Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10:30 – 13:30 on Wednesday, 2 October 2019
Ruffwood Suite, Education Centre, Ormskirk & District General Hospital, L39 2AZ

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration
PRELIMINARY BUSINESS			10:30
TB162/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**
TB163/19 (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**	
TB164/19 (D)	**Minutes of the Meeting held on 4 September 2019** To **approve** the minutes of the Public Board of Directors	**Chair**	
TB165/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**	
TB166/19 (D/V) **(V/P)**	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Staff Story:** 'Representing the Trust at an Inquest' To **receive** the Staff Story and **note** lessons learnt	**NEDs EDs** **Michelle Kitson / Dave Snow**	**30**
STRATEGIC CONTEXT			**11:10**
TB167/19 (D)	**Chief Executive's Report** To **receive** key issues and update from the CEO	**CEO**	**10**

Ref Nº.	Agenda Item	Lead	Duration
QUALITY & SAFETY			**11:20**
TB168/19 (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 f) Freedom to Speak Up Quarterly Update & Relaunch of Strategy To **receive** the presentation and reports	**DoN/MD** **Martin Abrams**	**45**
PERFORMANCE & GOVERNANCE			**12:05**
TB169/19 (P/D)	**Integrated Performance Report (IPR)** To **receive** the report	**COO**	**25**
TB170/19 (D)	**Financial Position at Month 5, 2019/20** To **receive** the report	**DoF**	**10**
TB171/19 (D)	**Risk Management:** **Corporate Risk Register (CRR)** To **receive** the monthly reports.	**DoN**	**5**
TB172/19 (P/D)	**Single Improvement Plan Update (SIP)** To **receive** the report	**DCEO/ DoS**	**10**
TB173/19 (D)	**Board Assurance Framework (BAF)** To **note** the report	**IADCG**	**5**
TB174/19 (D)	**Items for approval/ratification** **a) Statement of Compliance 2019/2020, Core Standards Self-Assessment, Emergency Preparedness, Resilience and Response (COO)** **b) Learning Lessons to Improve our People Practices Report (DoHR)** **c) Workforce Disability Equality Standard Information Report April 2019 – March 2020 (DoHR)** **d) Workforce Race Equality Standard Information Report April 2018 – March 2019 (DoHR)**	**Chair**	**10**

	e) Health & Wellbeing Strategy (DoHR)		
CONCLUDING BUSINESS			**13:10**
TB175/19 (V)	**Questions from Members of the Public**	**Public**	**10**
TB176/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda, including items for forward agenda – 6 November 2019	**Chair**	**10**
TB177/19 (V)	**Message from the Board** • To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	
TB178/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**	
TB179/19 (V)	**Date and time of next meeting:** **10:30, Wednesday 6 November 2019** Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN	**Chair**	**13:30 CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

Minutes of the Public Section of the Board of Directors' Meeting held on 4 September 2019
(subject to approval by the Board on 2 October 2019)

Present:	Mr N Masom	Chair
	Mr J Birrell	Non Executive Director
	Mr D Bricknell	Non Executive Director
	Ms J Cosgrove	Executive Director of Nursing, Midwifery & Therapies
	Mrs J Gorry	Non Executive Director
	Dr T Hankin	Executive Medical Director
	Mr S Nicholls	Chief Executive
	Mrs T Patten	Deputy Chief Executive/Director of Strategy
	Mr S Shanahan	Executive Director of Finance
	Mr G Singh	Non Executive Director
In attendance:	Mr S Christian	Chief Operating Officer
	Mrs A Davenport	Interim Associate Director of Corporate Governance
	Mrs P Gibson	Associate Non Executive Director
	Mrs C Griffiths	NHS Improvement
	Mrs J Royds	Director of Human Resources & Operational Development
	Mr T Ellis	PR & Communications Manager
	Mrs M Kitson (agenda item TB146/19 only)	Patient Experience Matron
Apologies:	Mrs J Morgan	Non Executive Director

TB142/19 CHAIRMAN'S WELCOME AND NOTE OF APOLOGIES

The meeting was opened. Apologies received from Jo Moran were accepted.

TB143/19 DECLARATION OF DIRECTORS' INTERESTS CONCERNING AGENDA ITEMS

No declarations of interest were made in relation to any agenda items.

TB144/19 MINUTES OF THE MEETING HELD ON 3 JULY 2019

The minutes of the meeting held on 3 July were agreed as a correct record and were approved, subject to the following amendments:

- Minute No. TB129/19 Clinical Negligence Scheme for Trusts – to add that the Board had approved the report demonstrating progress with evidence against 10 safety actions.

TB145/19 MATTERS ARISING/ACTION LIST

April 2019, Min No. TB072/19: Assurance & Performance/IPR – it was advised that the Trust was working with system partners and Venn Consulting to develop a tool to monitor Key Performance Indicators. Venn Consulting had completed its demand and capacity review which would be presented to the system next week and inform the identification of high impact actions for winter planning. The outcome of this review would be taken to the Finance, Performance & Investment Committee in September 2019 for ratification and an update provided to the Board in

October 2019 via the AAA Highlight Report**.**

Action: Chief Operating Officer
By: October Board

July 2019, Min No. TB127/19: Patient & Engagement Issues – it was confirmed that the ward refurbishment work had commenced, the initial focus being on ward areas, nurse stations, sluices etc, with rooms to be created for each ward. An article on this work, which had appeared in the local press, had been positively received. Wards 10^{A} and 10^{B} were to be refurbished in 2020/21. A progress report would be brought to the Board in December 2019

Action: Director of Nursing, Midwifery & Therapies
By: December Board

January 2019, Min No. TB028/19: Monthly Mortality Report/External Mortality Review – in light of the 11 key recommendations and 7 cases of very poor care identified from this review the Board had requested further assurance around the timely delivery of the agreed actions. It was noted that the Board still awaited confirmation that all actions had been completed.

Action: Medical Director
By: October Board

The Board was satisfied that the following actions had been completed and could therefore be removed from the action log:

February 2019, Min No. TB028/19: Monthly Mortality Report/External Mortality Review – the Medical Director had requested that this action be closed as sufficient SOPs were available**.**

January 2019, Min No. TB031/19: Integrated Performance Report – it was confirmed that trajectories for KPIs were now in place (where applicable).

April 2019, Min No. TB070/19: Chief Executive's Report – the paper on IT implementation had been provided for consideration by the Board in June 2019.

May 2019, Min No. TB093/19: AAA Report Workforce Committee – a report had been produced for consideration in the private section of the Board meeting in July 2019**.**

June 2019, Min No. TB107/19: NEDs' & Executives' Walkabouts – it was confirmed that the staff member retiring after 50 years of service had been appropriate recognised**.**

June 2019, Min No. TB110/19: NEDs' & Executives' Walkabouts – it had been clarified that the list of complaints was not weighted.

June 2019, Min No. TB112/19: IPR – a single page report had been created to identify total number of staff, available beds, deaths etc and had been included in the IPR.

June 2019, Min No. TB114/19: BAF – the Risk Appetite Statement had been added to the abridged Annual Report for the 2019 Annual General Meeting.

June 2019, Min No. TB115/19: Claims & Litigation Report – this report had been scheduled into the Audit Committee's annual cycle of business.

July 2019, Min No. TB134/19: Corporate Governance Manual – this had now been published on the Trust's website.

TB146/19 PATIENT AND ENGAGEMENT ISSUES

Non Executive and Executive Visits/Walkabouts

The revised, simplified paperwork introduced to support the Walkabouts, asking 3 questions: What are you proud of? What frustrates you? What can you do to change some of the frustrations into positives? was commended.

Julie Gorry and the Director of Finance had visited Ward 9B and the Critical Care Unit on 15 July 2019. Comfortable conversations had taken place with staff and there had been a significant amount of positive feedback.

Pauline Gibson and the Deputy Chief Executive/Director of Strategy had visited the same areas on 25 July 2019 and, again, there had been good conversations and positive feedback, with evidence of good engagement in relation to the changes taking place within the organisation.

The Chairman and Medical Director had visited a number of non clinical areas in Facilities, including the laundry, stores receiving bay, kitchen, and communication centre, as well as the mortuary and bereavement office. Challenging conversations had taken place with the kitchen staff who were working in hot conditions with broken equipment, in particular the industrial dishwasher, with staff having to hand wash crockery and thus potentially exposing staff and patients to risk of harm. Whilst the issues raised had been resolved and the staff had been happy that their concerns had been listened to and acted upon, the fact that these had not been picked up by the Trust's systems was of concern and was being looked into.

The need to undertake more visits to non-clinical areas was recognised.

The Director of Nursing, Midwifery & Therapies reminded the Board that walk rounds with the Facilities Team take place most mornings, as a result of which environmental issues were being picked up and expected standards communicated. A number of staff had also been recognised for their sterling work as part of the 'thanks a bunch' initiative.

The Chief Operating Officer reported that he had been privileged to spend 12 hours in a number of areas on the Ormskirk site as part of the 'back to the floor' process. During this time, he had been pleased to hear about a number of innovations introduced by staff, for example the implementation of a secondary triage system in Paediatric A&E; daily, 8am safety huddles in Theatres; and the refinement by a student nurse on her own initiative of the communication boards for Wards G and H.

The Chief Operating Officer and Senior PR & Communications Officer were commended for their thoughtful action, on one of the hottest days, in securing an ice-cream van to provide ice-cream free of charge to staff. This had naturally been very well received. Mrs Griffiths was also commended for her efforts in securing a fan for the CQC inspection team on a particularly hot day.

The Chairman reported that he had met with both Rosie Cooper MP, who had visited to sign Unison's Respect Your Youth Charter along with the Chief Executive and staff side representatives and was clearly very supportive of the Trust. The Chairman had also met with Damien Moore MP, who had visited A&E and had been very impressed by the department which, although very busy, appeared calm and in control. It was highlighted that there had been 45 attendances in the 2 hours prior to Mr Moore's arrival.

Patient Story: Hearing Impairment
Presented by Michelle Kitson, Patient Experience Manager

The Board was apprised of a number of problems encountered by patients with hearing impairments over the past few months and of action consequently now being taken to ensure a better patient experience for both these patients and those with sight impairments and reduce the risk of not understanding diagnoses or medication instructions. These included, in particular, the improvement of communications and confidentiality (revised patient leaflets; introduction of a text messaging service for appointments which was not currently available in Access & Booking and radiology; provision interpreters and advocates from the Merseyside Society for Deaf People to assist in face to face situations such as a complaint meeting). It was also proposed to provide longer appointments. Whilst the facility to put alerts in patient notes was already available in Medway, it was, however, highlighted that this system unfortunately does not interface with the Radiology, one of the key areas where concerns had been raised, therefore this was an issue

that still needed to be resolved.

It was confirmed that support was being provided by the Equality & Diversity Lead and that contact had also been made with local organisations to seek their assistance in putting in place the necessary measures to best improve the experience of such patients.

In terms of the most basic requirements, namely the availability of a loop system, it was confirmed that this facility was in place in some areas, but that there was often a lack of awareness. It was suggested that a loop system be provided as a matter of priority in radiology given the current issues in that department. It was advised that the wider availability of loop systems was to be looked at as part of PLACE. Staff training was also going to be reinstated.

Confirming that the Equality & Diversity Lead and Matron for Patient Experience would be responsible for maintaining momentum, the Director of Human Resources & Operational Development and Director of Nursing, Midwifery & Therapies were confident that a robust strategy was in place supported by the necessary external support.

The Patient Experience Manager was thanked for presenting the story.

RESOLVED:
The Board **received** the presentation and **noted** the improvement action being taken

TB147/19 CHIEF EXECUTIVE'S REPORT

The Chief Executive's Report to the Board was presented. Key issues were highlighted as follows:

It was advised that a team from the Care Quality Commission (CQC) had inspected the Trust's core services during 2 unannounced visits in July 2019, followed by a scheduled review of the 'well led' element towards the end of August 2019. Although there were still areas of work to be done, the inspections had gone well and feedback from staff had been interesting and positive. The Chief Executive was hopeful that CQC's report would be received in late September/early October before he was due to leave the Trust. It was highlighted that the outcome of the CQC report would impact on the Trust's 'challenged provider' status.

A long over-due £900K programme of improvements to 8 wards at Southport & Formby District General Hospital had been approved by the Hospital Management Board, with the first phase of work (Wards 7^{A}, 7^{B}, 9^{A}, 9^{B}, 11^{A} and 11^{B}) due to complete in December 2019 and work to start on Wards 10^{A} and 10^{B} in April 2020 to avoid the busier winter period.

Following an increase in the incidence of patients with Klebsiella, an antibiotic resistant micro-organism which does not normally cause infections, but which is a risk to patients with long-term catheter use, a difficult decision had been taken in July 2019 to temporarily close the North West Regional Spinal Injuries Unit to new admissions to enable essential upgrading and deep cleaning of bathrooms. It was confirmed that this was not a risk to the general public. It was anticipated that the Unit would re-open to admissions at the end of September 2019.

As reported earlier by the Chairman, strong links with local MPs were being maintained and it was hoped that they would support the Trust in its bid for capital to enable its sustainability strategy to be delivered.

It was highlighted that the Trust was continuing to experience high demand in A&E, with a 10% year on year increase. Despite this, patients were continuing to wait less time for transfer into hospital from ambulance; to receive more timely treatment; and to have a better experience of care.

As advised earlier, the Chief Executive confirmed that he had accepted the post of Chief

Executive at Wrightington, Wigan & Leigh NHS Foundation Trust and would be leaving on 31 October 2019. The recruitment process for his replacement was underway and it was hoped that an appointment would be made later in the month from a small cohort of excellent candidates.

Bringing the item to a close, the Chief Executive looked forward to welcoming people from across West Lancashire, Southport and Formby to this year's Open Day and Annual General Meeting to be held on 7 September 2019 at Ormskirk & District General Hospital.

RESOLVED:
The Board **noted** the report.

TB148/19 VISION 2020 & THE SINGLE IMPROVEMENT PLAN

The Board received the paper setting out the organisation's agreed strategic objectives to support its mission of providing safe, high quality services, along with the consolidated, prioritised action plan summarising the improvement activity necessary to deliver Vision 2020. Noting its content, it was recognised that this document would form a key part of the evidence base required to support the Trust's ambition to reverse its current designation as a 'challenged Trust'.

It was noted that there appeared to be a number of key strategic issues within Vision 2020 that may not currently be subject to appropriate scrutiny by the Board. These would be identified by the Deputy Chief Executive/Director of Strategy to ensure that the Board would be appropriately sighted on these issues going forward by the provision of formal papers for noting by the Board.

Action: Deputy Chief Executive/Director of Strategy
By: October Board

In response to a comment that there was significant duplication within the Single Improvement Plan and the IPR, it was clarified that performance was measured differently within these two documents, the former being focused on strategic delivery whilst the latter focuses on operational performance. The content of these documents would, however, be reviewed.

Action: Deputy Chief Executive/Director of Strategy
By: October Board

RESOLVED:
The Board **received** the paper

TB149/19 QUALITY & SAFETY REPORTS

The key issues from the 5 comprehensive reports provided in relation to this agenda item (Summary of Complaints & Compliments, Monthly Mortality Report, Quality Improvement Plan, Safe Staffing and CQC Preparation) were highlighted in a presentation to the Board, as follows:

Quality Improvement Priorities

Care of Older People - following Business Case approval, an Admiral Nurse had been recruited internally and interviews were due to take place for 2 x band 6 dementia and delirium nurses, thus improving skill set and capacity. Driven by risk assessments around falls, use of bed rails and cognitive impairment, the roll out of improved care plans was envisaged by the end of September 2019, resulting in improved patient safety. Other improvement initiatives included the launch of 'Mouth Care Matters on Ward 14B at the end of September 2019 and the re-launch of Southport & Formby HomeFirst Pathway on 9 September 2019. It was highlighted that 170 staff had enrolled on the Older People's Care training programme, focusing on person-centred high quality care and including Tier 2 dementia training in order to enhance knowledge and understanding. A significant improvement in the care of older patients was therefore anticipated.

Infection Prevention & Control – no incidence of MRSA bacteraemia had been reported for 2019/20 until August 2019. A root cause analysis was underway, however there were no

immediate concerns and no breakdown in practice had been identified. It was confirmed that estates work, which would have a beneficial impact in terms of maintaining cleanliness, was due to commence in early Autumn to improve ward layouts and work was also underway in the Regional Spinal Injuries Unit to refurbish bathroom and other relevant areas to address the recent incidence of Klebsiella.

CQC Update – following notification of the Provider Information Request (PIR) on 10 April 2019, the completed PIR had been submitted on time by close of play on 3 May 2019. A first unannounced review of core services had commenced on 9 July 2019 and, over 3 days, the CQC had visited Urgent & Emergency Care, Medicine, Surgery and Services for Children and Young People. The second unannounced review of core services had been undertaken between 30 July 2019 and 1 August 2019 of Sexual Health, Out-patients Ormskirk, End of Life Services and Critical Care. It was advised that some final pieces of information were to be submitted to the CQC, with its draft report anticipated in early October 2019 and, following factual accuracy checking, the aim was for the final report to be published by the end of October 2019.

It was confirmed that the Trust had committed to a significant amount of improvement work, including, in particular, around medicines management, and that there would be further areas to address following receipt of the report.

Complaints & Compliments – although the number of compliments had reduced slightly during the month, continuing a month on month trend, the Director of Nursing, Midwifery & Therapies was not unduly concerned. The number of complaints and concerned had also continued to decrease, to 18 formal complaints in July 2019. In the same month, 37 concerns had been raised, in the main regarding waiting times and requests for further information and advice.

Regional Spinal Injuries Unit – it was reported that, following the identification of Klebsiella bacteraemia, the decision had been taken to close the Unit to new admissions from 23 July 2019. Pending the re-opening of the Unit (hopefully by the end of September 2019 once the Trust was confident that the risk could be managed), patients were being supported in the community or within their referring hospitals and, reassuringly, a number of these patients had already been discharged. It was confirmed that there were currently 11 patients awaiting admission. By way of reassurance, it was highlighted that the Trust was working with Public Health England as this was an infection risk that the Trust had not previously experienced, with refurbishment work underway on bathrooms and isolation facilities (as mentioned earlier in the meeting) funded from capital contingency.

Safe Staffing – taking into account the use of temporary nursing workforce, the overall fill rate in July 2019 had been 88.25% compared with the national average of 90% and had decreased since June 2019. Reassurance was given that critical shifts are filled. It was confirmed that the vacancy rate for registered nurses had increased reflecting the increased establishment associated with the implementation of the Nursing Efficiency Review and natural attrition in-month. The Trust was, however, doing its utmost to recruit substantively and to then retain staff by ensuring opportunities to progress were available. It was highlighted that, for the first time, the CQC had not raised safe staffing levels as an area of concern.

Medicines Management – as alluded to above, medicines management had been identified as an area of concern by the CQC inspections in July 2019. Issues identified included out of date medicines, gaps in medicine charts, self-administration, secure storage, temperature checks, disposal of medicines and unavailable medicines. In particular, concerns had been raised around discharge prescriptions involving controlled drugs following the introduction, due to pressure to improve flow, of a 'work around' practice to facilitate prompt discharge of patients by providing prescriptions without a 'wet' signature (obtained the next day). It was confirmed that this practice had been stopped and that this matter had been addressed as a serious incident, with an external review having been commissioned.

It was highlighted that, against a backdrop of substantial budget reductions and under-investment, medicines management had already been recognised as a priority area for improvement for Quarter 1 of 2019/20 and, following a number of previous CQC inspections, a comprehensive internal service review had been undertaken, an ambitious action plan developed and a Statement of Case produced. Due to other priorities and financial constraints, however, this had not been approved at that time. A revised, overarching Medicines Management Development Plan had now been produced, led by the Medical Director, identifying actions across 4 timescales (immediate, 30 days, 3 months and 9 months) to address immediate concerns and improve safety and quality on a sustainable basis. Work had also commenced on the production of a comprehensive business case to bring medicines management (one of the biggest areas within the NHS from the perspective of both safety and cost) to the required standard, the 3 priority elements being electronic prescribing, 7 day service and workforce requirements.

Mortality – the data, demonstrating a sustained improvement across all disease groups (with the exception of renal failure) was presented. For the reporting period July 2018 to March 2019, performance was confirmed as follows:

- Summary Hospital Level Mortality Indicator (SHMI): 1.13 down to 1.02
- Hospital Standardised Mortality Ratio (HSMR): 117.5 down to 94.8
- Rolling HSMR: 82.8
- Pneumonia HSMR: 103.7
- HSMR for other respiratory diseases remained high, however there had been a significant and sustained reduction
- In hospital crude death rate for June 2019: 16 (31) below target
- Improvement in most mortality screening in June 2019: 54.17%

Noting that Dr Hankin was reasonably confident that performance below the average for SHMI and HSMR would be achieved, the Board members commended the work undertaken by all involved to achieve this considerable improvement. It was highlighted that, whereas the Trust had previously been a significant outlier, it was now becoming known as an exemplar organisation able to provide support and guidance to other organisations. It was advised that a proposal for a national collaborative in relation to mortality improvement was being worked up and that a request had been made for the Trust to be included in this.

In relation to the Trust's reputation more generally, the Deputy Chief Executive/Director of Strategy was pleased to report that, at the Sefton Overview & Scrutiny Committee on 3 September 2019, there had been an opportunity to give an update on the progress being made by the Trust and, as a result, the members had been impressed and assured by the stability of the organisation and its clear vision for the future.

Apprising the Board of the anticipated requirement for organisations to employ a medical examiner to scrutinise all non-coronial deaths, Dr Hankin would update the members, not least with regard to funding, once more definitive information had been received.

