external to the Trust with the shared aim to deliver excellent patient care. Staff welcome authentic leadership that fosters a culture of openness, honesty and trust to empower every individual, ensuring accountability and responsibility without a culture of blame. Our people want a visible, supportive leadership style where our leaders engage, listen and act on their staff feedback whilst actively encouraging innovation, creativity and learning through trial and error.

Our Trust values & behaviours framework is in development and will inform the behaviours we expect of all of our leaders and staff.

6. Leadership strategy

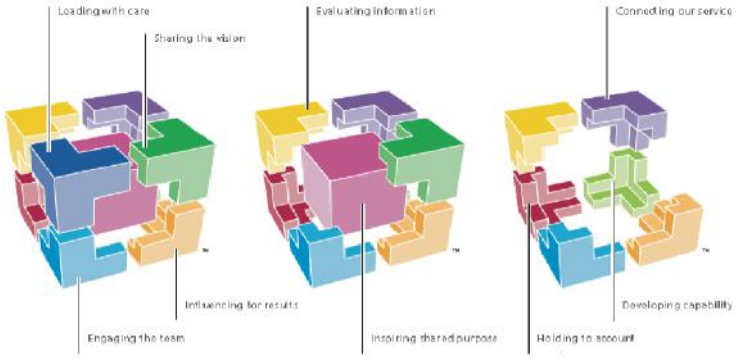
Our Leadership strategy delivered over the next three years will be made up of seven key components as set out in the diagram below.



6.1 Leadership Charter

Our Leadership Charter & development opportunities will be aligned to the national NHS Healthcare Leadership Model and we expect all of our people to actively seek to learn and demonstrate through every day practice the nine dimensions of leadership behaviour.

i. Leading with care
ii. Sharing the vision
iii. Evaluating information
iv. Influencing for results
v. Engaging the team Inspiring shared purpose
vi. Connecting our service
vii. Holding to account
viii. Developing capability
ix. Inspiring shared purpose



6.2 Leadership capacity, career development & succession planning

Following many years of high instability within the Executive leadership Board, a new substantive board has now been embedded; however these were external appointments with evidencing a lack of succession planning. By developing a succession plan, we can provide the opportunity for internal career development for talented leaders, supporting engagement, satisfaction and retention.

The current workforce planning approach will be broadened out to encompass succession planning, leadership career framework and talent management processes. It will be based upon the following principles:

Career progression	Learning, career planning & development	Performance management	Succession planning
• clear job requirements • future workforce planning based on strategy • values based recruitment • appropriate assessment • inclusive & transparent recruitment processes	• induction and preparation for new roles • leadership development opportunities • personal development plans • mentoring • coaching • job shadowing • job rotation	• setting clear expectations of performance • regular evaluation of job performance and individual potential • feedback • managing and improving performance • leadership charter • appraisal	• identifying critical posts • plan for the succession of critical posts • leadership development include opportunity to identify talent • talent pools

6.3 Leadership development

The leadership development offer will align with the national leadership development objectives, which recognises:

1. Systems leadership skills – to build trusting relationships with our health and social care partners and collaborate across boundaries.
2. Improvement skills – to establish and embed quality improvement methods across the organisation.
3. Compassionate, inclusive leadership skills – across all levels, paying attention to all the people you lead and challenging power imbalances.
4. Talent management – to plan for the future and fill senior roles with diverse, appropriately developed people.

The Trust has access to a wide range of leadership and management development interventions via NHS Leadership Academy (NW), Advanced Quality Alliance, Health Education England (NW), ESR eLearning modules and Apprenticeships.

It is the Trust vision over the next three years to develop a Leadership Development offer incorporating internal and external development opportunities, focussed on principles of transformational and collaborative leadership and underpinned by our leadership behaviours and values. The offer will be delivered via a blended learning approach, offering a bespoke approach to leadership development to

meet individual needs and aspirations. This will be supported by coaching and mentoring programmes, access to job shadowing and external secondments and continuous professional development sessions.

6.4 Talent management

The Trust does not have a specific promotions policy and appointments are made as vacancies arise and in accordance with the Recruitment and Selection Policy. We want staff to have trust in the process to select leaders and there is a need for a more defined, open and transparent approach that staff can trust and have confidence in.

Often managers are selected for leadership roles based on their operational or technical competence rather than on leadership capability and that they receive little or no development prior to taking up a new leadership role. Development once in role tends to be 'on the job' and unstructured and this has an impact both on the new leaders experience and that of the people they are responsible for leading and managing.

A new Talent Management approach will link with the succession planning process, leadership development and career planning framework. The processes will be underpinned by the Trust's values, and leaders will be assessed on their leadership style, capability and competence rather than purely on operational or technical expertise.

6.5 Responsibility, accountability and performance management

We aim to move away from a control and command, hierarchical style of leadership to an empowering, enabling and transformational shared leadership style. To do this, leaders must not only apply and be

selected for their leadership development and be developed against the required leadership behaviours and demonstrate Trust values, but must also be held to account against those standards.

Organisational appraisal and personal development planning processes are being revised and aligned to reflect the NHS Healthcare Leadership Model and the Trust values and behaviours once confirmed, but further development is needed to develop the desired leadership approach and to deliver the culture change required. The Trust's 2018 NHS staff survey findings show that appraisal completion is low and the quality of appraisals requires improvement. The challenges of abstracting staff and managers to undertake appraisals remain significant so the Trust will develop flexible and innovative approaches to support both high levels of completion and quality conversations.

The Trust aims to empower its people to deliver innovative improvements and excellent patient care, and to develop an environment that encourages staff to use their personal and professional judgment to achieve results. Ours must become a learning organisation, whereby staff are actively encouraged and supported to speak up, challenge, and where necessary raise concerns, whilst also not being afraid to admit to making mistakes. SOHT has embedded the Freedom to Speak Up Guardian in the organisation as part of its move to a more open and honest culture.

Changing culture and the environment in which we work requires steady leadership and also means policies and procedures will need to be reviewed over the coming years. This will enable and empower our people to use their initiative, to make a judgment and experience supportive leadership rather than be restrained and restricted by bureaucratic policies and procedures and detailed guidance. However, autonomy has to be earned and to earn the freedom to operate more autonomously appropriate, accountability frameworks need to be in place.

Improved performance management systems will be developed which appropriately encourage and support the new leadership behaviours and an 'earned autonomy' ethos. Our aim will be to adopt a 360 degree feedback framework to ensure that every individual gets a fair, open and honest appraisal of their performance against our leadership charter and Trust values whereby moving forward leadership development plans can be developed on an individual basis.

Our performance management approaches will be based on four core principles:

1. Full participation by the individual
2. Honesty and transparency
3. Regular feedback
4. Evidence of continuous improvement.

6.6 Leadership visibility and engagement

The leadership culture can be discerned by listening to what people say about leaders in the organisation. Feedback from staff suggests they would like to see greater visibility of leaders particularly the Executive and Trust Board. To support our leadership strategy, the staff engagement plan will include leadership engagement and communication activities which enable greater access to leaders and improved opportunities for information sharing and feedback. This will operate across the entire Trust and involve all staff, not just patient facing emergency care staff as historically been the case.

The Trust will publish a calendar of activities and ensure that these are accessible to all staff across all roles and locations.

Our SoProud conversations will enable two-way feedback and engagement to ensure our people have a direct impact on shaping the future of our services and their experience at work. New technologies

and social media platforms will be exploited alongside our existing methods to ensure that the vision and strategic objectives are widely communicated and understood and progress updates are provided in a timely manner. Leaders will be encouraged to prioritise face to face communication and ensure they are accessible and approachable to encourage feedback and learning. Leaders will be enabled to complete annual appraisals with their staff to ensure two way communication and ensure their teams feel valued and supported.

6.7 Reward and recognition

Cultures form around what actions or behaviours are seen to be rewarded and recognised with an organisation. It is therefore essential we seek to develop a reward and recognition approach and initiatives where the focus is on those leadership values and behaviours that the Trust lives by and that there is visible recognition of outstanding leadership behaviours at all levels.