Quality Improvement Plan – the Board noted the update paper, setting out progress with regard to the improvement plan in place, consolidated within a number of themes to deliver 4 key quality priorities (Care of the Older Patient, Care of the Deteriorating Patient, Infection Prevention & Control and Medicines Management). It was confirmed that key themes identified by the recent CQC inspection had been included. As previously requested, it was agreed that a mapping exercise would be undertaken to clarify where and how all the areas for improvement were being addressed and to ensure that focus on continual improvement will be maintained.

Action: Director of Nursing, Midwifery & Therapies
By: October Board

The Board was reminded of the proposed 'twinning' arrangement with Leeds Teaching Hospitals NHS Trust to secure clinical support and supervision, in particular in relation to older people's care. Whilst there had been no progress in relation to this particular area, it was confirmed that

the support of its Head of Pharmacy, Professor Liz Kay, had been secured to review medicines management.

RESOLVED:
The Board **received** the Complaints & Compliments Report, the Monthly Mortality Report and the Monthly Safe Staffing Report and was **assured** by the Quality Improvement Report and the CQC Preparation Update.

TB150/19 MEDICAL APPRAISAL & REVALIDATION ANNUAL REPORT 2018/19

The Board noted the paper providing assurance that appropriate plans were in place to ensure the Trust's compliance with its legal obligations in relation to medical appraisal and revalidation. It was highlighted that, with 92.9% of appraisals having been completed on time in 2018/19, the Trust's compliance rate was one of the highest in the local health economy. With regard to the 2 unapproved missed or late appraisals, it was confirmed that 1 had been attributable to a doctor being subject to 'a process', with the other having since been completed and the doctor therefore being fit to practice. It was also confirmed that, in terms of approved missed or late appraisals, 6 had been attributable to sickness or maternity leave and 6 to clinical commitments or 'other'. Mr Singh requested an update regarding deferrals, and the reasons for these, over the past 5 years.
Action: Medical Director
By: October Board

The Medical Director commended the system in place at the Trust, in particular the facility to map complaints and compliments to individual doctors.

RESOLVED:
The Board was **assured** that the appropriate processes were in place to ensure the provision of high quality annual appraisals and **approved** sign off of the Statement of Compliance.

TB151/19 INTEGRATED PERFORMANCE REPORT

The IPR for month 4 was received, reflecting an improvement in relation to 30 indicators ($^{1}/_{3}$ of these relating to 'efficiency') and a deterioration in relation to 22 indicators ($^{1}/_{2}$ of these relating to 'well led', in the main across Finance and HR metrics), with 8 indicators having remained unchanged. In reviewing the individual metrics, the following issues were highlighted:

Deteriorating Indicators

Fractured Neck of Femur repairs within 36 hours of admission – having failed to achieve this target for $^{11}/_{25}$ patients in July 2019 performance had deteriorated to 47.37%. This had been attributable in the main to the lack of available trauma lists to accommodate the high number of patients admitted over a short period of time in mid July. In August 2019, this target had been missed for $^{10}/_{37}$ patients. The Board was reminded that, for Fractured Neck of Femur, the Trust was a significant outlier in terms of mortality and hence an action plan had been put in place.

Referral to Treatment (RTT) - whilst, at 92.7%, performance remained above the national target of 92%, the month on month deterioration since December 2018 was continuing due to the inability to discharge from the Priority Tracking List (PTL) which had increased by 3.5%. As previously reported, medical resource shortages were contributing significantly to the deteriorating position, in particular in anaesthetics where a 40% vacancy rate had led to the cancellation of a significant number of elective theatre sessions over recent months in order to enable emergency and on-call activity to take precedence. It was confirmed that, having agreed the Business Case, the Trust was moving at pace to secure the necessary appointments.

Diagnostic Waits =/>6 weeks – at 4.09% in July 2019 against the 1% target, performance had improved. Workforce constraints in radiology and endoscopy were, however, continuing to affect performance against this metric, with activity levels also being adversely impacted by the recent tax reform implications as a result of which consultants were no longer willing to work extra

shifts. With regard to radiology, temporary solutions were being pursued and outsourcing arrangements were in place with a number of organisations to provide services at tariff. Regarding endoscopy, it was highlighted that there had been a 10% increase in demand year on year driven, in particular, by cancer pathways. To assist in addressing this, the Trust was engaging with external providers and was looking at the provision of in-house training to increase the availability of endoscopy sessions from a nursing workforce.

Length of Stay – the month on month deterioration in performance was continuing (average length of stay having increased to 7.29 days in July), but was linked to the improving metric for stranded patients. Acknowledging the need to improve performance and achieve the target of a 0.5 day reduction, it was confirmed that action was being taken to address medical workforce issues, embed the principles of SAFER/Red2Green and, in relation to elective activity, reduce the number of pre-op bed days. It was anticipated that the development of better pathways and processes for elderly care as part of the ambition to become a leader in this field (in line with Vision 2020) would result in a reduction in length of stay.

Improving Indicators

Ambulance Handovers – performance had improved significantly, with 54.66% of handovers having been achieved within 15 minutes of arrival in July 2019 compared with 38.12% in July of the previous year. It was highlighted that the Trust had moved from the middle to the upper quartile for its performance.

A&E 4 hour standard – against the national target of 95%, despite seeing a significant number of attendances in July 2019, 88.6% compliance had been achieved. Whilst the Trust had also failed to achieve its trajectory target of 90.3% (by 1.7%) for July 2019, it was continuing to perform comparatively well in the context of national performance of 86.5%, ranking 47th out of 123.

Stroke 90% Stay on Stroke Ward – following an improvement in patient flow and operational grip, the target of 80% had been over-achieved by 8% in July 2019.

In reviewing the Activity Summary, it was confirmed that, as agreed at August's Finance Performance & Investment Committee, RTT, GP referrals and cancer referrals would be included in future. Key issues highlighted were the 10% increase in A&E activity overall (15% in relation to the Southport site) equating to c25 additional patients per day and the 15% increase in admissions in July 2019, equating to c7 extra patients per day. It was acknowledged that this would be challenging if not addressed by the System as a whole. The increase in daycase admissions, against a backdrop of theatre list cancellations due to anaesthetic resource issues reported earlier, was also highlighted.

Theatre Utilisation – it was confirmed that work was continuing to improve theatre utilisation, with positive results beginning to be seen regarding the number of sessions starting on time or early, the number of cancellations and in session utilisation rates.

Cancer – the Trust was experiencing an increase in demand in cancer referrals, with 1,000 having been received in July 2019, impacting on the capacity to deliver elective activity. As a result, the Trust was not performing to trajectory. Breaches were being managed.

Acknowledging that the focus tended to always be on areas of concern, the Board commended the Chief Operating Officer and his teams (management and clinical) on the sterling work being done to improve performance.

In terms of system-wide winter planning the Board was reminded that the work to develop the plan for 2019/20 was being led by Southport & Formby CCG. Regrettably, it had not yet proved possible for all the necessary parties to meet together. It was confirmed that Venn Consulting had been commissioned by the Regulators to undertake a comprehensive review on behalf of

the System to inform the development of the plan. Venn Consulting's interim report had been received and would be shared with all interested parties shortly, following which high impact actions would be agreed. In the interim, the Trust' operational winter planning group was pursuing local tactical actions, including planning for the eventuality that a sufficiently robust system-wide plan may not be agreed.

The Chief Executive advised that he was becoming increasingly concerned at the lack of a joined up system plan and the potential for the Trust to once again have to bear all the pressures associated with the winter months, both clinically and financially. Recognising that this would constitute a collective failure, the Board supported the Chief Executive's intention to relay this to his peers.

The Director of Nursing, Midwifery & Therapies echoed these concerns, advising that there unfortunately appeared to be less co-operation this year and that, despite the lessons learned in the previous year(s), no appreciable progress was being made. It was suggested that it may be necessary for the Chairman to also formally escalate these concerns.

Should a system-wide plan not be agreed, it was clarified that, as always, patient safety and quality would be paramount, with the financial consequences of winter pressures being a secondary consideration.

The Board was reminded that, whilst a blended block/tariff style contract was in place with the Southport & Formby and South Sefton CCGs, the contract in place with West Lancashire CCG was subject to Payment by Results (PbR) rules hence full payment for activity associated with the latter's patients should be forthcoming. It was also anticipated that Venn Consulting's final report would prove helpful in terms of supporting the Trust's requirement for between 35 and 45 intermediate care beds. The CQC's report would also be utilised to support the Trust's 'case of need'.

Citing as an example the detail provided in the Director of Nursing, Midwifery & Therapies' Assurance Report with regard to the 3 incidents referred to StEIS during July 2019, Mr Birrell suggested that it would be helpful for information such as this to also be included within the narrative for the relevant indicator within the IPR itself as this would enable Board members to more easily triangulate the information. The inclusion of precise figures wherever possible was similarly requested.

Action: Director of Nursing, Midwifery & Therapies/Chief Operating Officer/ Interim Performance Manager/Interim Company Secretary
By: October Board

The Executive Assurance Reports were noted.

RESOLVED:
The Board **received** the IPR and the Executives' Assurance Assessments

TB152/19 FINANCIAL POSITION AT MONTH 4 2019/20, INCLUDING BUSINESS CASE UPDATE

The report for month 4 of 2019/20 was received, confirming that, in month, taking into account Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRP), a deficit of £1.543M had been incurred against a planned deficit of £0.975M, resulting in an adverse variance of £0.569M against plan. Year to date, a deficit of £5.431M had been achieved against a plan of £4.889M (adverse variance of £0.543M). Reminding the Board that non-recurrent support had been included in achieving the Quarter 1 position, it was reiterated that such support would not be available in future months.

The underlying financial position had remained largely unchanged during months 1 to 4, with the deficit running at an average of £2.7M per month (without PSF/FRF being taken into consideration) and it was confirmed that, should the Trust continue to incur expenditure at this level, it would not deliver its 2019/20 control total. This slow deterioration in the run rate was of

concern and was under review in the context of agreed business cases that were now beginning to come on stream.

Key issues continuing to impact on the run rate and hence achievement of the control total were:

Agency Costs - expenditure had increased in month to £0.966M and was reflective of the significant vacancy factor in medical workforce. It was advised that NHS Improvement was looking to develop a medical staff bank across Cheshire & Merseyside and working with the Trust to help bring medical agency spend down. It was highlighted that the Trust had been commended for the reduction it had achieved on nursing agency expenditure, although occasional recourse to Thornbury remained necessary to ensure safe staffing levels.

CIP - delivery of CIP was below plan at month 4 by £0.257M, however this was a significant improvement on the Quarter 1 position, and the forecast outturn was now £5M, leaving an unidentified gap of £1.3M

Contract Arbitration – although all disputed issues had been resolve in the Trust's favour, NHS Improvement had disagreed that the Trust had given the necessary formal notification with regard to the pathway change in relation to the Clinical Decision Unit. As a result, the Trust would now only receive the full income benefit from October 2019, creating a non-recurrent pressure of between £0.4M and £0.6M in 2019/20.

In relation to cash, it was confirmed that an agreement was in place with the Southport & Formby and South Sefton CCGs whereby cash support was being provided, reducing the interest payments associated with the loans required from the Department of Health & Social Care (DHSC). It was noted that this cash support would start to be clawed back from October 2019, meaning that no new DHSC loans will be required until November 2019.

Regarding capital, it was confirmed that the Trust remained on track to deliver the 2019/20 Capital Plan signed off by the Board. Whilst there had been a number of adjustments to the plan to accommodate, for example, the programme of ward upgrades and bathroom refurbishments in the Spinal Injuries Unit discussed earlier in the meeting, these would be delivered within the Board-agreed overall capital funding envelope.

In looking forward to Quarter 2 it was advised that a similar exercise would be undertaken to that for Quarter 1 to identify any further non recurring support to assist in achieving to plan.

RESOLVED:
The Board **received** the report

TB153/19 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL REPORT 2018/19

The Board received the Emergency Preparedness, Resilience and Response Annual Report for 2018/19 providing assurance that the arrangements in place within the organisation for business continuity management and emergency preparedness were robust and confirming that, as a Category 1 responder, the Trust's 6 legal obligations under the Civil Contingencies Act 2004 (co-operation with other responders, risk assessment, emergency planning, communicating with the public, sharing information and business continuity management) had been met.

It was noted that there had been a number of incidents this year which had enabled the Trust's plans to be tested, for example the CT scanner had been out of operation on multiple occasions impacting on patient experience and reputationally, with such issues being addressed through formal meetings of the Resilience Group.

The Chairman highlighted that, as a Board, the potential impact of a 'no deal' Brexit had not been fully considered. Mr Bricknell advised that this issue had been raised previously, when it

had been believed that there would be no immediate impact, but that, in the longer term, there may be an impact on staffing. With regard to the availability of medicines, members were reminded that Trusts had been instructed not to stock pile. The Chief Operating Officer confirmed that a national conference on the impact of Brexit was due to take place shortly, following which he would ensure that feedback is provided to the relevant Assurance Committees.

RESOLVED:
The Board **approved** the Annual Report for 2018/19

TB154/19 RISK MANAGEMENT: CORPORATE RISK REGISTER

It was highlighted that there were currently 9 risks on the high level risk register. Since the last meeting, 3 new risks had been added to the Register: 1977 'paediatric dietetics', 2021 'in hospital mortality' and 2056 'missing patient appointments/ admissions'.

With regard to risk 2021 it was believed that the rating had been over-stated. This risk, around escalation for senior review, was to be reviewed by the Medical Director and it was anticipated that the risk score would reduce.

Risk 2056 had been added following the identification of a number of individual incidents where patients not on an RTT pathway (for example ward referrals) had not been tracked. External stakeholders had been notified and an improvement plan with controls and mitigating actions had been produced, with weekly meetings established and temporary additional resource put in to ensure appropriate review of this cohort of patients going forward. A technical issue had also been identified with Medway, leading to the duplication of pathways and requiring human input to close down the dormant ones.

Mr Bricknall confirmed that the Quality & Safety Committee had received an update on this and had been concerned that the number of patients not appropriately followed up may prove to be considerable. The Board would be provided with the necessary assurances once the scale of the problem had been identified. The Chief Executive expected the numbers to be small.

It was highlighted that, prior to the next meeting, a new risk relating to 'fragile services' would be added, amalgamating all relevant specialities and consequently enabling the closure of risks 1688 'inadequate staffing levels in anaesthetics', 1987 'haematology/oncology reduction in medical capacity following consultant resignation' and newly added risk 1977 'paediatric dietetics band 6'.

RESOLVED:
The Board **received** the Risk Register report.

TB155/19 ITEMS FOR APPROVAL/RATIFICATION

The Board received the new Leadership Strategy setting out the Trust's approach to leadership development over the course of the next 3 years (2019 to 2022) to deliver compassionate and inclusive leadership and create a healthy culture. This had been initially presented to, and approved by, the Workforce Committee in July 2019. It was highlighted that talent management at all levels was a key element of the Strategy, in which regard the Trust had become an early adopter of the NHS Leadership Academy's Talen Management Diagnostic Tool.

Noting the 7 key components to delivering the Strategy and the programme of internal development, the Board gave its approval, subject to the inclusion of indicators whereby success could be measured and the correction of the 1st sentence in section 5 as it was felt that this was somewhat contradictory given that leadership was necessarily and inherently hierarchical.

RESOLVED:

The Board **approved** the Strategy subject to the above amendments

TB156/19 QUESTIONS FROM MEMBERS OF THE PUBLIC

Ms Judith Wright sought clarity on the number of vacant consultant posts within the organisation. Confirming that there were currently 20 such vacancies, the key areas of challenge being in anaesthetics and radiology, reassurance was given that the Trust was utilising temporary workforce solutions where necessary to ensure a safe service and, only as a last resort, using outsourcing arrangements. It was explained that the Trust's position was reflective of the situation nationally due to the number of doctors being trained being insufficient.

With regard to the outsourcing of radiology to Telemedicine it was confirmed that this service was being provided at tariff, therefore neither the Trust nor the 'public purse' were incurring any additional costs, although the Trust was not receiving the income.

Ms Wright also queried how Telemedicine was able to recruit radiologists when the Trust could not do so. It was clarified that Telemedicine's ability to provide this service was probably a combination of being able to offer higher pay rates and utilise the expertise of both retired consultants and those based outside the UK to report on scans electronically.

TB157/19 ANY OTHER BUSINESS

No other items of business were raised.

TB158/19 ITEMS FOR FORWARD AGENDA

- Whole System Health and Social Care Economy Dashboard

TB159/19 MESSAGE FROM THE BOARD

- CQC Feedback
- Improvement in mortality performance
- Improvement in ambulance handover performance
- Recruitment of Admiral Nurse
- Feedback from Executive/Non Executive Walkabouts

TB160/19 MEETING EVALUATION

- Noise from adjoining room distracting
- Preference for no additional meetings/training sessions to take place before Board meetings
- Format of risk report and risk scoring to be revised

TB161/19 DATE AND TIME OF NEXT MEETING

08:45, Wednesday, 2 October 2019
Ruffwood Suite, Clinical Education Centre, Ormskirk & District General Hospital, L39 2AZ

Board Attendance 2019/20												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓	✓	✓	✓		✓						
Jim Birrell	✓	✓	✓	✓		✓						
David Bricknell	✓	✓	✓	✓		✓						
Ged Clarke	✓											
Juliette Cosgrove	✓	✓	✓	✓		✓						
Julie Gorry	✓	✓	✓	✓		✓						
Terry Hankin	✓	✓	✓	✓		✓						
Joanne Morgan		✓	✓	✓		**A**						
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	✓	✓	✓	✓		✓						
Anita Davenport						✓						
A = Apologies ✓ = In attendance												

Public Board Matters Arising Action Log
as at 2 October 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	Oct 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.	**BLUE**
			To provide an update via the AAA Highlight Report				**October Update**: Update will be provided within the IPR agenda item.	**GREEN**
TB127/19	July 2019	**Patient and Engagement Issues**	To provide a progress update on the refurbishment of MDT Room	**DCEO/DoS**	Dec 2019	Dec 2019	**December Update**	**GREEN**

Public Board Matters Arising Action Log
as at 2 October 2019

Southport and Ormskirk Hospital NHS Trust

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**
			Board awaiting confirmation that all actions have been completed.				**October Update:** Dr Hankin to meet with Dr Goddard/Mrs Power/Mrs Flood-Jones to sign off External Mortality Review (RAM) Project	**GREEN**
TB148/19	Sept 2019	**Vision 2020 & the Single Improvement Plan**	To identify key strategic issues within V2020 not currently subject to appropriate scrutiny by the Board and, going forward, provide formal papers for noting by the Board	**DCEO/DoS**	Oct 2019	Oct 2019	**October Update:** Review of Vision 2020 to be concluded as part of Strategy Development session prior to Christmas	**GREEN**

Public Board Matters Arising Action Log
as at 2 October 2019

Southport and Ormskirk Hospital NHS Trust

TB149/19	Sept 2019	**Quality Improvement Plan**	To undertake a mapping exercise to clarify where and how all areas for improvement are being addressed and ensure focus on continual improvement will be maintained	**DoN**	Oct 2019	Oct 2019	**October Update:** Mapping underway, pending results of CQC inspection report, which may possibly require reconsideration	**GREEN**

Public Board Matters Arising Action Log
as at 2 October 2019

NHS Southport and Ormskirk Hospital NHS Trust

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB127/19	July 2019	**Patient and Engagement Issues**	Screenshots of the refurbished MDT room to be shared with Board	**DCEO/DoS**	Sep 2019	Dec 2019	**September 2019 Update** Communications issued. Plans will be brought to the September Board for circulation. Action completed.	**BLUE**
TB148/19	Sept 2019	**Vision 2020 & the Single Improvement Plan**	To review the content of the IPR and Single Improvement Plan to remove duplication	**DCEO/DoS**	Oct 2019	Oct 2019	**October Update: Complete**	**BLUE**
TB150/19	Sept 2019	**Medical Appraisal & Revalidation Annual Report 18/19**	To provide to Mr Singh an update regarding deferrals	**MD**	Oct 2019	Oct 2019	**October Update:** Dr Hankin e-mailed record of referrals to Mr Singh. A verbal update will be provided at the meeting	**BLUE**
TB151/19	Sept 2019	**IPR**	To include additional information (eg StEIS reported incidents) and precise figures in the IPR to enable easier triangulation of information.	**DoN/COO/IPM/ICS**	Oct 2019	Oct 2019	**October Update:** Specific information is provided within the narrative of the IPR where this information is available. Every endeavour is made to be as detailed as possible in order to provide full explanation	**BLUE**

Representing the trust at an Inquest

Dr Dave Snow

Associate Medical Director

Historical Case

- Case from 2015
- Came to inquest in 2019

Particularly difficult case

- Family
- Staff

What did we do well?

Questions?

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB167/19**	**Report Title**	**Chief Executive Report to Board**
Executive Lead	Chief Executive		
Lead Officer			
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓ To Note ☐ To Receive	

Executive Summary

- Next Trust chief executive appointed
- Ormskirk hospital open day

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)*

N/A

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

CHIEF EXECUTIVE'S REPORT TO BOARD – September 2019

Next Trust chief executive appointed

I want to congratulate Trish Armstrong-Child who has been appointed the next chief executive of the Trust.

She is currently the deputy chief executive and director of nursing at Bolton NHS Foundation Trust. During her six years there, she played a key role in shaping the organisation into one recently rated by the Care Quality Commission as "good" overall and "outstanding" for leadership at all levels.

Trish qualified as a registered general nurse in 1992. She completed her training at Whiston hospital, Merseyside, and worked at other North West trusts as staff nurse, sister and matron. She went on to hold senior positions in nursing and NHS operational management, including deputy director of operations at the Royal Liverpool and Broadgreen University Hospitals NHS Trust. She joined the board of Bolton in 2013.

In 2018, Trish was awarded an honorary doctorate from the University of Bolton for her "outstanding contribution to health care". Bolton has strong links with the university and she worked with them to establish a pre-registration nursing degree. In awarding the honour, the university said she had quadrupled the places open to nursing students.

She was awarded a MBE for services to nursing in the 2019 New Year's Honours List.

I will leave the Trust on October 31. Trish's start date and interim arrangements will be announced shortly.

Successful open day at Ormskirk hospital

More than 400 visitors attended our annual open day in September which this year was held at Ormskirk hospital.

Kicking off with one of Dr Paula Briggs menopause "pop-up" cafes, the open day also incorporated our annual general meeting and a recruitment event for registered nurses.

I am especially grateful to all those staff showing off the work of their teams and departments, including theatres, radiology, maternity and paediatrics.

Unlike 2018 we were blessed with glorious sunshine which provided a splendid backdrop to the rededication of our baby memorial garden. The service was led by Trust chaplain the Rev Martin Abrams and the garden was officially opened by Rosie Cooper, MP for West Lancashire.

In brief …

Sexual health clinic opening
Staff at Sefton Sexual Health Services celebrated the official opening of their St Hugh's building clinic in Bootle. Deputy Chief Executive Therese Patten and Wendy Hicks, matron for the service, were joined by Cllr Ian Moncur, Sefton council's cabinet member for health and well-being, who marked the occasion with a ribbon-cutting. They were joined by dozens of staff and stakeholders. The Trust opened the clinic earlier this year following a £260,000 investment.

Therapy ponies
Following on from the introduction of a new policy which allows therapy animals into the Trust, we were pleased to welcome therapy ponies last month. They delighted patients in the children's department at Ormskirk hospital and the Garden of Reflection at Southport.

PLACE volunteers
Patient-Led Assessments of the Care Environment (PLACE) assessments involve local people assessing the hospital environment and how it supports clinical care. We were delighted to hear from more than 80 people following a public appeal for volunteers to help with the process. The assessments will take place over two days at both hospitals this October.

Goodbye and thank you

This is my final chief executive's report to Board before leaving to become chief executive at Wrightington, Wigan and Leigh NHS Foundation Trust.

I want to pay tribute to my Board colleagues and every member of staff for their heroic efforts moving the Trust forward over my 18 months here after what had been a number of very challenging years.

My mission was to stabilise the Trust, make it was a safe and calm environment in which to practice and receive treatment, and put it on a sustainable trajectory for improvement.

This year we have begun to see the early fruits of that joint endeavour – the huge improvement in patient mortality perhaps being the most dramatic of all.

We now have the beginnings of a solid foundation from which to chart a future course for the Trust, delivering the very best possible care for local people.

Thank you again to everyone who worked so hard to make this possible.

Silas Nicholls
October 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

October 2019

Agenda Item	**TB168/19a**	**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 August and the improvements put in place following closure of complaints in July 2019.

The numbers of complaints and concerns are decreasing; some of the same themes are coming through.

- Clinical Treatment – in particularly co-ordination of medical treatment
- Verbal communication
- Cleanliness
- Staff attitude/behaviour

The themes are subject to going improvement work within the Trust.

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

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

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

Continue to monitor complaints and compliments.

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

Previously Presented at:

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

Complaints & Compliments

August 2019

1.0 Introduction

This report provides a breakdown on the number of compliments, complaints, concerns received in the month of August, 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 Business Unit received the most compliments with 73 in total and F Ward receiving 24 compliments in the month.

Urgent Care Business Unit received 47 Compliments, with the Physiotherapy department receiving the highest number (14), followed by the Short Stay Unit (11).

Women & Children's Business Unit received 10 compliments, of which 8 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 17 formal complaints were received in August.

Urgent Care and Planned Care received equal numbers of complaints in month (6), with Ward 11A and G Ward both receiving 2 complaints in month. Specialist Services received 5 complaints, of which 2 related to Paediatric Outpatients.

The following themes were identified:

- Clinical Treatment – in particularly co-ordination of medical treatment
- Verbal communication
- Cleanliness
- Staff attitude/behaviour

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

Within Urgent Care Business Unit

- A review of medicine management competencies has taken place with additional training being implemented with staff.
- Review in place of the discharge checklist, currently does not include DNACPR as part of checklist, to be included going forward.
- Review of new agency induction processes taking place and then dissemination of processes to all permanent staff to ensure the processes are implemented when new agency staff start in a clinical area.
- Circulate lessons learned to all inpatient wards regarding need to ensure that relatives are contacted if serious changes in patient's condition or if the patient moves ward also to ensure that the communication is documented in the patient's records.
- Training on the fitting of nebulisers has taken place
- Review of processes for staff identifying and assessing patients who are not taking adequate diet and actions to be taken if concerns identified.

Within Planned Care Business Unit

- Team are working with an external provider re the provision of medication within the home for rheumatology patients, to ensure improvements going forward.
- Improvements in communication and documentation put in place with patient's relatives, with emphasis ongoing care when the patient remains as an inpatient.
- Multidisciplinary team meetings have been put in place to coordinate care going forward with full family involvement.

2.2 Concerns

There have been a total number of 39 concerns raised this month. Many were requests for information, but a total of 13 related to appointment issues or waiting times.

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

2 October 2019

Agenda Item	**TB168/19b**	**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 – April 2019

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

3.0 Appendices

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

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

Previously Presented at:

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

1.0 Mortality Report

Executive Summary

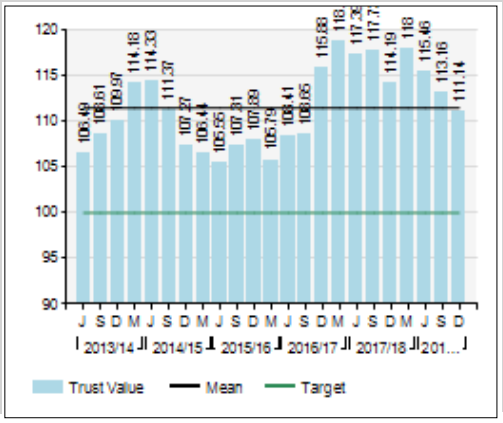
- Headline figures remain in an improved position.
- Previous work on UTI and sepsis to ensure mortality is correctly assigned may have impacted the reported UTI mortality rate as numbers are small.
- Respiratory illness is on an improving trajectory.
- Mortality screening is now at a more acceptable rate.
- In hospital deaths rose in July, but the crude rate remains at a historically low level.

Key national and local mortality indicators

	2018/19								2019/20				Target
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Rolling 12 Month HSMR	116.0	114.8	112.8	112.3	112.0	102.9	98.7	94.8					*100.0*
Monthly HSMR	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	157.8	152.8	136.6	136.6	138.1	133.0	118.4	105.9					*100.0*
Local HSMR LRTI	159.1	154.0	137.6	137.4	138.9	134.1	119.5	106.8					*100.0*
Local HSMR Pneumonia	126.2	128.8	121.7	122.1	120.1	112.6	104.8	103.7					*100.0*
Local HSMR Septicemia	87.3	87.7	89.9	89.7	90.2	81.1	79.1	80.0					*100.0*
Local HSMR Stroke	126.1	114.8	107.9	110.1	112.0	100.3	100.2	103.5					*100.0*
Local HSMR UTI	112.6	116.4	114.9	123.5	120.0	106.2	109.0	80.0					*100.0*
Local HSMR Acute Renal Failure	104.2	96.8	96.1	107.4	128.8	126.8	115.0	101.3					*100.0*
Mortality Screens - %	72.73%	58.90%	53.45%	58.82%	50.62%	63.44%	61.67%	44.44%	35.16%	31.71%	54.17%	88.14%	*90.00%*
SJRs		33.0	21.0	13.0	7.0	13.0	4.0	9.0	6.0	4.0	9.0	11.0	*0.0*
2nd Review		0.0	3.0	2.0	0.0	2.0	1.0	0.0	0.0	0.0	0.0	0.0	*0.0*
In Hospital Deaths	66.0	72.0	59.0	69.0	81.0	94.0	60.0	72.0	91.0	82.0	48.0	60.0	*77.0*
In Hospital Deaths Crude Rate	21.1	22.2	17.4	20.6	24.4	27.4	19.2	21.5	30.1	25.6	16.0	17.7	*31.0*
LD Deaths	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	*1.0*
Steis Incidents	8.0	1.0	10.0	2.0	3.0	4.0	6.0	3.0	4.0	5.0	5.0	6.0	*5.0*

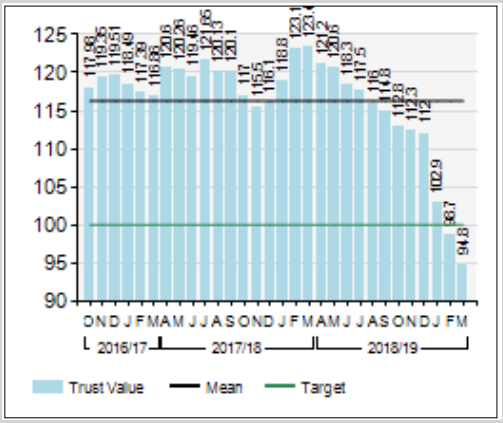
Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

SHMI - Summary Hospital Level Mortality Indicator



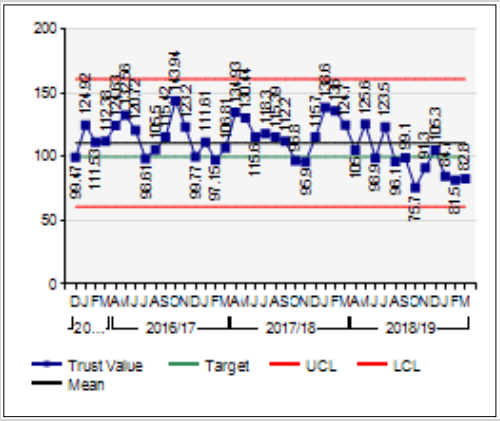
The SHMI in the current report is above the target level of 100, although this is within confidence intervals, which means that our mortality rate as measured by the SHMI is within the expected range. This has been achieved by ensuring that there is enough staff to cope with the amount of and severity of patient illness, the focus on improving flow in the organization, the creation of a nursing team to identify and prevent deterioration and by working to ensure our care is accurately recorded in the case notes and accurately coded.

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



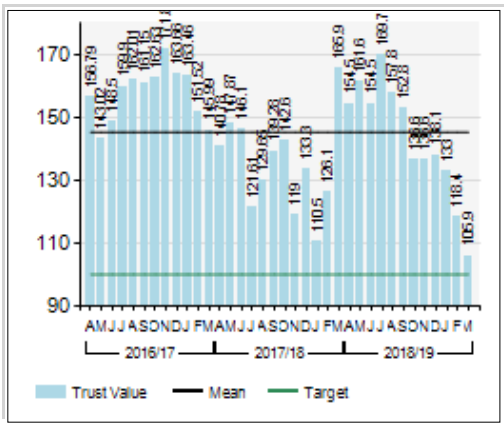
See SHMI. The work on improving SHMI also improves HSMR.

HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



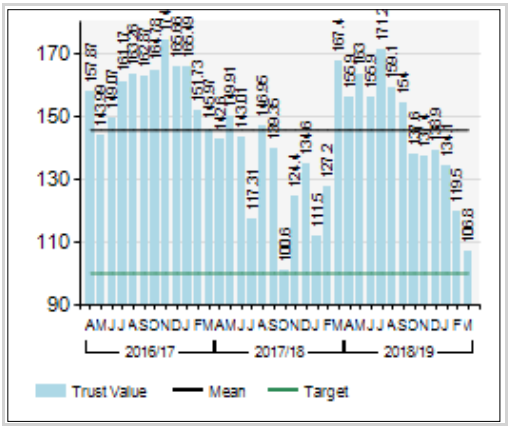
Monthly HSMR is also affected by the same factors as rolling HSMR. This is within tolerances.

Local HSMR Bronchitis



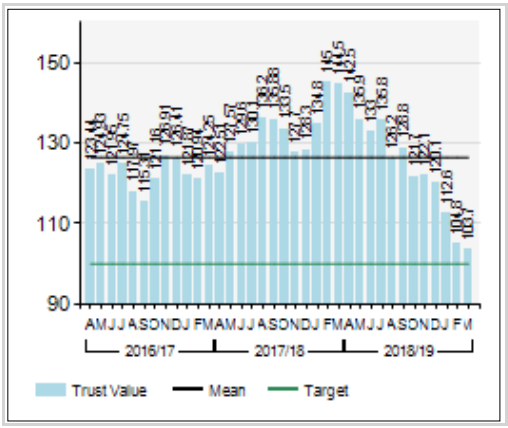
The HSMR around bronchitis is on an improving trajectory. This is being led by improving the diagnosis. Ie, identifying the deterioration of the chronic underlying condition rather than the often minor infection as the primary condition being treated. Also ensuring that significant infection with organ failure is identified as sepsis rather than simple infection.

Local HSMR Lower Respiratory Tract Infection



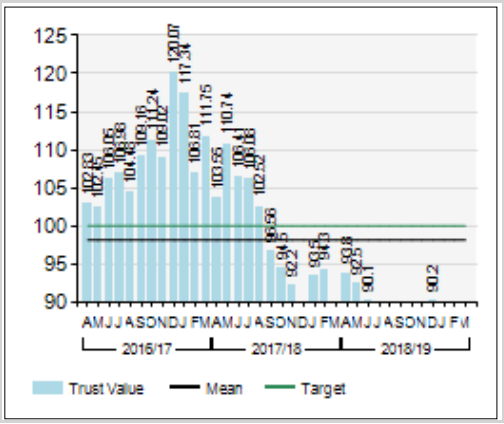
LRTI and Bronchitis are considered together in this report.

Local HSMR Pneumonia



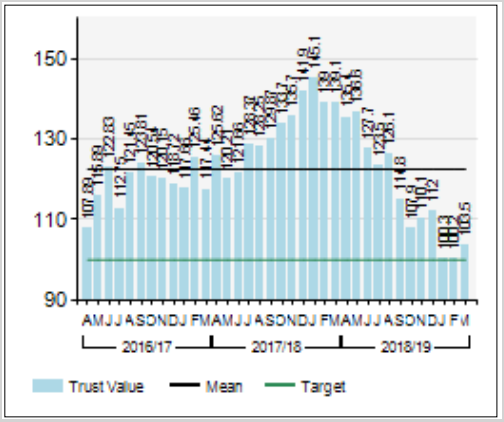
The HSMR for pneumonia is on a continual improving trajectory. This again is being driven by ensuring the diagnosis is accurate by early senior review by improved processes at admission. This ensures that patients are on the correct treatment pathway. Pneumonia occurs in patients with significant medical co-morbidity and this, if recorded correctly will give a more accurate picture of the mortality due to pneumonia.

Local HSMR Septicemia



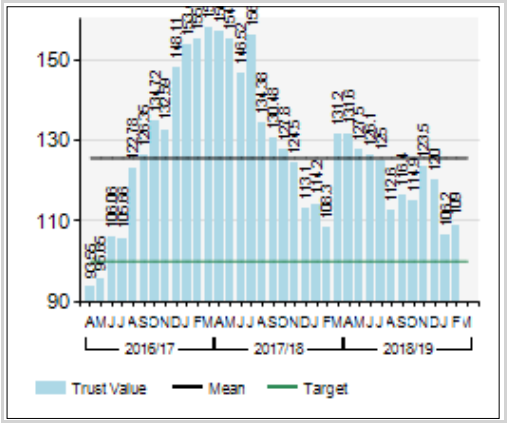
The HSMR for sepsis remains at an acceptable level. This is due to the work done to embed sepsis and the sepsis pathway as a standard response to patients deteriorating with infection. The Critical Care Outreach Team are regularly identifying patients with sepsis that have not responded to initial treatment and ensuring they are referred to critical care promptly where early organ support can be instituted.

Local HSMR Stroke



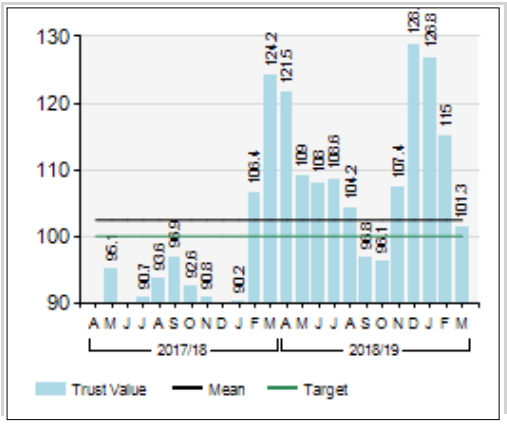
Stroke mortality has seen a significant improvement. This has been achieved by improvements to flow ensuring acute stroke patients are cared for in the appropriate place by the appropriate teams. Stroke mortality rates are also improved by the collection of accurate data on co-morbidity as stroke frequently occurs in patients with other co-morbidity such as Atrial Fibrillation.

Local HSMR Urinary Tract Infection



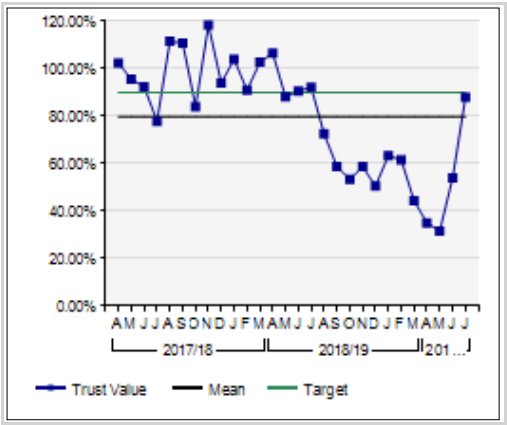
Urinary tract infection is s significant problem in the hospital and the local area due to the immobility and incontinence suffered in an elderly population. Efforts to both maintain mobility and continence are expected to reduce rates of infection and subsequent de-conditioning and mortality. Improved catheter care and increased removal of catheters when no-longer required are also important projects, as are improvements in nutritional care.

Local HSMR Acute Renal Failure



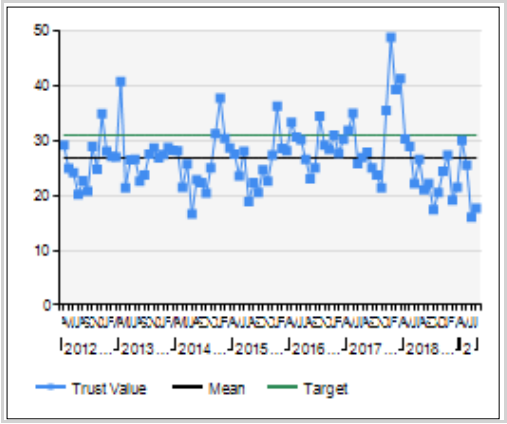
The AKI steering group meets on a monthly basis to devise improvement strategies for AKI. This is based on performance on the AQ standards. Measures put in place already such as e-mail alerts, the AKI pathway and automated alerting of pharmacy to AKIs is expected to improve the responsiveness of care. The impact of this work on mortality rates should be seen in reports approximately three months hence.

Mortality Screens - % Deaths Screened



Mortality screening has returned to an appropriate level after the deployment of iPads in the bereavement suite. This has allowed fast, reliable access to the system by certifying medical practitioners. Any unscreened patients are followed up in order to further improve screening rates.

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



Crude mortality remains in a historically improved position, with a smaller degree of variation, which is often seasonal. This may reflect the investment in staffing during the previous winters pressures moderating the seasonal spike.

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

External Mortality Review (EMR) & RCA Cases Action Plan

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 24th September 2019
Patient Flow	EMR Action 1	Improve Patient Flow	Improve patient flow so that patients requiring admission do not have to wait for an appropriate bed and are not nursed on corridors. Focusing on:	Patient Flow Improvement Programme (Feeding into RAM 2 'Appropriate Assessment & Admission')	Executive Lead: Chief Operating Officer	Nov-18	Mar-20	25%	G	The Patient Flow Improvement Programme (PFIP) is made up of four workstreams: 1. Improve Emergency Department and Assessment Units Services 2. Standardisation of Best Practice Ward Processes (to reduce length of stay) 3. Surgical Ambulatory Emergency Care Improvement Project (in association with NHSE AEC) 4.Improving Patient Flow Pathways (with Strata Patient Flow Networking Solutions) 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					20%	G	Strata Health (patient flow network solutions) is working with both the Trust and community partners to investigate system solutions to improve patient flow and ensure the most appropriate streamlined referral systems in line with refined pathways for our patients. Workshops have now been held with the Trust and community partners to map pathways for: 1. Care Act Notification to Social Care 2. Frailty Pathway / Comprehensive Frailty Decision Tool 3. Discharge to Assess 4. Ambulatory Care Pathways Further meetings are to be held in September to refine the pathways and finalise the immediate and long term activities required to deliver electronic improvement solutions as soon as possible. Community partners will be joining Trust teams for the A&E Community Stakeholder Meeting, End to End Process Mapping Meeting, Additional Pathways Scoping over the next month.
		b. Criteria led discharge	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.					40%	A	A key objective of 'Length of Stay Work Stream 2' 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.
		c. Proactive escalation planning	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.					80%	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 The PDSA Quality Improvement activity on Ward 9A is still underway to increase observations in line the policy to 95% . 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.					90%	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. In line with NHSI best practice, 'Red to Green' multidisciplinary Board Rounds are held daily to confirm the tasks, tests and proceedures required to progress each patient to appropriate, safe and timely discharge. Discharge Facilitators are to attend both the Red to Green Board Rounds and Clinical Board Rounds to support communication and continuity.