The Trust has created a separate category at our Time to shine Staff Awards which seeks to acknowledge and recognise the values and behaviours being consistently demonstrated:

- Compassion in Action Award

The Trust will build on this as it develops its reward and recognition strategy and will be closely linked with the accountability and performance area and the staff engagement and involvement plan.

7. Conclusion

“Leadership is a collective activity”: (Professor Michael West). As described in the national framework, compassionate and inclusive behaviours are the key to creating cultures that engage and support all staff and teams, so that continuous improvement becomes the norm.

In order to become successful, SOHT must not only develop its leaders as individuals but create a structure that will ensure leaders can work effectively across internal and external boundaries to deliver the Trust strategy and ensure that the Trust is a compassionate, inclusive and enjoyable place to work.

We are proud of our ambitious and innovative leadership strategy and understand that the delivery of the leadership transformation plan and cultural shift will take time but will lead to a positive future for the organisation. The senior leadership team will continue to monitor and report our progress and most importantly evaluate the positive impact on the health, wellbeing and engagement of our people.

8. APPENDIX A

SOUTHPORT & ORMSKIRK NHS TRUST - LEADERSHIP FRAMEWORK

Internal development	Indicative Roles (not fixed)	NHS Leadership Academy	Apprenticeship programmes
Essential Skills for Managers In-house opportunities ESR eLearning modules Functional Skills AQuA Quality Improvement Internal Coaching 360 Feedback	Supervisors / Team Leaders / Bands 2-4	Edward Jenner (online)	Team Leader Level 2 & 3 Facilities Management Level 3 HR Support Level 3 Improvement Technician Level 3 Business Admin Level 4 Associate Project Manager Level 4 Management (Higher Level) Level 5 Chartered Manager/Degree Level 6
Essential Skills for Managers In-house opportunities ESR eLearning modules AQuA Quality Improvement Internal Coaching NW Mentoring Scheme 360 Feedback	New Leaders / Managers Band 5-6 / newly qualified non-medical clinicians	Edward Jenner (online) Mary Seacole Programme BAME (Stepping Up)	Team Leader Level 3 Improvement Technician Level 3 Associate Project Manager Level 4 Learning Mentor Level 3 Assessor/Coach Level 4 Business Admin Level 4 Improvement Practitioner Level 4 Operations Manager Level 5 Management (Higher Level) Level 5 Chartered Manager/Degree Level 6 MSc/MA/MBA Senior Leader Level 7
Essential Skills for Managers In-house opportunities ESR eLearning modules AQuA Quality Improvement Internal Coaching NW Mentoring Scheme 360 Feedback	Middle Managers / Leaders / Band 7 / Newly appointed Consultants and SAS Doctors	Edward Jenner (online) Mary Seacole Programme BAME (Stepping Up)	Learning Mentor Level 3 Assessor/Coach Level 4 Associate Project Manager Level 4 Operations Manager Level 5 Management (Higher Level) Level 5 Improvement Specialist level 5 Improvement Leader Level 6 Chartered Manager/Degree Level 6 MSc/MA/MBA Senior Leader Level 7
360 feedback Personal development AQuA Quality Improvement Internal Coaching NW Mentoring Scheme New Consultants Programme	Senior Managers / Leaders / Consultants / Senior Clinicians / Matrons	Elizabeth Garrett Anderson BAME (Ready Now) Nye Bevan Clinical Executive Fast Track Aspirant Talent Programme Coaching Network	Improvement Leader Level 6 Chartered Manager/Degree Level 6 MSc/MA/MBA Senior Leader Level 7
360 feedback Personal Development External coaching Triumvirate Development Programme NW Mentoring Scheme	Directors /ADO's/ Deputy Directors / AMD's	Aspiring Chief Executive Programme Clinical Executive Fast Track Nye Bevan BAME Ready now Aspiring COO & DoN	MSc/MA/MBA Senior Leader Level 7
AQuA Board Development Programme External Executive Coaching 360 Feedback NW Mentoring Scheme	Executives	Top Leaders Chief Exec Development Programme	

APPRAISAL & TALENT MANAGEMENT

SUPPORTIVE CARING OPEN AND HONEST PROFESSIONAL EFFICIENT