External Mortality Action Plan, Board Assurance Report – Page 2

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 24th September 2019
Correct Pathways of Care	RCA Action 1	Improve Delivery of Pathways of Care	Ensure that pathways of care for key causes of clinical deterioration are; up to date, available, clear and used across the organisation. These must include Sepsis, Pneumonia and AKI. Training gaps on these processes for doctors and nurses must be identified and closed organisation-wide, to include the basic investigative and therapeutic strategies for the first hours of care and criteria for referral.	Reducing Avoidable Mortality 2 'Correct Pathways of Care'	Associate Medical Director of Patient Safety	Mar-18	Ongoing until end of project March 2020	40%	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. Clinical and Clinical Audit teams members representation Trust is attending the AQUA Detection and Response Collaborative on 11th October 2019. The event will involve presentations and workshops about deterioration, quality improvement and service redesign for the treatment of pneumonia, sepsis and Acute Kidney Injury.
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. The findings of the re-audit in August will be reported here once they have been received along with an assessement of the impact of the changes put in place.
	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 meeting to assess the pilot on Ward 10A (Medical Ward) is arranged for Friday 27th September 2019. The findings will decide the next steps either for further development or roll out. 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).

External Mortality Action Plan, Board Assurance Report – Page 3

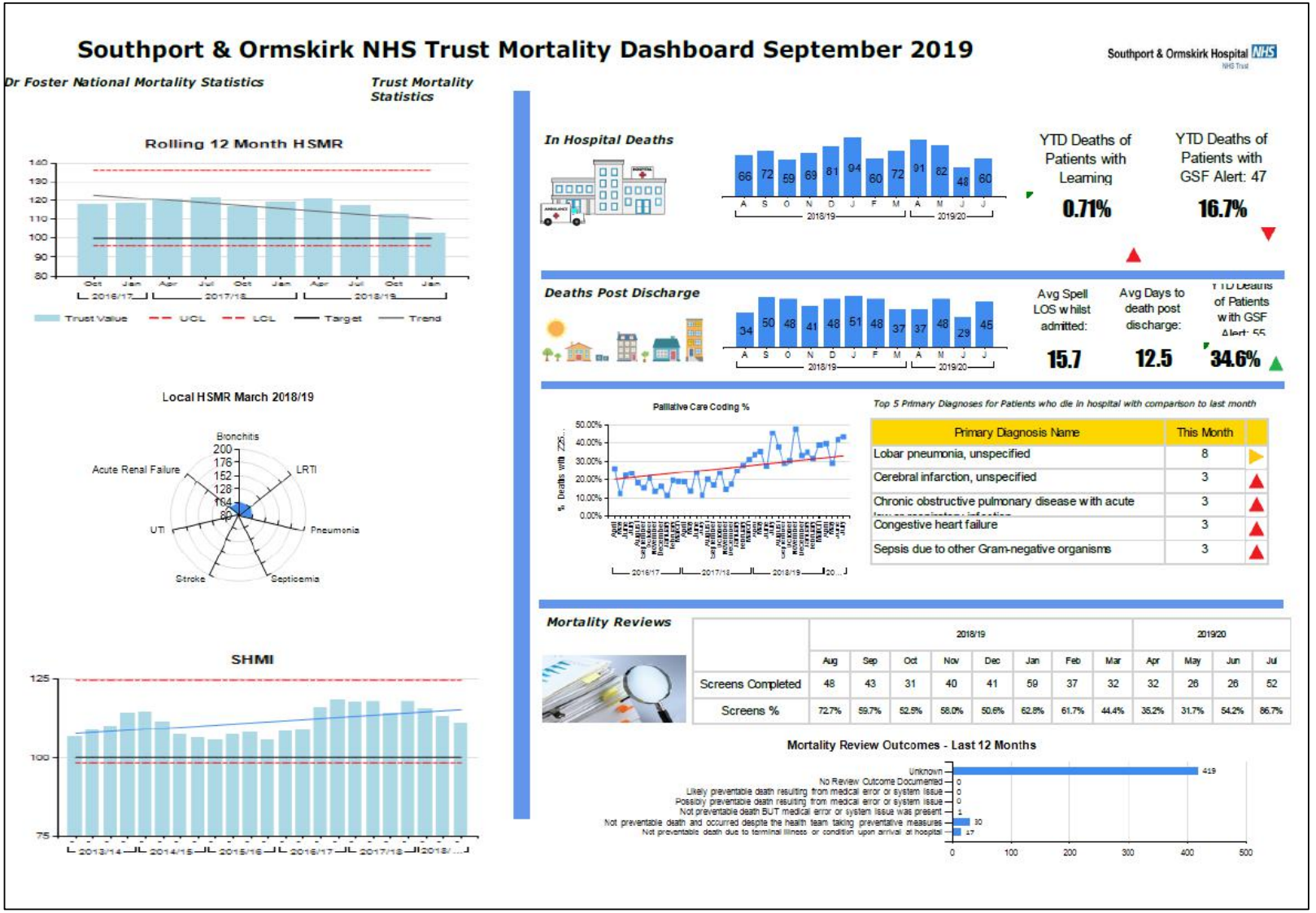
	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 24th September 2019
Documentation & Observations	EMR Action 5	Review Standards of Documentation	Review standards of documentation to ensure that staff always sign and date their entries and that handover of care is clearly documented including the responsible Consultant.	Documentation' Project (May 2019) Feeding into RAM 2 ('Observations & Documentation')	Deputy Director of Nursing	Apr-19	Mar-21	7%	R	New programme management is being assigned to the Trust's Documentation Project in order to ensure that the scope of work considers all of the long term requirements for medics, nursing and therapies in line with the IT Roadmap. 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. To date, a 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.
	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	40%	G	As part of the NHSI Quality Improvement Programme, a PDSA improvement cycle has been undertaken on Ward 9A (Short Stay Unit); **to review and improve the way that observations are taken, documented and reviewed**. Findings were presented at the QI Celebration Event at Southport on 12th September. More work is required to ascertain whether clear improvement is being made; once the most successful methods have been identified, the approach can be rolled out across other wards. 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. 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.
	RCA Action 5	Physiological Monitoring Process	Implement the RCP/NICE NEWS2 physiological monitoring process, with clear pathways for the monitoring and escalation of elevated scores to senior decision makers. This must include a regular senior review of the appropriateness of escalation			Jan-19	Jun-19	80%	G	

External Mortality Action Plan, Board Assurance Report – Page 4

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 24th September 2019
Future Care Planning	EMR Action 10	Ensure prompt commencement of well documented individual end of life care plans	Ensure that individual end of life care plans are commenced promptly and that the care plans are well documented including preferred place of care. Consider wider use of Emergency Health Care Plans to prevent readmission for patients approaching the end of their life.	RAM 1 & RAM 2 ('Future Care Planning')	Medical & Education Director, Queenscourt Hospice	Sep-18	Mar-21	30%	A	Members of the Reducing Avoidable Mortality and the Older People's Care Project Groups are collaborating on Future Care Planning activity; in particular the cultural shift towards proactive Anticipatory Clinical Management Planning and a system wide approach to Care Management Plans. Strata Healthcare has presented a potential solution to deliver a single electronic portal for Advanced Care Plans for patients which could be shared across all local health care providers; this is currently being worked up with representatives from the Trust, Social Care and the CCGs as part of the Strata Frailty Pathway. A targeted training programme is being developed as part of the Future Care Planning workstream of the Older Peoples' Care Programme. The findings of the National Audit of Care at End of Life are informing and supporting the case for Advance Care Planning and the Anticipatory Clinical Management Planning model.
Learning from Deaths	EMR Action 11	Robust mortality review process with central reporting with a focus of disemination of learning from deaths.	Ensure development of a more robust mortality review process with central reporting. There should be an emphasis on dissemination of learning from deaths across all specialties with involvement from medical, nursing and allied healthcare professionals. and including colleagues from Primary Care.	RAM 2 ('Future Care Planning')	Associate Medical Director of Patient Safety with Associate Director of Integrated Governance	Jul-18	Mar-20	50%	G	The Screening of deaths increased from 32.9% in May to 89.8% in July. This high level of screening was carried through into August when 84.6% of deaths were reviewed. The increased compliance is attributed to improved access to IT and effective communications. The AMD for patient safety has been meeting with leads from each department to discuss barriers to the completion of SJRs. Recognition of those likely to be dying increasing - 59% had an individual plan for the care of those thought likely to be dying developed with them and those important to them (2018/19). Documentation of individual plans for care of those thought likely to be dying improving, but still a long way to go - education is ongoing. 66% people who die in hospital have documented preferred place of care and for these 70% achieved it by dying in hospital (2018/19). 127 people who PPC was not hospital were transferred in the Rapid End of Life Transfer process when dying was recognised and acheived their PPC. (2018/19). Members of the Reducing Avoidable Mortality and the Older People's Care Project Groups are collaborating on Future Care Planning activity; in particular the cultural shift towards proactive Anticipatory Clinical Management Planning and a system wide approach to Care Management Plans.
	RCA Action 6	Mortality & Morbidity Reviews must occur in departments with evidence produced of agreed actions and improvement projects	Mortality and Morbidity review must occur in departments with evidence produced of agreed actions and improvement projects, as defined by the cases presented. These improvements, generated by clinical teams, must have evidence of review by CBU and senior management to demonstrate openly how change is supported.			Jul-18	Mar-20	50%	G	Learning from Deaths is a standalone work stream in the newly revised Trust Mortality Project; Recognition and Care of the Deteriorating Patient. The overriding objective is to ensure the most effective dissemination of lessons learned with assurance that learning has been embedded. A structure has been agreed in principle to identify a governance lead clinician in each CBU to drive to M&M processes and identify the key work streams for improvement which will in turn be reported to the Mortality Operational Group. A monthly lessons learned bulletin cascades the general lessons from Level 2 Structured Judgement Reviews that are escalated to MOG. The Associate Medical Director for Patient Care is working with the Clinical Lead for Education to incorporate lessons learned dissemination through the junior doctors training programme. The AMD for Patient Safety, Clinical Lead for Education and Head of Risk are to meet to discuss the development of best practice.
Specialist Services	RCA Action 7	Management of Diabetes	Review and update the trusts policy and approach to the management of inpatient diabetes. Ensure available, clear guidance exists for the management of diabetic emergencies and that appropriate patients are identified and referred to the inpatient diabetic service. Resource and support this service to provide the necessary support to clinical teams.	Tbc	CD Medicine / AMD of Urgent Care	Apr-19	Mar-21	50%	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	30%	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.

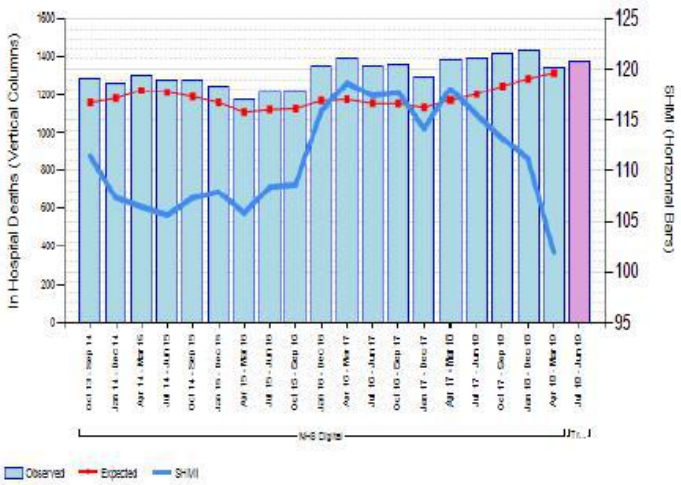
3.0 Appendices

Appendix 1: Mortality Dashboard – Reporting Month September 2019 for Reporting Data July 2019



SHMI Breakdown

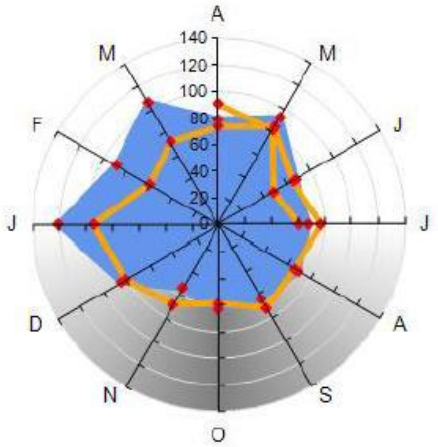
Southport & Ormskirk Hospital NHS



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.

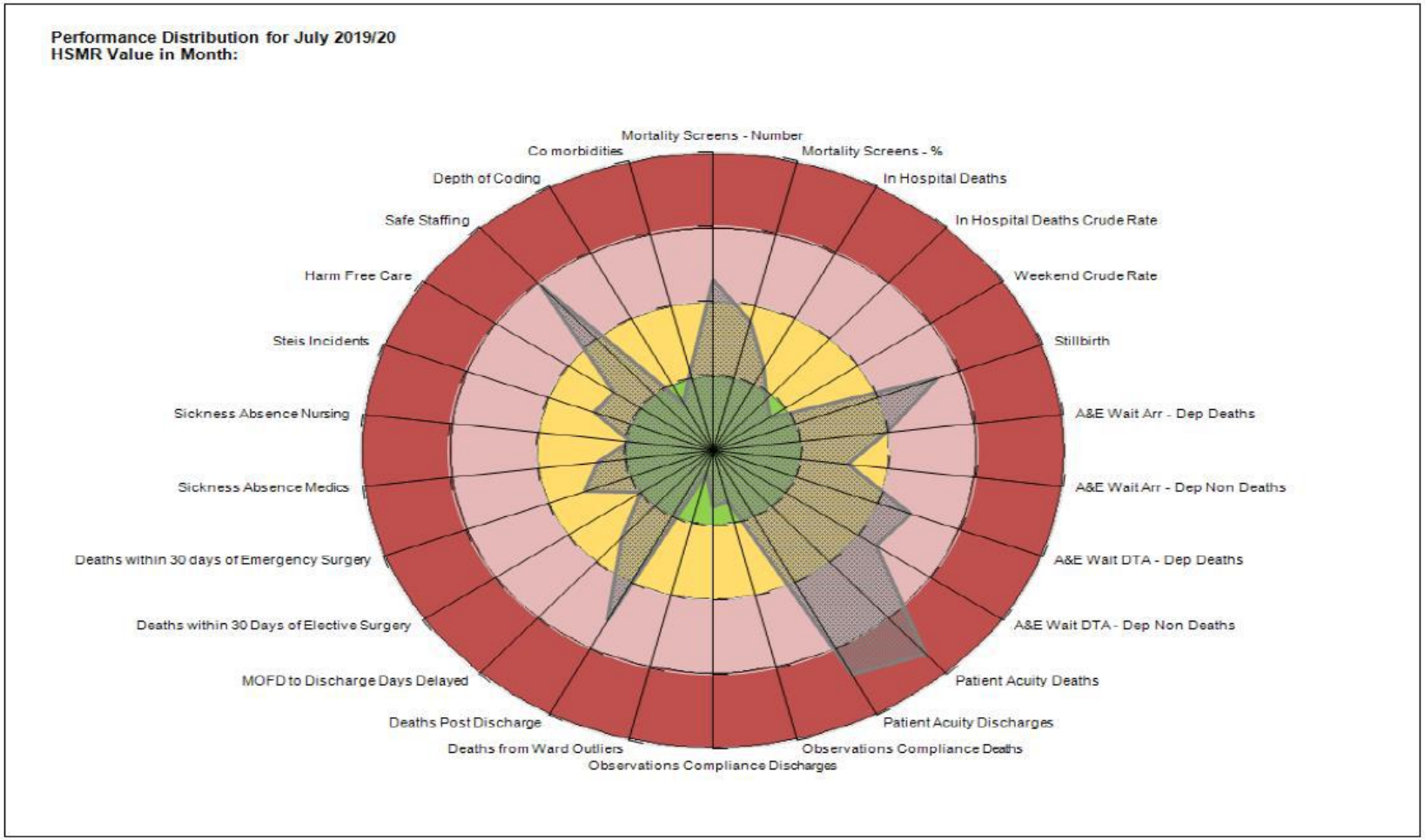
In Hospital Deaths Seasonality Distribution



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, July 2019



Performance Measuring

For each indicator the mean, upper and lower control limit are calculated in accordance with statistical process control methodology (Mean +/- 3 Sigma). The gauge represents the performance of the trust value being displayed within these parameters (green = lower control limit, red = upper control limit).

If the indicator is nearer to the green this means that performance is **better** compared to usual, if the indicator is nearer to the red it means performance is **worse** compared to usual.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB168/19c**	**Report Title**	**Quality Improvement Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Paul Jebb, Deputy Director of Nursing Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper provides 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 ✓ Responsive ✓ Safe ✓ Well Led	☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ✓ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
Board of Directors to note the report and next steps	
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 OCTOBER 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

In addition to the four identified Trust Quality Priorities, another four quality areas have been identified and are reported to Hospital Improvement Board (HIB) based on the Vision 20/20 Single Improvement Plan (Appendix A), this outcomes include

- Clinical Workforce Development (incorporating clinical education, medical staffing numbers and professional standards)
- Quality Standards Compliance (Quality Improvement and CQC preparation and delivery of Quality Improvement Plan)
- Patient Experience and Engagement
- Safeguarding (Improve training compliance and documentation regarding MCA and DoLs)

3. NEXT STEPS

The IPR continues to be developed this will include the KPIs included in the Quality Improvement Strategy which were agreed by the Improvement Work stream Leads, this will also be incorporated into the Performance and Accountability Framework.

Currently the IPR contains a number of Quality Strategy KPIs which will be supplemented by additional indicators relative to the four Quality Priorities that are not currently included. Due to the refresh of Vision 2020 and recent agreement of four Quality Priorities the

supplementary report containing progress on KPIs and progress against plan is also being refreshed.

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:

Frailty Model
Internal Business case approved - recruitment commenced, group established meeting every 3 weeks to drive this. The group has 3 main pieces of work:
1. Establish the plan for development of a Frailty Assessment Unit.
2. Develop the plan for establishing a ward model based on ward 35.
3. Manage the recruitment and implementation of the business case.
This group will report into PFIB. S&F Care Home Forum- a provider and manager forum has been established, parallel to this we are developing 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
Malnutrition in adults' policy approved and launched on the Intranet.
Training E-learning BAPEN Module available on ESR being launched in parallel with the ward roll-out of the new care plan, training also being delivered on the Older Peoples Care Training Programme, with over 150 people due to have attended by the end of November. Business Intelligence is working on a new collection of KPIs to measure and monitor improvement which is viewable now in draft form to be finalised imminently.
New NOF Pathway approved and in use including the provision of Ensure Plus Advance post-operatively (needs to be reviewed and audited)
The Mouth Care Matters Group have started drafting the mouth care policy using the HEE template, this will be sent to the PRG for approval by the end of September. Products have been reviewed and a select list adhering to the guidance in the new policy and care plan have been agreed and these are all available on NHS supply chain for wards to order. The new care plan is in second draft and will be rolled out for a trial on ward 14B starting on 30th September. Following this any further changes required will be made and the roll out will then continue across the Trust and a roll out plan will be shared.
Hydration management education delivered in Older Peoples Care Training Programme, further work to be developed when Ward Catering Assistants are in post and a review of fluid balance charts / intentional rounding to be done by the Documentation group.
NG Group established, process mapped for best practice, wider stakeholder group have been invited to check and challenge on the proposed new process. Suppliers have been invited into the next session in October to demonstrate their offerings.
Ward roll out plan established, 10B has rolled out the new care plan and education and performance is improving demonstrable in the MUST completion within 24hours, with monthly feedback provided to the ward manager and matron. Roll out has been paused until the new dietetic lead comes into post on 1st November.

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 launched and being rolled out. Currently on all wards at SDGH except SIU and ITU and expected to have rolled out across the Trust by the end of September 2019 except for ITU and SIU. BI are

creating a dashboard to demonstrate improvements and re-programme the feed for the quality contract and FAIR reporting nationally as we are transitioning from vitalpac to paper and a medway proforma, expecting to see the impact accurately following the full roll-out.
Draft pathway for 24 hour care remains in final draft form, we are awaiting confirmation on who will be reviewing the patients discharged with a 'resolving delirium' before we cna launch the pathway. 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 have all been appointed to and we await start dates.
Ward resource pack developed in draft now being costed up and charitable funds bid will be submitted in October 2019.
Environment in circulation areas to be made dementia friendly as part of the refurbishment, charitable funds bid required for work in patient bays to be developed further once Dementia and Delirium Team are in post.
Family, Carer and Relative support to be developed in partnership with Michelle Kitson when the Dementia and Delirium Team are in post. Enhanced communication and refreshing of John's Campaign to be encompassed - target team starting date December 2019.
Nutrition and Hydration finger menu launched and to be reviewed and development of a pictorial menu required, awaiting new Dietetic Lead starting in post November 2019.

Continence
Group established, met and scoped out work to be done the next meeting will be held 30/9/19. Company reps have been contacted to plan a review of available products and these recommendations will be made with the group in the new documentation. Specialists within the community are supporting this piece of work.
Continence management SOP to be developed
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.
Champions to be established and an 'offer' to be developed
New Assessment and Care Planning Documents to be developed
Onward referral process and pathway to be established and appropriate documentation/comms to be created
Information and resources to be developed by group
Continence assessment to be incorporated into Therapy and CGA Frailty Assessments.

End of Life Care
150 members of staff have completed a questionnaire about their knowledge and confidence and is pulling together themes form these to steer education offers and an education strategy which will link with the accreditation system- The Team from Queens Court are delivering a 1.5 hour session monthly as part of the Older Peoples Care Training Programme.
Ward accreditation scheme – we are working with QCH to develop an accreditation scheme to measure wards against a range of elements which would ensure and assure on the delivery of excellent end of life care. The process of accrediting is expected to take the whole of 2020, however we are hoping to agree a start date when we meet in October.
A piece of work exploring DNACPR completion has begun, with a view to looking at a rolling education session for medics on the process, legalities, risks and feedback

form themes once reviewed.

Falls
Policy approved and uploaded
Falls Strategy is being developed with a view to launch in November.
Risk Assessment part of the bundle and care plan, currently on all wards at SDGH except SIU and ITU and expected to have rolled out across the Trust by the end of September 2019 except for ITU and SIU.
Bundle currently on all wards at SDGH except SIU and ITU and expected to have rolled out across the Trust by the end of September 2019 except for ITU and SIU
Post- Falls Assessment proforma developed by Doctors, checked and challenged, amendments being made will combine one form for Nursing and medics post-fall going forwards, to be reviewed at falls group meeting September 19.
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.

Care of the Deteriorating Patient:

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.

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.

One of the objectives of Work Stream Two 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

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 support escalation of the deteriorating patient.

A final evaluation of the pilot on Ward 10A (Medical Ward) is planned for September. 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).

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.

Members of the Reducing Avoidable Mortality and the Older People's Care Project Groups are collaborating on Future Care Planning activity; in particular the cultural shift towards proactive Anticipatory Clinical Management Planning and a system wide approach to Care Management Plans.

A targeted training programme is being developed as part of the Future Care Planning workstream of the Older Peoples' Care Programme. The findings of the National Audit of Care at End of Life are informing and supporting the case for Advance Care Planning and the Anticipatory Clinical Management Planning model.

A replacement Band 7 Diabetic Specialist Nurse has been recruited and is due to start in a full time capacity in October

Infection Prevention and Control (IPC):

MRSA bacteraemia reported in August on ward 9B/FESS and the patient was successfully treated and discharged to home, unfortunately this was the first MRSA bacteraemia in 23 months. An RCA has been completed and learning identified include:

- Start MRSA suppression treatment on admission if patient known to have history of being MRSA positive
- Staff accessing the patient's record on Medway need also to access the patient's Medway alert which is clearly visible on the front page of the patient's electronic record
- If treating for infection and has a history of being MRSA positive then prescribe antimicrobials that cover for this organism as well common organisms related to probable source of infection
- Doctors, nurses and pharmacists all have a role to play in ensuring that appropriate treatment for MRSA is prescribed whether for suppression treatment, or when treating for an infection

Clostridium difficile
The Trust target for the year as set by NHSI is for no more than 16 cases this fiscal year; this year the definitions for Trust attributed cases has changed from after 3 days to after 2 days being attributable to the Trust, also if a patient has been discharged and is tested by the GP and is positive then this is attributed to the Trust if the patient was an in-patient within the last 28 days, to date the Trust has had 14 cases. In reviewing the C diff cases common issues include rapid isolation of patients complaining of diarrhoea symptoms and urgent acquisition of stool samples

E coli bacteraemia
In reviewing April to August last year to April to August this year the Trust has had one less case. One of the main causes of E coli bacteraemia is urinary tract infection with some of these being related to catheters. Methods for reducing these infections include increasing hydration and reducing catheter usage. The Trust is continuing to work towards improving the nutrition and hydration of patients and the IPC team are monitoring and providing education on catheter use

Device related bacteraemia
In August 2 cases of cannula related bacteraemia were noted. The IPC team have been monitoring the documentation of cannulae and identified that the documentation of cannulae is not robust and have therefore established a task and finish group to determine how this can be improved

Isolation room signage
All side rooms on the Southport site and on wards G & H on the Ormskirk site have now got permanent isolation signs that can be changed dependent on whether isolation is required or not. In July 61% of side rooms had appropriate signage with the doors closed in August 96%. This is something the IPC team will continue to monitor

Contaminated blood cultures
From April the percentage of contaminated samples has ranged from 4.82-7.52% with the most recent result being 6%. There is acceptance that blood culture contamination can occur, however this should not exceed 3%. The Consultant Microbiologist has provided a blood culture policy and the laboratory continue to provide blood culture packs with a pictorial guide and the A&E practice education facilitator has produced an education pack which is being rolled out as a train-the-trainer resource

Catheter care plan audit
Catheter care plan audits were commenced by the IPC team in July and August, the results of the initial audit in July was poor with only 51% of patients with catheters having a care plan; in August this improved to 64%
Part of the audit was to verify that a daily review had occurred to record whether the catheter was still needed – the less time a catheter is in place then the less chance of an infection occurring. In the initial audit only 16% of care plans had been reviewed; this increased to 36% in August.
The IPC team to continue to provide formal education as part of annual mandatory training as well as ad hoc training when conducting audits and will feedback to Matrons

Spinal Centre refurbishments and deep cleaning
The centre has a lack of isolation facility, hence work was ongoing in room 1 (acute respiratory care area) to provide 2 isolation cubicles and a bathroom. This work has now been completed and these areas are now in use. The centre was also identified as having an increased incidence of patients colonised with Gentamycin resistant ESBL producing Klebsiella pneumoniae. Subsequent to this IPC inspections identified cleaning issues with some of these issues being associated with the degradation of surfaces due to general wear and tear. Hence the inpatient area has been going through a process of refurbishment and cleaning specifically with respect to patient rooms and bathrooms. This process has been overseen by local partners from PHE and the local CCGs in collaboration with NHSI and NHS England who have been informed of our progress. The national IPC lead for PHE has also been involved in this process and will be returning for a further visit in September. Completion of the work is due to finish at the end of September. The trust needs to ensure that following completion that sufficient domestic staff are allocated to maintain the refurbished environment

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.

Plans were developed for immediate, 30 days, 3 months and 9 months. These plans are progressing with the:

- Immediate plan completed and all actions are blue.
- 30 day plan completed and 1 action in blue, other actions in green
- 3 month plan progressing well with three areas in red relating to audit of

prescription only supplements to be completed the development of a pharmacy dashboard and pharmacy performance reviews.
9 month plan is also progressing with one are blue and two area red relating to triangulation of audit programme and the development of a pharmacy and medicines optimisation plan

The CQC and NHSI noted concerns re the Model Hospital data and shortfall in Pharmacy staffing levels. A business case has been developed and is scheduled for QIA on 1.10.19 with the COO requesting that this be taken forward ASAP once through the QIA process.

The Trust has confirmed its wish to obtain funds for ePMA from NHS D /X and await a decision by the end of September.

4. QI TRAINING

The celebration event on 12th September to report on the QI projects that have been worked on throughout the recent training, has been held and work continues to develop our QI approach

5. CONCLUSION

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

6. RECOMMENDATION

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB168/19d**	**Report Title**	**Monthly** Safe Nurse & Midwifery Staffing Report – August 2019
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 August 2019 is set out below:

The purpose of this report is to provide the Board with the current position of nursing staffing in line with National Quality Board, National Institute of Health & Care Excellence and NHS Improvement guidance. The report includes as a comparable metric, Care Hours per Patient Day (CHpPD) which supports the recording and reporting of nursing and care staff deployment.

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

Alert

- For the month of August 2019 the Trust reports safe staffing against the national average (90%) at 87.04%.

Advise

- The draft Clinical Indicators Dashboard data unavailable prior to the production of the committee report and will be tabled.
- CHpPD reporting remains under review to support accuracy of data reporting. Trust CHpPD reports at 8.7

Assure

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

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

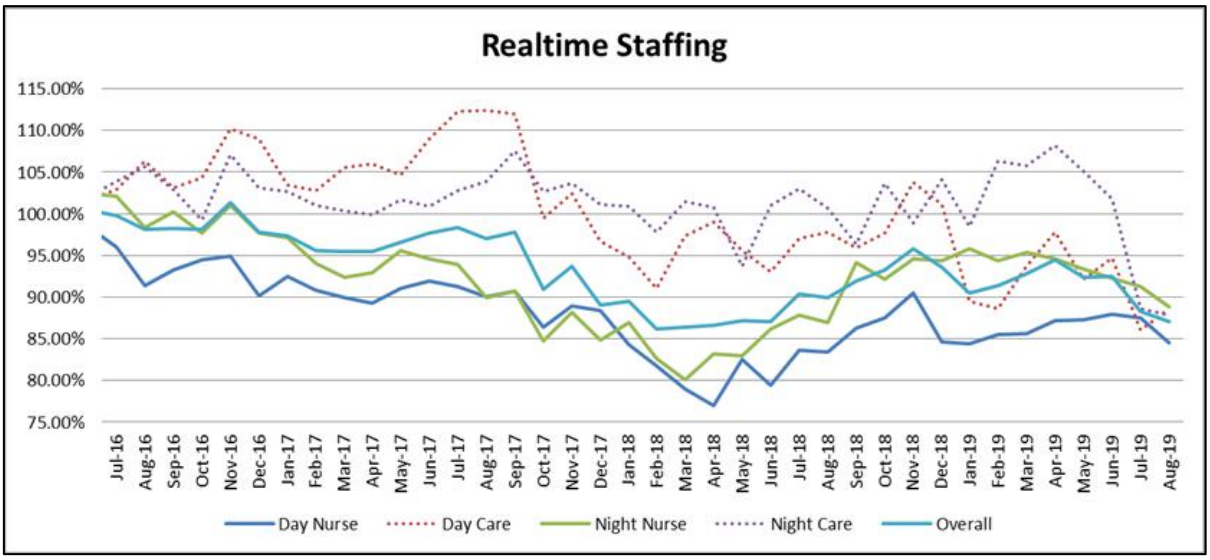
For Information: Literally, to inform the Board

1. Introduction

This report provides an overview of the staffing levels in August 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 August 2019 was 87.04% (appendix 1).

- 84.47% Registered Nurses on days
- 88.78% Registered Nurses on nights
- 88.56% Care staff on days
- 87.85% Care staff on nights



The overall CHpPD for the Trust has decreased in month to 8.7 hours (appendix 1) and remains slightly above the national average of 7 hours CHpPD, The Trust current reporting for CHpPD includes Registered Nurses/Registered Midwives and healthcare assistants, it is anticipated that in the future where Allied Health Professionals, such as Physiotherapists are included in a ward establishment (and e-roster) that they will also be included in the care hours per patient day reported.

Planned care clinical business unit (CBU) report overall 10.1, Urgent Care CBU 6.2 and Women's and Children's 23.2 overall. Further scrutiny into the CHpPD identifies H ward and maternity sitting outside national measures within model hospital, reflected in the ward/department activity which undertake large amounts of day case type activity and high throughput or community activity.
The month of August has highlighted a deficit in the reporting mechanisms associated with the Trusts Allocation on Arrival flexible staff group and redeployment to areas worked. The business intelligence and rostering teams are reviewing trust processes to assure future shifts are "resource balanced" timely. This means the registered nurse or healthcare worker who has moved from the allocation area to a ward area will be showing in the actual figures for that area they are supporting. This will also reflect in the Trust overall fill rate.

2. August Safe Staffing

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

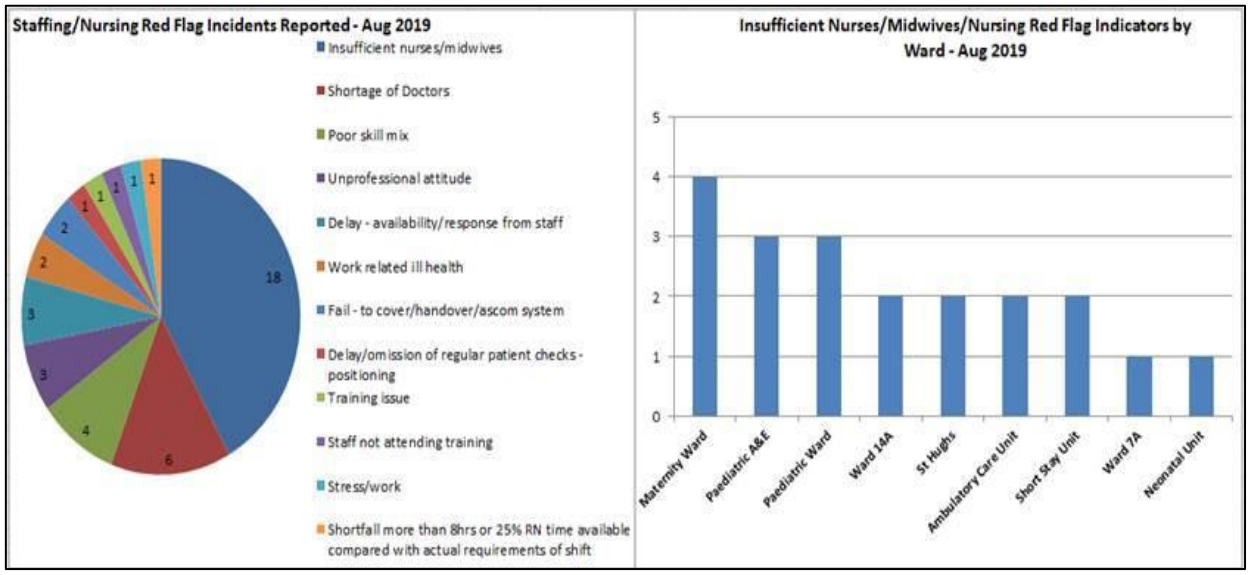
	Funded WTE	Contracted WTE	Vacancy
Registered	947.11	786.57	160.84
Non-registered	444.00	360.06	83.94
Total	1,391.41	1,146.63	244.78

Active recruitment to posts is in place with 29 Healthcare assistants due to start between now and October subject to notice periods and recruitment checks. A further 21 Care Support Workers have been recruited jointly with NHSP.

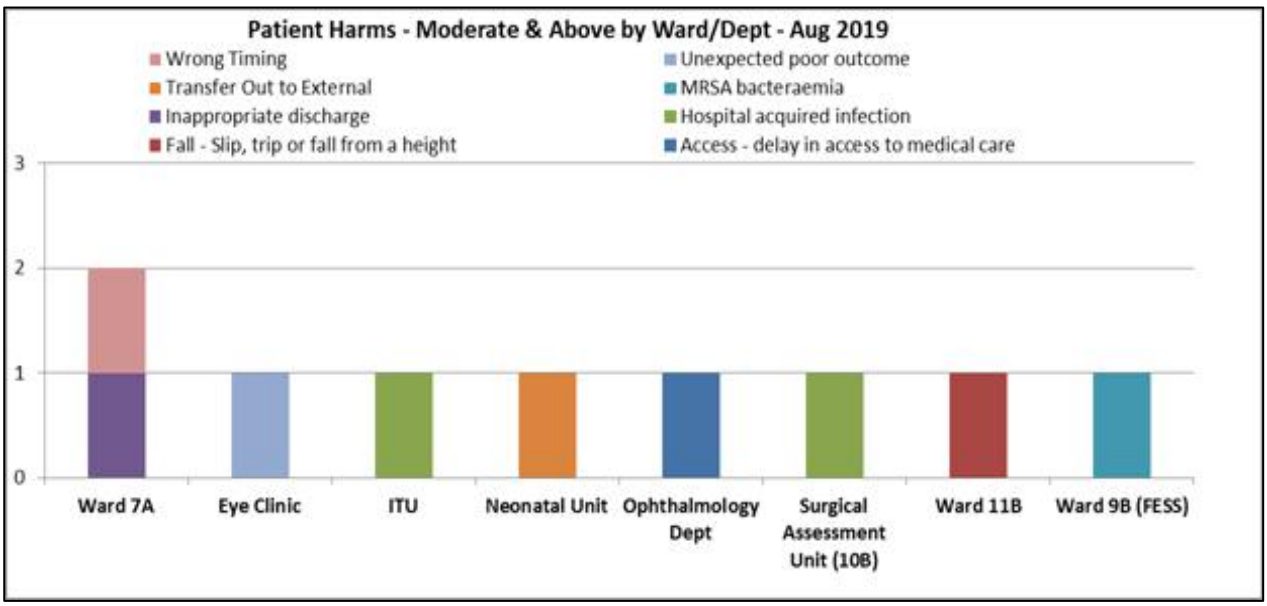
Improved dashboard data reporting aligned to the delivery of improved roster performance are being introduced into the existing support and challenge meetings with CBU's.

3. Staffing Related Reported Incidents August 2019

In August 43 staffing incidents/nursing red flags were reported, 19 more than the previous month. 20 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, 12 more than July. No harm was identified as a result of these incidents. Six of these incidents related to Paediatric areas and a further 4 to Maternity. None of these incidents resulted in harm to patients

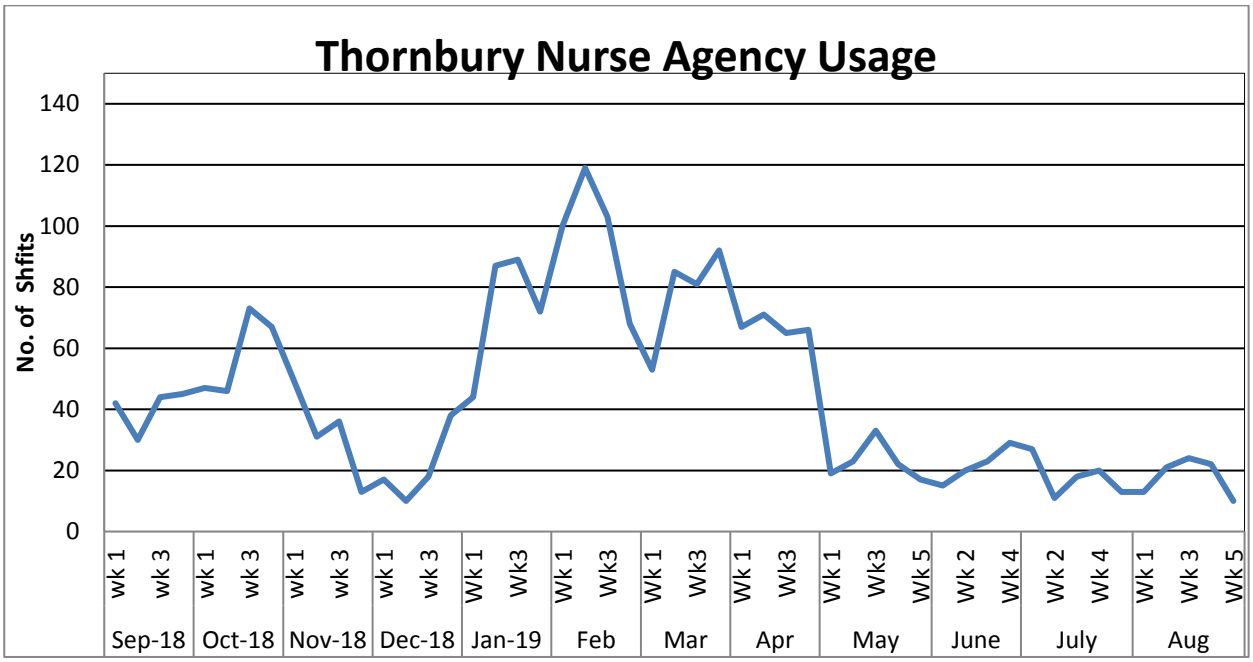


In August 9 moderate or above incidents were reported, 2 more than reported in July. Two of these incidents were on Ward 7A.



4. Non Framework Nurse Agency Usage

The Trust is 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.



August increase in Thornbury usage (Hrs) by 5%

5. Clinical Indicators Dashboard

As part of our gap analysis for NICE guidance (Safe staffing for nursing in adult inpatient wards in acute hospitals, 2014) we continue to develop a clinical metrics dashboard that will triangulate staffing with clinical metrics and patient outcomes. Reporting of the dashboard will be tabled at the Board meeting.

6. Recommendations

The 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) – August 2019

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Ward 7A-SDGH	300 - GENERAL MEDICINE	1,395.50	1,153.75	1,708.50	1,332.50	1,126.50	922.50	887.50	815.00	827	82.68%	77.99%	81.89%	91.83%	2.5	2.6	5.1		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	906.25	881.25	370.00	389.50	729.50	729.00	362.50	326.50	251	97.24%	105.27%	99.93%	90.07%	6.4	2.9	9.3		
EAU	300 - GENERAL MEDICINE	1,502.23	1,326.73	1,147.00	1,099.00	1,090.50	978.25	727.50	750.50	494	88.32%	95.82%	89.71%	103.16%	4.7	3.7	8.4		
FESS Ward	300 - GENERAL MEDICINE	1,728.95	1,153.62	1,452.75	1,652.95	1,100.50	952.50	771.00	777.58	840	66.72%	113.78%	86.55%	100.85%	2.5	2.9	5.4		
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,517.98	1,191.15	1,381.00	1,371.50	1,098.00	978.00	1,101.50	1,077.50	812	78.47%	99.31%	89.07%	97.82%	2.7	3.0	5.7		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,912.75	1,540.73	1,730.48	1,408.48	1,476.50	1,056.50	1,114.00	740.00	891	80.55%	81.39%	71.55%	66.43%	2.9	2.4	5.3		
Short Stay Unit	300 - GENERAL MEDICINE	1,473.25	1,135.50	1,839.25	1,545.92	1,386.00	920.00	1,094.50	1,058.00	849	77.07%	84.05%	66.38%	96.67%	2.4	3.1	5.5	Y	Shortfall more than 8hrs or 25% RN time available compared with actual requirements of shift-mitigated within trust processes
Ward 15a General Med	300 - GENERAL MEDICINE	1,528.83	1,194.50	1,474.42	1,618.67	1,096.75	1,014.25	1,305.00	1,434.00	723	78.13%	109.78%	92.48%	109.89%	3.1	4.2	7.3		
Stroke Ward	300 - GENERAL MEDICINE	1,422.00	1,208.50	1,284.42	1,353.42	1,096.50	1,001.00	734.50	779.50	576	84.99%	105.37%	91.29%	106.13%	3.8	3.7	7.5		
Rehab & Discharge Lounge	314 - REHABILITATION	1,749.48	1,127.05	2,183.50	1,834.25	737.50	731.00	1,452.50	1,021.00	743	64.42%	84.01%	99.12%	70.29%	2.5	3.8	6.3		
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,910.67	1,355.58	2,244.50	1,787.50	1,117.00	925.00	1,895.25	1,487.25	904	70.95%	79.64%	82.81%	78.47%	2.5	3.6	6.1	Y	Delay/omission of regular patient checks - mitigated within internal trust processes
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,230.75	1,085.00	1,342.00	1,206.00	750.50	726.00	404.00	404.00	440	88.16%	89.87%	96.74%	100.00%	4.1	3.7	7.8		
Ward H	110 - TRAUMA & ORTHOPAEDICS	744.25	534.75	725.00	397.50	742.50	503.00	297.00	200.50	96	71.85%	54.83%	67.74%	67.51%	10.8	6.2	17.0		
Surgical Ward	100 - GENERAL SURGERY	1,296.50	1,043.00	1,122.75	1,074.75	735.50	675.50	367.50	390.50	509	80.45%	95.72%	91.84%	106.26%	3.4	2.9	6.3		
Spinal Injuries Unit	400 - NEUROLOGY	2,965.00	2,721.75	3,097.50	2,899.00	2,240.75	2,097.00	1,340.75	1,290.50	809	91.80%	93.59%	93.58%	96.25%	6.0	5.2	11.1		
Ward G	101 - UROLOGY	999.25	777.25	1,038.00	711.00	748.00	653.00	361.00	313.00	268	77.78%	68.50%	87.30%	86.70%	5.3	3.8	9.2		
TOTAL		**24,283.65**	**19,430.11**	**24,141.07**	**21,681.94**	**17,272.50**	**14,862.50**	**14,216.00**	**12,865.33**	**10032**	**80.01%**	**89.81%**	**86.05%**	**90.50%**	**3.42**	**3.44**	**6.86**		

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		4,209.50	4,140.50	2,377.00	1,491.50	3,909.75	3,668.50	958.50	836.00		98.36%	62.75%	93.83%	87.22%					
Ambulatory Care Unit		615.20	375.50	462.25	417.25	347.50	251.50	359.50	263.50		61.04%	90.27%	72.37%	73.30%					
TOTAL		**4,824.70**	**4,516.00**	**2,839.25**	**1,908.75**	**4,257.25**	**3,920.00**	**1,318.00**	**1,099.50**		**93.60%**	**62.87%**	**67.23%**	**83.42%**	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	4,811.25	3,850.67	1,182.00	926.00	4,079.00	3,617.50	1,116.00	538.00	363	80.03%	78.34%	88.69%	48.21%	20.6	4.0	24.6		

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	8,409.33	8,093.25	1,779.25	1,570.25	3,588.50	3,525.75	1,103.00	1,067.00	448	96.24%	88.25%	98.25%	96.74%	25.9	5.9	31.8		
MAU	501 - OBSTETRICS														#DIV/0!	#DIV/0!	#DIV/0!		
TOTAL		**8,409.33**	**8,093.25**	**1,779.25**	**1,570.25**	**3,588.50**	**3,525.75**	**1,103.00**	**1,067.00**	**448**	**96.24%**	**88.25%**	**98.25%**	**96.74%**	**25.94**	**5.89**	**31.82**		

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	1,110.25	1,117.00	222.00	136.50	1,113.75	1,113.75	0.00	0.00	205	100.61%	61.49%	100.00%	#DIV/0!	10.9	0.7	11.5		
Paediatric Unit	420 - PAEDIATRICS	2,161.25	1,953.75	1,061.25	886.75	1,483.00	1,267.50	431.50	347.50	254	90.40%	83.56%	85.47%	80.53%	12.7	4.9	17.5		
TOTAL		**3,271.50**	**3,070.75**	**1,283.25**	**1,023.25**	**2,596.75**	**2,381.25**	**431.50**	**347.50**	**459.00**	**93.86%**	**79.74%**	**91.70%**	**80.53%**	**11.88**	**2.99**	**14.86**		
PLANNED		13,957.67	11,368.00	10,751.75	9,001.75	10,413.25	9,197.00	5,781.50	4,623.75	3,389	81.45%	83.72%	88.32%	79.97%	6.1	4.0	10.1		
URGENT		15,137.23	11,912.78	14,571.32	13,606.19	10,938.25	9,283.00	9,550.50	8,779.58	7006	78.70%	93.38%	84.87%	91.93%	3.0	3.2	6.2		
W&C		11,680.83	11,164.00	3,062.50	2,593.50	6,185.25	5,907.00	1,534.50	1,414.50	907	95.58%	84.69%	95.50%	92.18%	18.8	4.4	23.2		
TRUST TOTALS		**40,775.73**	**34,444.78**	**28,385.57**	**25,201.44**	**27,536.75**	**24,387.00**	**16,866.50**	**14,817.83**	**11,302**	84.47%	88.78%	88.56%	87.85%	5.2	3.5	**8.75**		

Green- 80% and above
Red- Under 80%

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB168/19e**	**Report Title**	**CQC PREPARATION 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 CQC Inspections in November/December 2017 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018. The Report also provides an overview of the recent two unannounced core services and Well Led inspections undertaken between July 2019 and August 2019.

The Board 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 ✓ 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)*	
Board of Directors to note the report and next steps	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

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.

The Report also provides an overview of the recent two unannounced core services and Well Led inspections undertaken between July and August 2019.

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 (PIR), this was submitted within deadline on 3 May 2019, since then the Trust has had two unannounced core service inspections, the final part of the inspection, the Well Led review was held on 20 – 22 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

OVERALL SUMMARY

Rating	Must Do	Should Do	Total
Delivered and Sustained	12	2	14
Action Completed	41	37	78
On track to deliver	11	11	22
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) continued 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. The QID group has been reviewed and it is proposed that the work streams will now be incorporated into the work of the quality assurance panels.

We will continue to review a series of Key Line of Enquiry (KLOE) through the quality assurance panels with go and see visits being a fundamental aspect of the sustainability of any improvements. This will continue to 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 the Trust with input from external consultants is being planned for October 2019.

These KLOE 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 Quality Assurance Panels going forward.

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

In order to enhance assurance of clinical standards SONNAS continues to be rolled out as planned.

5. CQC CORE SERVICE INSPECTIONS

The CQC carried out an unannounced visit on 9 – 11 July 2019 and a second visit on 29 July – 1 August, as previously reported to board.

It is anticipated that the draft CQC report will be shared for factual accuracy in early October 2019, with the published report being expected in later October.

6. WELL LED REVIEW

The Well Led review took place between 20 – 22 August.

All executives were interviewed along with the non-executive chairs of Quality & Safety Committee and the Audit Committee.

During this review the CQC team also met with consultants and held a focus group with the facilities teams, as well as reviewing the process around the SJR process and learning from deaths.

7. MEDICINES MANAGEMENT

Following the development of the medicines management improvement plans, work has continued to improve the governance relating to medicines management and the plans are

on target to be achieved within the identified timescales, with the immediate plans concluded.

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

The external report commissioned from Prof Liz Kay is nearing completion and a business case relating to pharmacy has been developed.

8. RECCOMENDATIONS

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB168/19f**	**Report Title**	**Freedom to Speak Up Report Quarter 1 2019 (to 30th June 2019)**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Fiona Barnes, Deputy Director of Nursing Midwifery and Therapies Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ☐ To Assure		☐ For Note ✓ For Information

Key Messages and Recommendations

This report identifies the number of concerns raised to the FTSU Guardian during quarter 1 2019, which shows a further increase on previous quarters.

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

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

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

An ongoing FTSU vision and strategy document will be presented to the board in the early autumn for approval.

At the board's request examples of change following concerns raised is included in this report.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ☐ **SO1** Agree with partners a long term acute services strategy
- ☐ **SO2** Improve clinical outcomes and patient safety
- ☐ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services

✓ **SO5** Ensure staff feel valued in a culture of open and honest communication ✓ **SO6** Establish a stable, compassionate leadership team
Governance *(the report supports a…..)*
✓ Statutory requirement ☐ Annual Business Plan Priority ☐ Linked to a Key Risk on BAF / HLRR Ref: _____ ☐ Service Change ☐ Best Practice ☐ Other List (Rationale) _____
Impact *(is there an impact arising from the report on the following?)*

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

Next Steps *(List the required actions following agreement by Board/Committee/Group)*
To receive the report and note progress made during 2019-2020. To support future plans 2020 – 2021
Previously Presented at:

✓ Audit Committee ☐ Finance Performance & Investment Committee ✓ Quality & Safety Committee	✓ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO 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

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

Freedom to Speak up Guardian 2019-20

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

1 Report on Submission to National Guardians Office

Quarter 1 1st April - 30th June 2019

Date to be submitted to NGO: TBC (NGO is using new software and report a delay)

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

Number of concerns raised: **31**

1.1 During quarter 1, 31 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG). This is in addition to the 16 issues which were raised through the Speak Straight to Silas initiative.

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

Table 1: Concerns raised during Quarter 1

Month	No raised	Raised Anon*	Issues / Themes / Outcomes & Status	Staff Group Raising Concern
Apr	17	0	Safeguarding of a patient. Issue closed evidence found it had already been dealt with. Culture to change around datix reporting so it is seen as professional or have the ability to anonymise them. Concern escalated and closed. Concern raised around waiting list enhancement. Closed after clarification. Five concerns of bullying and harassment. Four closed after escalation, two of which received assurance from independent review. One remains open. Five concerns raised in one department around leadership, processes and attitude of manager. These are ongoing. Patient safety/quality closed as escalated to external	HCA 1 Clinical Educator 1 Nurse 2 Catering 1 Paeds Dietician 1 Estates 1 Medical Appliances 1 HR 5 Facilities 1 Sterile Services 1 Junior Doctor 1 Ward Sister 1

			nursing provider for investigation. Concern raised about staffing levels and effect on patient safety. Ongoing. Concern about staffing levels. Resolved after involvement from FTSU. Concern around behaviour escalated. Resolved and closed.	
May	6	0	One concern was raised about Patient Safety/Quality after an article was published about A+E. Closed after a statement was sent out. A concern was raised regarding annual leave and treatment by manager/team. Staff member has raised their concerns with the manager but does not get any feedback. Ongoing support being provided. A concern regarding team/staff relationship. Finding it difficult to work at present due to the behaviour of others but does not want it escalating at present. Three concerns are related to behaviours of managers; staff being bullied and harassed. One concern is closed. The other concerns have/ are being escalated.	Manager 2 HCA 1 Nurse 1 Education 1 Secretary 1
June	8	0	Concern raised about claims. Independent investigation ongoing. No system for ordering basic essential equipment. Has been raised before. Now closed as a solution found. Concern raised about sickness policy and support given. Remains open. Member of staff raised concerns regarding patient safety and quality of service. Incidents are reported via Datix but feedback is never received. Issue of gender pay inequality was raised. These concerns are being looked into. Ongoing issues and support for a person with a disability. Outside support has previously been offered and the member of staff member is now shadowing other staff in order to maximise their employment possibilities. Concern raised by a number of staff regarding patient safety, low staffing levels and unsafe systems/ processes. Staff feel they get no support or	Nurse 1 Domestic 1 Theatre Staff 1 Education 1 Catering 1 Estates 1 Consultant 1 Therapy 1

			opportunities. No feedback from datix reports. Ongoing. Behaviour of manager. Unprofessional, bullying and harassment. Ongoing. Poor management, lack of leadership, policy not being followed, not supported and no communication. Ongoing.	

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

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

1.2 Feedback post raising concern

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

During quarter 1 feedback was received from 8 people. All of the feedback was positive with positive outcomes.

Given your experience, would you speak up again?

All answered yes.

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

It was commented that some staff on a team were unsure of what FTSU do and suggested a PR poster of the team and how they can help; staff need the service as unfortunately they feel overwhelmed by some of the issues in the department and feel reassured that they have a safe place to go to.

It was suggested that feedback should happen within a timescale as a manager failed to do it in a timely manner. They also suggested more staff side being involved in being speaking up champions as sometimes people are hesitant to speak up to a manager.

One person stated that there is a definite need for a FTSUG in all large organisations as there were several occasions in their past that it would have been ideal for.

A team commented they feel the management structure enables corporate bullying to continue. They work closely together and are not impartial.

Some examples:

I would most definitely speak up again in the future if the occasion arrived. Martin has been extremely supportive of this situation and has advised me appropriately. Many Thanks Martin.

Yes would speak up again. Feels the issues need to be addressed and it seems when I get you involved it seems to cause a reaction or shall I say progress. As for improving the service, when I mentioned to staff that I contacted yourself and your team they were unsure what you did. (I think they thought you were busy enough without being involved in our issues) so perhaps a PR poster of your team and how you can help. I think we need the service as unfortunately my fellow team leader and myself do feel overwhelmed by some of the issues in the department and we feel reassured that we have a safe place.

1. Given my experience would I speak up again?
A. Most definitely, these problems would escalate without intervention and its also nice to know someone is there to listen.
2. Any other comments I would like to make or suggest on improving the service?
A. I would definitely suggest that a feedback should happen within a timescale as I had to email the line manager for an update as I was worried about my member and I felt she just looked into it then left the people concerned in limbo.
I would also suggest more staff side being involved in being a speaking up guardian as sometimes people are hesitant to speak up to a manager.

Would speak up again. - For improving your service – no. There is a definite need for a 'you' in all large organisations. There were several occasions in the past – especially in the Army days – when a 'you' would have been great. Not so much for myself but I can think of many others that it would have been ideal for.

Yes, we all feel if we had any issues in the future we would not be afraid to speak up to yourselves. We felt like you were non-judgemental and listened to us.

We do however feel that the management structure enables corporate bullying to continue. They work closely together and are not impartial.

Table 2 : Straight to Silas inquiries – April – June 2019

17 Concerns received

Month	Number	Themes	Staff group
April	6	Complaint about care (1) Suggestion (2) Meeting with Silas request (1) Parking (2) Heating (1)	STHK (1) CMO (1) Audit (1) Admin (1) Therapies (1) Theatres (1) Ward staff (1)
May	3	Parking (2) Office Conditions (1)	Ward staff (2) Admin
June	7	Suggestion (3) Funding (1) Recruitment problem (1) Pathology future (1) Inadequate facilities (1)	Clinical Ed (1) Clinical (2) Ward staff (2) Pathology (1) Training (1)

Changes as a Result of Speaking Up

These are included in the development plan below

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

Background

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

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

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

Findings

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

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

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

Response

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

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

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

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

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

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

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

Current position is detailed below

Table 5 : self-assessment tool current position

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

4 Ongoing Strategy and Development Plans

Looking forward the organisation has committed itself to developing FTSU and has produced the following development and vision plan. A once page summary is included at the end.

Freedom to Speak Up - Strategy
Background

The National Guardian's Office (NGO) was established following the second report of Lord Frances who investigated the failings of two Mid Staffordshire hospitals between 2005 and 2009. Part of his first report suggested there were over 1200 needless deaths and he discovered there had been whistle-blowers raising concerns as early as 2005, but there was evidence their concerns were ignored and those who raised concerns were bullied into silence.

The NGO appoints a National Guardian for the NHS, has a policy for the NHS to be adopted by all trusts, and requires all trusts appoint a local Freedom to Speak up Guardian (FTSUG). The NGO also undertakes case reviews where there is concern about a trust's response to those who speak up.

In August and September 2017 the National Guardian's Office conducted its first Case Review of the speaking up processes, policies and culture at Southport and Ormskirk NHS Trust. This was because it had received information that the trust's response to its workers speaking up was not in accordance with good practice.

As a result of the review 21 recommendations were made to the trust, and one to CQC. From the recommendations an extensive action plan was developed between the trust, the NGO and NHSI.

Both locally and nationally there has been significant monitoring of the implementation of the action plan. In April 2019 the RAG rating of the action plan was reported as:

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

Freedom To Speak Up Guardian

In September 2017 Martin Abrams was seconded to the role of FTSUG and in the spring of 2019 the post of FTSUG was advertised and following the recruitment process Martin Abrams was appointed to the role (.5WT).

Year 2018 – 2019

Following the year end (31st March 2019) an annual report was produced which highlighted that within the trust

- 75 concerns had been raised during the year indicating staff appear to have responded positively to the appointment of the FTSU Guardian. Data also indicates that since the appointment there has been an increasing number of concerns raised*.
- Significant positive feedback had been received from those raising concerns
- The FTSU Guardian service appears to be utilised by a widening set of staff groups within the trust.
- It is pleasing to report that the majority of concerns were reportedly raised in an open manner, suggesting a changing environment where staff felt more confident to speak up about concerns.
- There were, however, a smaller number of concerns which were raised in an anonymous or confidential manner. This suggests that further on-going support is needed to build a more open culture in relation to raising concerns.
- A key focus of the FTSU Guardian has been to develop a communication strategy, supported by the trust's Communication Team.
- This initiative has included using posters, pay slip inserts and the further development of the trust's internet site. Information about the role of the FTSU Guardian is now included within the New Starter and Junior Doctor Induction.
- In addition, a personalised approach has been taken to introducing the role to staff through regular attendance at team meetings, department walk arounds and senior management meetings.
- The Guardian has also attended national meetings and training events and is supported by the Deputy Director of Nursing, and Associate Director of HR in delivering the agreed action plan.
- During the last 12 months the recruitment of 10 FTSU champions has taken place, with specific training delivered to support their role.
- The board of directors has also received FTSU training in Autumn 18
- Another key recommendation from the NGO review was to develop an Equality and Diversity role for the trust. This post was filled in September 18 and the post holder is working closely with the FTSU guardian.
- Mersey Internal Audit completed a review on the Raising Concerns Policy in December 2018 and rated compliance as significant assurance.

*compared to previous years:

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

In addition to the FTSUG the hospital's Chief Executive Officer (CEO) has established a "Straight to Silas" initiative through which concerns can be raised directly with him.

During the year 2018 – 2019 30 concerns were raised.

Organisational Changes

Following the presentation of the annual report to board (May 2019) a request was made that some organisation changes be documents. These are to be included in the report to board following the quarterly reporting to the NGO at the beginning of July 2019. These changes include:

The trust board has asked for examples of changes that have happened within the organisation as a result of speaking up.

The Trust appointed a permanent Freedom to Speak Up Guardian, Martin Abrams, in summer 2018 followed by the recruitment and training of 10 staff speaking up champions.

There has been a significant increase in concerns raised, indicating staff across the Trust feel more confident in speaking up. From three in 2015/16, 75 staff came forward with their concerns in 2018/19.

Feedback from many staff raising concerns shows changes have been made to their working environments as a result.

More complex concerns about behaviour have resulted in ongoing internal and external support to various areas within the organisation

In some areas there has been a change in behaviours and approach. When approached, some of the individuals cited in concerns said they had not realised the impact their behaviours had until they were alerted to it.

Among other concerns raised were:

- Proposed changes to the staff car parking scheme which was dealt with swiftly, Trust policy changed and a proposed scheme changes put on hold

- A member of pharmacy staff reporting wards were not always printing off discharge information for GPs. Through discussions at medicines safety committee and matrons' meetings, ward clerks now support nurses with this task. The work has been well received with incomplete discharges dropping from up to 300 to less than 20

- A concern for patient safety following a colleague not being replaced. The Guardian's intervention resulted in a recommendation that funding for the post be reinstated

- Concerns about the patient concealment trolley being pushed along the main corridor at lunch time in front of the coffee shop and members of the public. Porters are now to use an alternative route during the day to reduce the risk of causing passers-by distress

Following a significant number of concerns about behaviours, the Trust has invested in "SO Proud conversations" led by the organisational development team and supported by NHS Elect.

Through "big brews" in the restaurants and more staff consultations on "what makes a good day", the Trust wants to understand what makes a good day at work and the behaviours needed to make it happen.

Some Trust processes have changed after concerns that have led to better consultation and a commitment to the use of impact analyses. There have also been process changes in some ward areas as a result of safety concerns.

The Guardian has supported staff reaching resolution to various HR issues and recruitment, including:

- Support in the interpretation of lone working practice
- Support during the process of departmental change
- Changes to storage cage used and signage after concerns about them blocking fire exits

These are just some examples of changes that have happened as a result of FTSU

Summary

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

Recommendations

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

2019 – 2020 to date

At the end of the first quarter (30th June 2019) 31 concerns have been raised with the FTSUG

Freedom to speak up

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Freedom to Speak Up

Our Vision and Strategy

Since the first ever National Guardians Office Case Review (Summer / Autumn 2017) Southport and Ormskirk Hospital Trust has achieved a great deal in making speaking up business as usual. This is how we want to develop over the next couple of years.

Our vision

- For everyone to feel comfortable in raising a concern, and feel safe to speak up again in the future
- Concerns to be welcomed and investigated and timely feedback given
- For speaking up to make a difference to the quality of patient care and our staff experience
- For staff to feel appreciated for raising their concern

Leadership

- The Trust Board will drive the strategy and support the embedding of the speaking up culture across the organisation. The board will receive regular updates from the FTSUG
- Senior Leaders will support the development of a speaking up culture.
- The Freedom to Speak Up Guardian will drive forward the ethos of ensuring staff who speak up are treated fairly, compassionately and quickly

How will we achieve this?

- Supporting areas that are presenting concerns, and liaising with senior leadership to resolve any problems
- Induction on FTSU for all staff and ongoing training
- Ensuring we are working to best practice standards and supporting change following staff feedback, EG Big Conversations, Big Brew etc
- Ensuring the Freedom to Speak Up Guardian and Champions have high levels of visibility and access throughout the trust
- Addressing any negative feedback about the Freedom to Speak Up process
- Providing regular updates on improvements made in response to concerns
- The Freedom to Speak Up Guardian will continue to access national support and best practice training

How will we measure success?

- Feedback from staff regarding their knowledge or experience of the Freedom to Speak Up process
- Monitoring the number of concerns raised with the FTSUG and Champions

For more information please see our "Speaking Up" intranet pages
Contact Martin Abrams Telephone: 01704 704693 Mobile: 07467 374824
Email: martin.abrams@nhs.net or soh-tr.speakingup@nhs.net

Freedom to Speak Up

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Leadership

- The Trust Board will drive the strategy and support the embedding of the **speaking up culture** across the organisation. The board will receive regular updates from the **FTSUG**
- **Senior Leaders** will support the development of a **speaking up culture.**
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Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

October 2019

Agenda Item	**TB169/19**	**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.

Update on development:
The development of the IPR has been an ongoing process over the last year. To date, several improvements have been made to both the structure and content of the report to enable ease of use and clarity of understanding. The improvements include:

- SPC charts for each indicator in line with NHSI recommendations
- The inclusion of targets where these were previously not included
- The addition of trajectories of performance where this is practicable and appropriate
- The division of the 'red/green' box on the detailed report to enable a clear picture of where the Trust is performing against both target and trajectory -now included in this report
- Summary of direction of travel of most improving or deteriorating indicators and activity data - now excluded from the paper and presented by the COO
- Executive sign off, for their respective KPIs
- Continued support to colleagues in developing good quality and useful narrative
- Ongoing data cleansing and data quality audits

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)*

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

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NHS Trust

Board Report - August 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	1	1	1			
C-Diff	3	3	13	3			
Never Events	0	0	1	0			
VTE Prophylaxis Assessments	95%	97.5%	97.5%	120			
Harm Free (Safety Thermometer)	95%	98.3%	97.7%	6			
Falls - Moderate/Severe/Death	1	1	9	1			
Patient Safety Incidents - Low, Near Miss or No Harm		653	3847	653			
Safe Staffing	90%	87%	90.9%	N/A			
Fractured Neck of Femur	90%	69.7%	69.5%	23			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Percentage of Deaths Screened	100%	88.1%	48.9%	7			
SHMI (Summary Hospital-level Mortality Indicator)	100	101.9		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	96.3	96.3	N/A			
WHO Checklist	100%	100%	100%	0			
Stroke - 90% Stay on Stroke Ward	80%	73.3%	68.6%	8			
Sepsis - Timely Identification	90%	100%	97.9%	N/A			
Sepsis - Timely Treatment	90%	95.7%	85.7%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	17	114	17			
Written Complaints	35	15	100	15			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	95.4%	94.2%	23			

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%	87.7%	88.6%	1281			
Accident & Emergency - 12+ Hour trolley waits	1	0	30	0			
Ambulance Handovers <=15 Mins	99%	56.1%	53.1%	704			
Diagnostic waits	1.01%	3.7%	4%	108			
14 day GP referral to Outpatients	93%	93.8%	94.5%	66			
31 day treatment	96%	100%	98.8%	0			
31 day treatment (Surgery)	94%	100%	100%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	78.9%	78.3%	9.5			
62 day GP referral to treatment	85%	78.9%	76.7%	9.5			
Referral to treatment: on-going	92%	92.6%	93.5%	820			
Bed Occupancy - SDGH	93%	90%	93.2%	N/A			
Bed Occupancy - ODGH	60%	47.8%	46.8%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	100%	97.1%	0			
Duty of Candour - Evidence of Letter	100%	100%	97%	0			
I&E surplus or deficit/total revenue	-1%	-9.1%	-19%	N/A			
Liquidity	-106	-116	-116	N/A			
Distance from Control Total	0%	-1.3%	-7.9%	N/A			
Capital Service Capacity	0.21	-0.83	-3.559	N/A			
% Agency Staff (cost)	5.45%	8.7%	8.1%	N/A			
Use of Resources (Finance) Score	3	4	3	N/A			
Distance from Agency Spend Cap	0%	129%	129%	N/A			
Staff Turnover	0.76%	1.3%	6.8%	N/A			
Staff Turnover (Rolling)	10%	11.9%		N/A			
Vacancy Rate - Medical	5%	9.7%		N/A			
Vacancy Rate - Nursing	8%	17.9%		N/A			
Sickness Rate	5%	4.9%	5%	N/A			
Personal Development Review	85%	71.6%	72.1%	N/A			
Mandatory Training	85%	87.3%	86.8%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.8	8.5	N/A			
Time to Recruit		64	333	N/A			

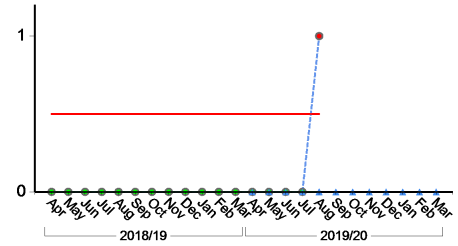
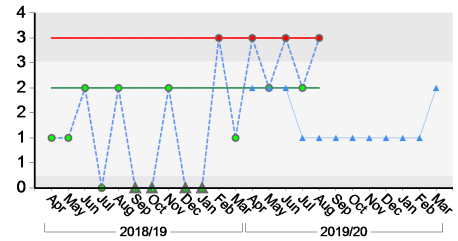
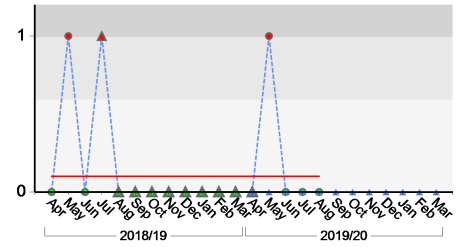
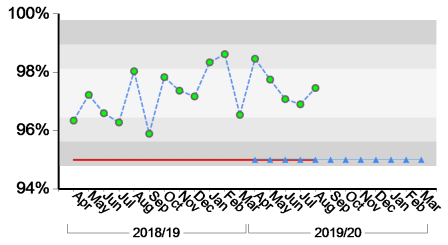
Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	65	62	65			
DTOC - Number of Beds lost per month		253		253			
Length Of Stay	6.5	6.9	7.2	N/A			
New:Follow Up	2.64	2.5	2.4	N/A			
DNA (Did Not Attend) rate	8%	7.5%	7.1%	1687			
Cancelled Ops	0.61%	0.1%	0.3%	2			
Theatre Utilisation - SDGH	80%	60.5%	59.6%	N/A			
Theatre Utilisation - ODGH	90%	71.8%	68.8%	N/A			
Stranded Patients (>6 Days LOS)	170	167	900	167			
Super Stranded Patients (>20 Days LOS)	58	65	352	65			
Southport A&E Conversion Rate	20%	20.6%		1067			

Reporting Frequency is monthly except for SHMI which is quarterly.

Board Report - August 2019

NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	In August, 1st MRSA bacteraemia in 23 months - Nationally there is a zero tolerance for MRSA bacteraemia and unlike other trusts in England, Southport & Ormskirk is considered to be a low incidence Trust - the single case on ward 11B will not change this status, however on the surface the initial investigation identified a delay in starting the suppression treatment even though on admission the patient was known to be MRSA positive and even though the IPC team informed the ward on admission to commence treatment. The patient had extremely poor venous access with multiple failed attempts at cannulisation and phlebotomy documented starting with the paramedics who initially attended the patient to the time 3 days later when blood was acquired for culture - there is a possibility that this was a contaminant, however the patient was treated for the bacteraemia. A Datix has been completed on this case and has been presented at SIRG, the formal RCA has been scheduled and actions will be determined from this.	
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year.	In August 6 cases of C diff were reported to the PHE with 3 of these being attributed to the hospital. - If the 3 cases for appeal are successful this will bring the Trust under trajectory. One of the hospital cases is considered a "community occurrence hospital association" and had been a patient on ward 11B; 8 days following discharge the GP sent a stool specimen which was positive. The patient has a number of risk factors and co-morbidities; advice was provided to the GP by the Consultant Microbiologist and the community IPC nurse was informed. There was also an 11B case who received antibiotics prior to admission and also following admission due to UTI. The 3rd case was on ward SSU who had a single soft stool which was found to be C diff positive - the patient was receiving palliative care and chose not to be treated and had no further symptoms. Each of these patients were reviewed by their respective clinical teams in collaboration with the Consultant Microbiologist and were subsequently reviewed on C diff ward rounds. Each of the cases is reported on Datix and reviewed by SIRG as well as going through the RCA process.	
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 August 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 slightly deteriorated month on month for the previous four months but improved in August and remains within the normal range for the trust - The trust maintains compliance	

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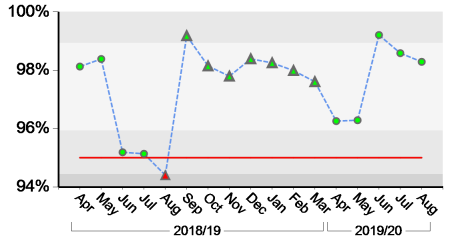
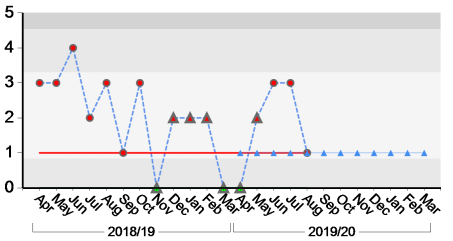
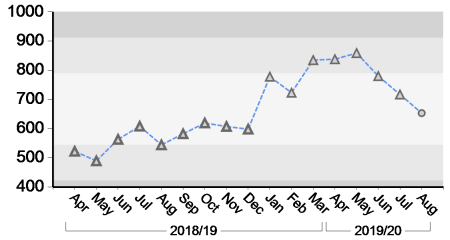
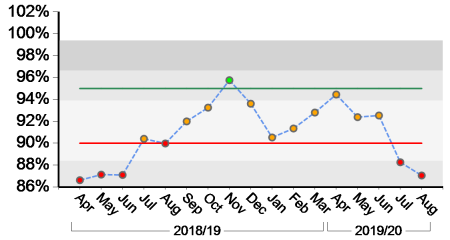
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	The trust remains consistently compliant. - Performance in August was 98.29%	
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 is demonstrating a reduced number of falls in comparison with the previous three months. - The roll out of the falls assessment and care planning bundle almost complete and is now on all wards at SDGH with the exception of ICU and SIU. The bundle will be on the appropriate wards at ODGH by the end of September and on ITU and SIU once the documents are approved as relevant for the specialties - aiming for by the end of October. Staff have access and are completing when able, an e-learning module to enhance education and knowledge about falls risk factors and the use of bed rails. The post-falls assessment is in draft and will be tested in October. The success of the work is interdependent on the roll out of the enhanced supervision policy which has not yet been rolled out - this is currently out for comments and then roll out will commence by the end of October. Currently there is a risk that without the ability to get required 1-1s or additional supervision for those who require it, falls will continue to be a risk.	
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 647 lower level incidents reported in August a decrease from 717 last month. - 25 Near miss incidents, 557 No harm and 65 Low harm incidents. 79 of these were DoL's applications , 39 safeguarding . The other categories with the highest reported incidents relate to Bed management issues such as delay in transfer to the ward -49 reported , same sex breaches 17 reported and patients nursed in the corridor in A&E -19 reported ,16 delay in treatment ; the other category relates to patient falls where 65 incidents , themes -20 delay in treatment , 15 unexpected admission to NNU .65 of these incidents relate to externally acquired pressure ulcers. Occasionally there may be minor discrepancies in numbers between the data being extracted and the narrator updating. The narrative numbers are correct.	
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 is reported below compliance levels due to the revised numbers following the Nursing Establishment review - The trust's ongoing plan to deliver improvements is supported through the Trusts investment to nursing establishments. Band 5 and HCA recruitment events are planned throughout September. Data reporting errors relating to Allocate on Arrival have been identified which, once rectified will reflect the more accurate figure for the fill rate of 89.15%	

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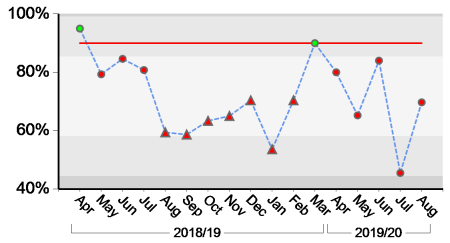
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Significant rise in #Nof patients for the month of August. - Extra trauma list added to accommodate increase in patients. Problems with theatres and anaesthetists lead to some delays with trauma lists commencing timely.	

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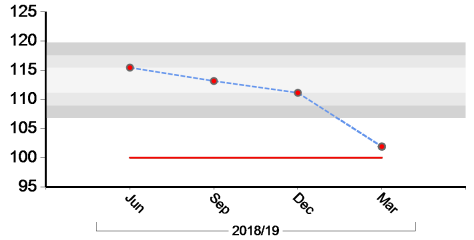
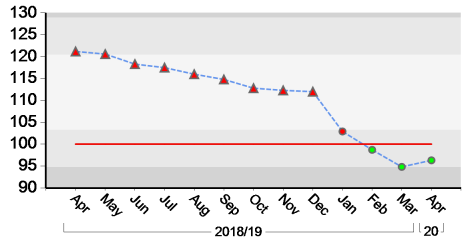
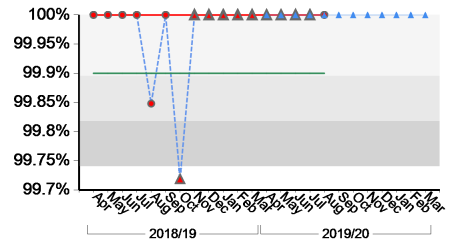
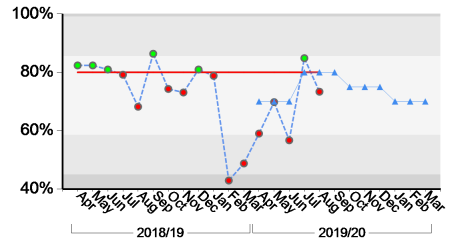
NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name (Colour - Perf | Traj)	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 August 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 has deteriorated compared to the previous month. The trust achieved below the 80% target at 73.33% - 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 :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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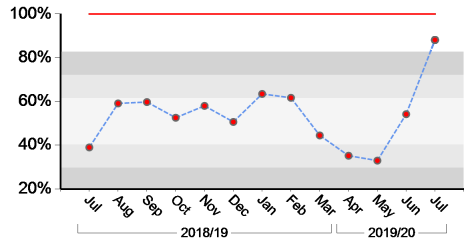
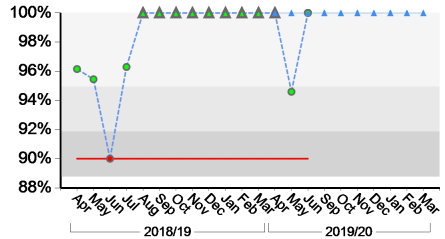
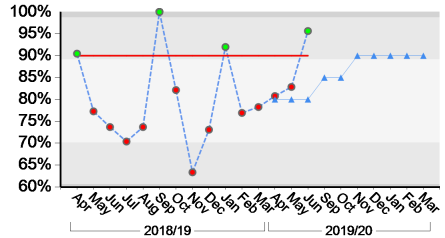
Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Percentage of Deaths Screened	Percentage of Deaths Screened - DATIX	Significant improvment in month to 88.14%. - this improvement is since the implementation of the iPAD system and the reminder posters.	
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.	Early Warning Score documentation in A&E reached 100% in June - In June 2019 we achieved 100% for NEWS recorded within 1 hour of arrival. We have started to use "plot the dots" SPC charts to monitor monthly variation.	
Sepsis - Timely Treatment	Sepsis Timely treatment for sepsis in emergency departments and acute inpatient settings- the rate of rapid administration of antibiotics within one hour of diagnosis of sepsis.	In June 2019 we achieved above 90% compliance with administration of antibiotics with in 1 hour of diagnosis. - We have started to use "plot the dots" SPC charts to monitor monthly variation.	

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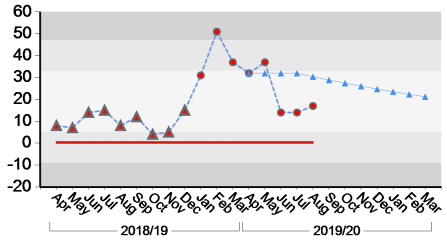
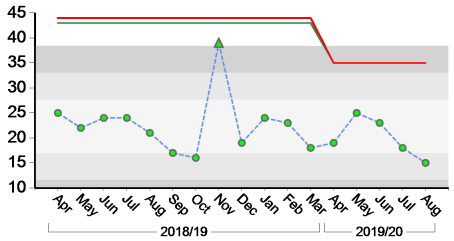
Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name (Colour - Perf | Traj)	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.	The improvements throughout the previous 2 months has been maintained for a third month with only a marginal increas in month. - 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 will continue to follow policy and work with all teams, and report breaches if they occur	
Written Complaints	The total number of complaints received. A lower number is good.	There were 15 complaints in August - this is lower than July (18) however this remains within normal range for the time of year. The themes are as follows 1. staff attitude/behaviour 2. clinical treatment issues – including co-ordination of care/failure to perform observations 3.staff attitude 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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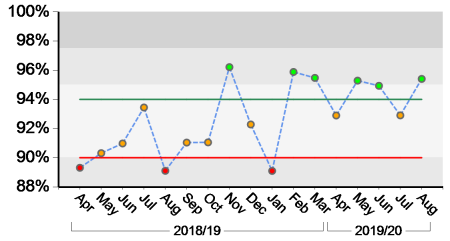
Southport and Ormskirk Hospital NHS Trust

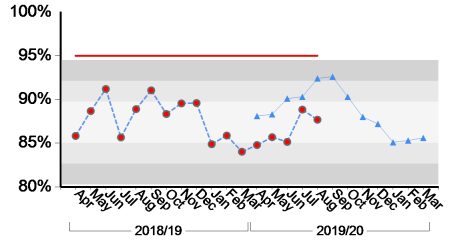
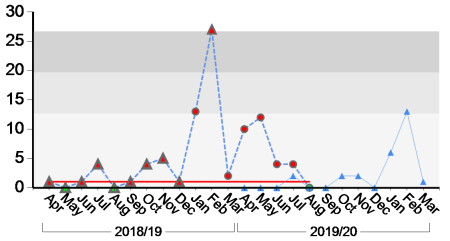
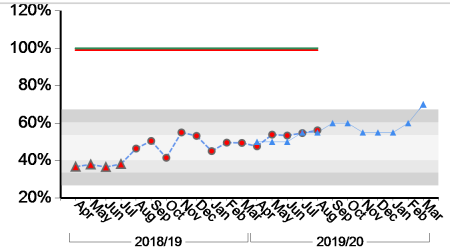
Caring

Indicator Name (Colour - Perf | Traj)	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 increased on previous month, however the overall Trust response rate remains low at 6.48%. - Planned care response rate decreased on previous month 16.88% - 98.48% would recommend. Urgent care response rate decreased on previous month 4.86% - 91.02% would recommend. W&C response rate 4.5% decreased on previous month - 97.27% would recommend. Plans are being implemented to ensure a digital system is in place in areas from 1st October 2019.	

Board Report - August 2019

NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	Performance across the Trust against the 4-hour standard fell in August 2019, with a 2.5% decrease on the Southport site. - There was a 7.7% increase in attendances at Southport (395 additional patients with a shift in case mix that saw 428 additional majors category patients). There was a 1.7% increase in admission rate (193 additional admissions). ED welcomed a new consultant at the start of August and remains on track for a further consultant to join on 1 October 2019. The Tier 1 workforce position improved following August changeover with all trainee posts filled, and the majority of night shifts now have 4 doctors as a result. Tier 2 had 1 remaining ST vacancy in August, which has been filled from 4/4/19, however the urgent need to recruit additional SAS doctors remains a significant concern, taking into account ongoing shift in case mix and attendance times across late and night shifts. As short terms measures, additional shifts are put out to bank and agency to try and enhance staffing levels. A revised workforce strategy is currently under review with an innovative approach to attract candidates taking into account the current market. ED continues to develop Physicians Associates to add additional resilience and capacity to the Tier 1 workforce with 6 in post (2 signed off and 4 in their supernumerary year), and recruitment to further ANP posts planned. There was a reduction in the use of ACU as an escalation area in August, increasing the opportunity to consistently stream from ED. ACU has plans in place to run a Perfect Week w/c 16 September and it is anticipated that the service will remain open 2 evenings a week in preparation for winter to maximise opportunities to stream.	
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0.	There were zero 12 hour breaches during the month - this is the first time in 12 months that this has been reported. The Trust continues to work with all partners, internal and external, in order to manage patient flow across the healthcare system.	
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.	Over 56% of ambulance handovers were completed within 15 minutes during August 2019 - this is the best performance for over 2 years. The estates work completed across winter 2018/19 to create dedicated ambulance space has increased capacity to not only handover patients timely but also ensure that the electronic timestamp is completed in real time. There has been no progress made for a HAS screen to be installed in resus so patients brought in by ambulance and taken directly into resus still have a delay in capturing the electronic timestamp for handover. This has been escalated to PFIB. Difficulties are still experienced during periods of heightened pressure when patient flow across the department is restricted. Workstreams 1 and 2 are working on high impact actions to improve different aspects of patient flow across the system (including front door schemes of triage and streaming, workforce, red to green) to collectively improve patient flow. NWAS attended the site in August to complete a second audit on ambulance activity and further opportunities to improve handover performance. ED continues to work with NWAS Sector Manager and local ALOs	

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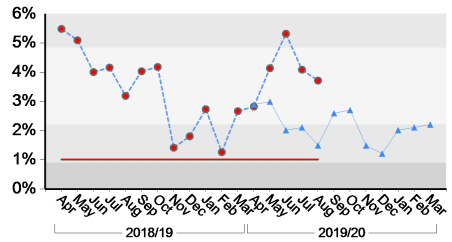
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	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 3.72% in August - Breaches were as follows: Audiology 6 patients (2.8%) Capacity due to vacancies. Cardiology - Echo 2 pts (0.7%) Capacity due to vacancies - locums extended Colonoscopy 27 pts (19.9%) 4 - patient choice, 23 - capacity Computed Tomography 3pts (1.0%) 2 - patient choice, 1 - required further information Cystoscopy including Gyn 10 pts (10%) patient choice, theatre capacity due to urgent cases Flexi Sigmoidoscopy 3pts 6.8% patient choice Gastroscopy 2pts 1.5% capacity - sickness MRI 10pts 2.1% patient choice, MRI scanner issue, 1 x interpreter required Non Obs Ultrasound 38pts 4.1% 27 required next muscular-skeletal scan appointment, patient choice, patient cancellation Urodynamics 7 pts (9.7%) Patient choice, 1 x clinic cancellation, 1 x patient cancellation, Reduced consultant activity - specialist service - Video Urodynamics (UroI) 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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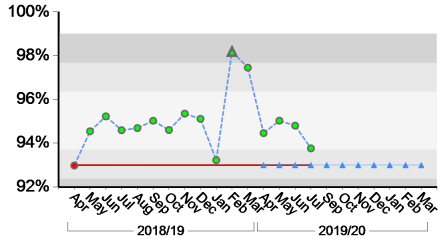
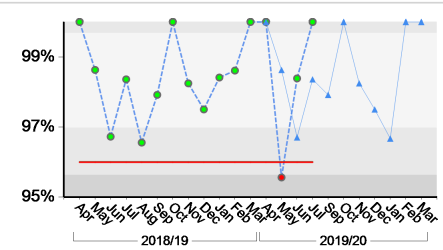
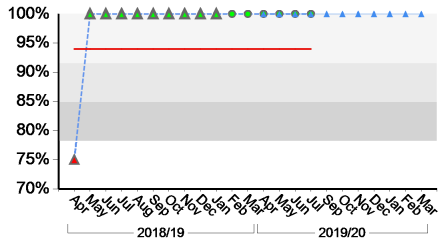
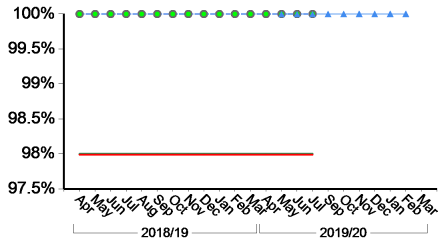
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	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.	Trust compliant against standard - July saw the Trust receive and see the highest number of two week wait referrals ever (1058). In spite of this compliance was maintained.	
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 compliance back at 100% - the Trust has reported breaches in previous months due to capacity constraints. There are now plans in place to address these and extra vigilance has ensured that no breaches occurred this month.	
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 of 100% maintained - The Trust continues to maintain it's compliance against this standard at 100%	
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').	Compliance against standard at 100% - For all months where patients have been reported against this standard, the Trust has complied with 100% meeting target	

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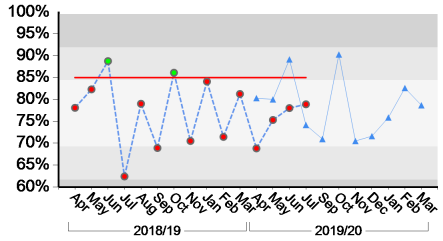
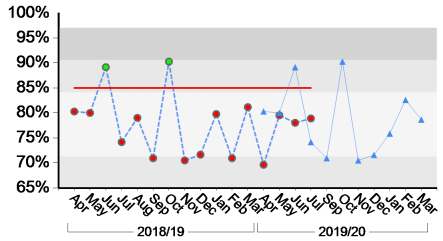
NHS Southport and Ormskirk Hospital NHS Trust

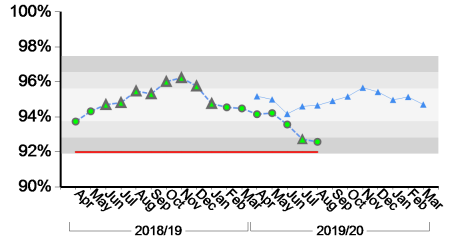
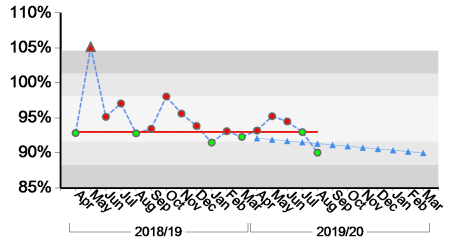
Responsive

Indicator Name (Colour - Perf | Traj)	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.	Trust performance under 85% threshold - Trust had 9.5 breaches in the month of July. These were; 1 full Gynae 1 full Haematology, 2 full Lower GI, 1 full skin, 3 full urology, 1 full other half Head & Neck	
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.	Trust still endeavouring to meet 62 day target - Cancer Action programme is well underway to ensure changes are put in place to establish timed pathway of 7 day steps	

Board Report - August 2019

Southport and Ormskirk Hospital NHS Trust

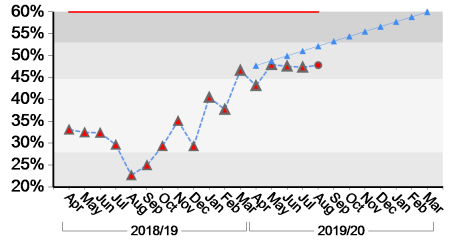
Responsive

Indicator Name (Colour - Perf | Traj)	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.	RTT remains above the 92% target - Performance is currently being impacted by issues within anaesthetics and various workforce issues within specialities. These workforce shortfalls have historically been addressed with WLIs. Current pensions issues have meant this is no longer a solution. This has been escalated to the Executive team.	
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	August saw a reduction in occupancy for Southport site - target level was achieved at 90.04% - 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 - August 2019

NHS Southport and Ormskirk Hospital NHS Trust

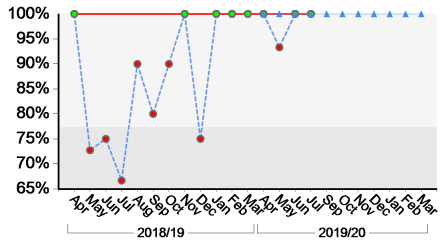
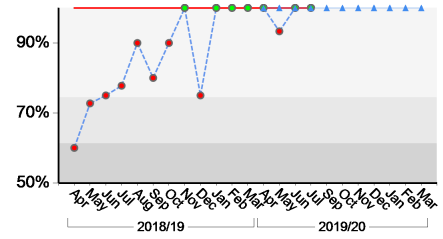
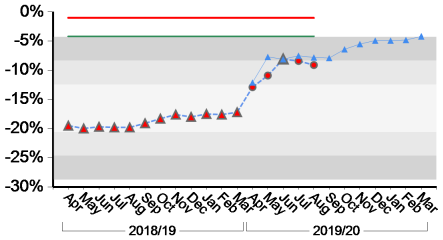
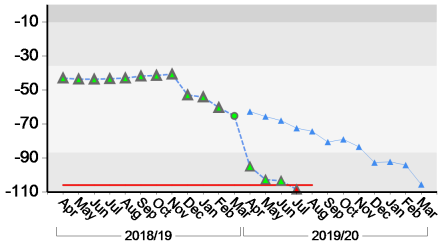
Responsive

Indicator Name (Colour - Perf | Traj)	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 static at ODGH at 47.85% - Elective activity is currently being impacted by the loss of anaesthetics and the associated reduction in cases. Recruitment of anaesthetists is ongoing. Cancellations are distributed amongst the specialties. The order of priority is: maintaining critical care, then acute care, then the Ormskirk site. This is monitored through the theatre scheduling meeting and weekly PTL	

Board Report - August 2019

NHS Southport and Ormskirk Hospital NHS Trust

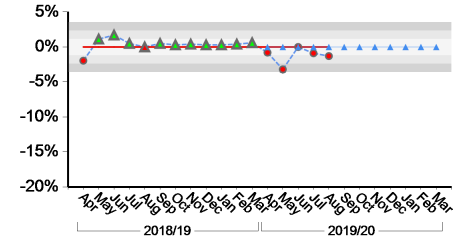
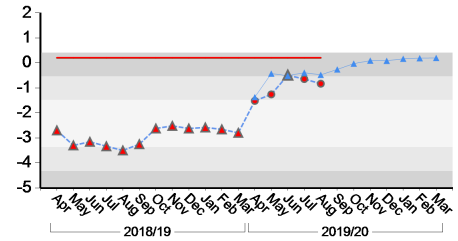
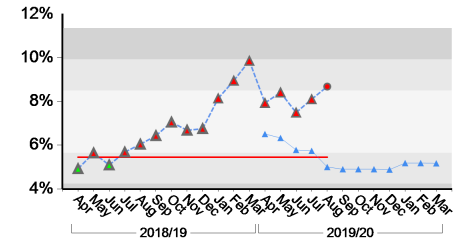
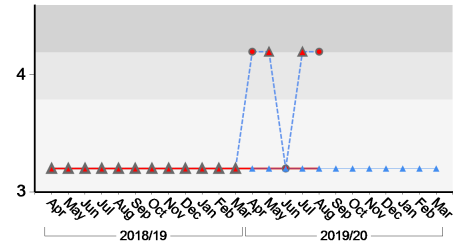
Well-Led

Indicator Name (Colour - Perf | Traj)	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 100% standard relating to duty of candour continues to be met -	
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 100% standard relating to duty of candour continues to be met -	
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 and the Quarter 1 position - The target is an I&E margin of -7.8% and the Trust achieved -9.1%. 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 - August 2019

Southport and Ormskirk Hospital NHS Trust

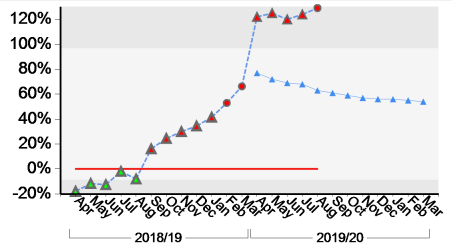
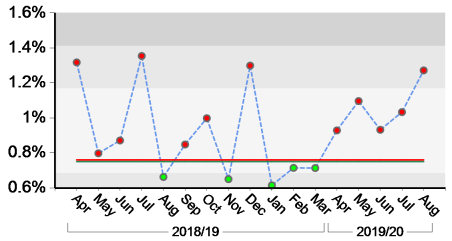
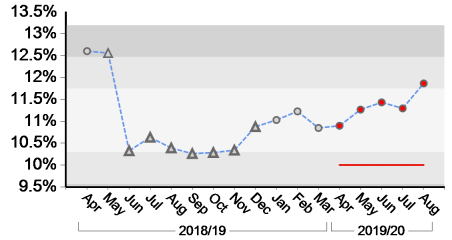
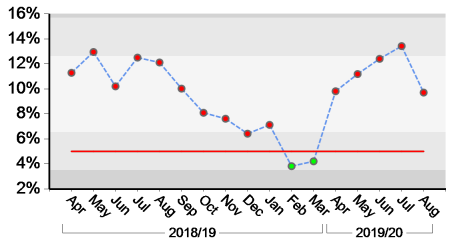
Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Distance from Control Total	Distance from Control Total.	Further deterioration to this metric in August - As the Trust is now more than 1% away from plan the rating for this metric has deteriorated from a 2 to a 3. Expenditure levels incurred in the first five 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.	Further deterioration to this metric in August - 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 static in August - Although the overall score remains at a 4, one of the metrics - distance from financial plan metric has deteriorated from a 2 to a 3 due to the Trust being more than 1% away from plan. All the other metrics remain at 4- Capital service cover, Liquidity, I&E margin and agency rating making the overall score a 4.	

Board Report - August 2019

Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Continued material overspend against the cap - Quarter 4 18/19 agency spend has continued into 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 is increasing - August saw a turnover of 1.27% - There was an increase in month with 38 leavers in August compared to 31 in July - the highest since December 2018. 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 increased in August at 11.87% compared to 11.3% in July - There was an increase in month with 38 leavers in August compared to 31 in July - the highest since December 2018. 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.	The medical vacancy rate saw a significant drop in August to 9.71% - Applications to medical posts have increased since the implementation of the BMJ advertising campaign. Further plans are in development to scope increased utilisation of social media to promote campaigns. Contracting completed with framework agency. Engaged with hard to recruit specialties including Radiology and Anaesthetics. Anaesthetic PAs recruitment in progress; offers made to grow alternative future workforce with plans in place to commence in Q3/4. Detailed project plan in place to support reduction in time to hire managed through model hospital program board and Workforce Improvement Board. Medical establishment control implementation - Process to be implemented to identify recruitment areas	

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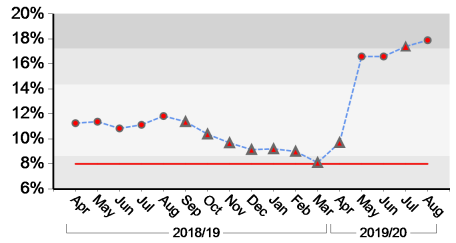
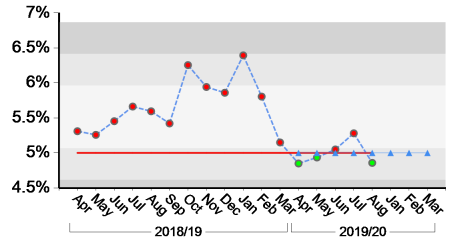
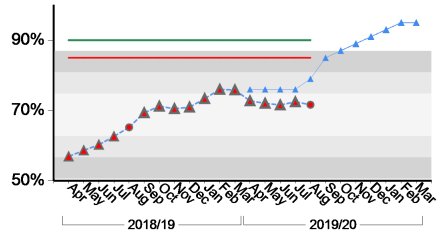
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Reflective of trust investment to nursing establishments and attrition for the month of July - Ongoing recruitment to HCA and RN vacancies across the financial year. In October the Trust should see the start of 29 HCA posts. By December 2019 we aim to be fully recruited to 59 HCA posts and will continue to work on a trajectory to reach 51 Registered Nurses by March 2020.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	August 2019's sickness absence rate has improved in month to 4.86% - 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 rolling 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 decreased slightly in month to 71.61% in August. - Data cleansing identified that PDR's are taking place but that the dates are not being successfully recorded on ESR.Support is being provided from the PMO team and Information team in continuing the data cleanse and educating on process.	

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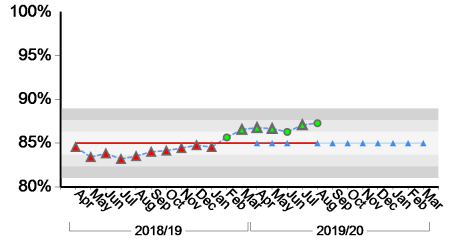
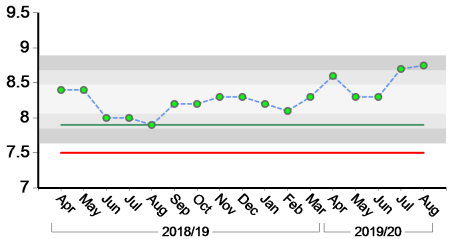
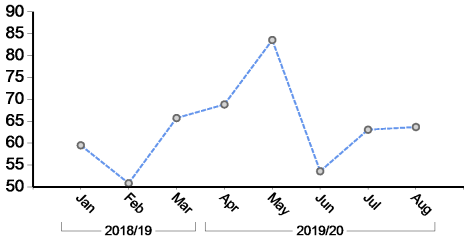
Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Core mandatory training continues on an upward trajectory to 87.28% - and therefore remains stable, performing above the 85% Trust target.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Performance remains above the national average of 7 hours CHpPD - Planned Care business unit report 10.1 and Womens and Childrens reports 23.2 identifying ward/dept areas sitting outside of national measures within model hospital. Reporting processes for Flexible worker through allocate on arrival are under review to support trust overall fill rate and CHpPD. A number of areas are included in the analysis (i.e. maternity and day case areas). There will be a cleansing exercise to ensure e data is correct next month	
Time to Recruit	The number of working days from Advert Close to Start Date. Please note that candidates requiring a Visa are included.	New indicator on IPR - Model Hospital KPI - Time to recruit is a focus at the HR Performance Review Board and a key workstream within the Workforce Improvement Programme. Future reports will include updates on progress towards achieving the target of 30 days	

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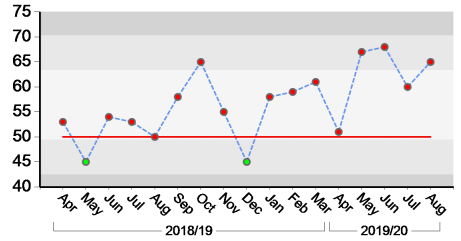
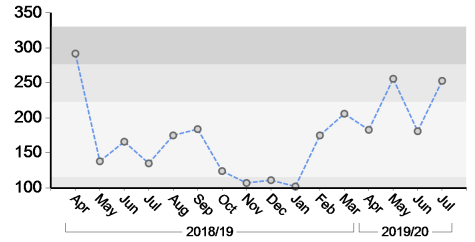
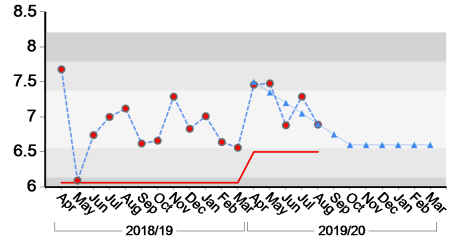
NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name (Colour - Perf | Traj)	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.	The figure remains stable at 65 in August - Although there was an increase in month the overall bed days lost remain between 60-65; improvements in recording of data on medway is giving us a correct measure to work with. We continue to work with community and LA teams to support movement of patients from acute care once medically fit. there remains a proportion of patients who require on-going therapy which can not be supported in the community due to the level of dependency. Daily huddles continue with information from the discharge facilitators from Red2Green board rounds; SAFER engagement events have occurred at ward level	
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 July was significantly higher (253) compared to June (181) -	
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.	LoS has returned to the previous month's levels at 6.89 compared to 7.29 in July - workstreams reporting through to Patient Flow Improvement Programme to support utilisation of assessment areas (work stream 1) and reducing LoS (workstream 2); engagement events with all in-patient wards to support SAFER at ward level have been completed; continued daily review through discharge huddle with system partners with delays identified through ward red2green board rounds on all in-patient wards	

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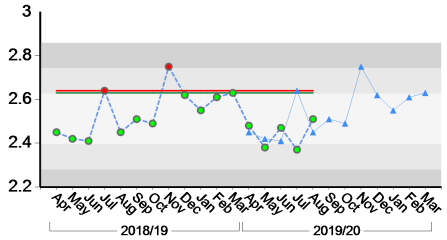
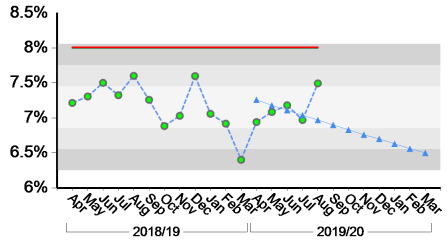
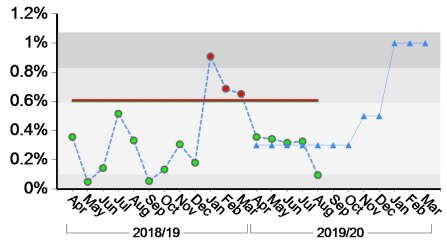
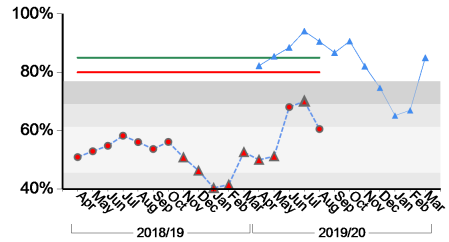
NHS Southport and Ormskirk Hospital NHS Trust

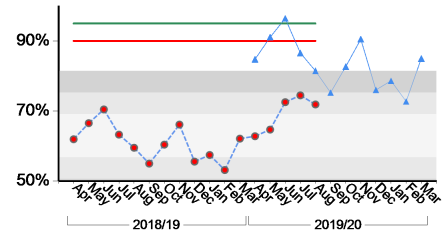
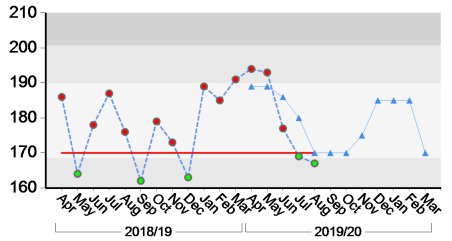
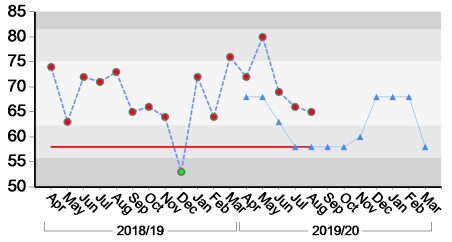
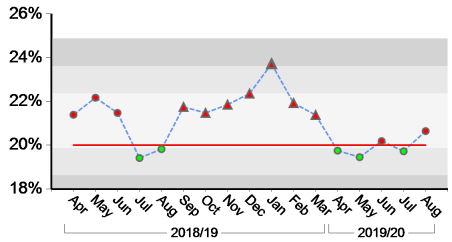
Efficiency

Indicator Name (Colour - Perf | Traj)	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 maintain performance -	
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	The DNA rate increased in August to 7.49% - 1687 out of 22511 - 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 fifth month in a row - returning back to performance within the normal range for the trust at 0.09% - 2 elective operations out of 2120 were cancelled at short notice in August	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Reduction in performance is due to emergency and Trauma under utilisation - Theatre utilisation for elective lists at SDGH is 73.08%. Golden Patient roll-out to all specialties by the end of September	

Board Report - August 2019

NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Utilisation dropped in month as a result of anaesthetic issues and an increase in cancellations on the day - Workforce remains under review with insourcing options being reviewed. 48hr TCI calls will recommence following nurse staffing review for this initiative. Late starts in Gynae and urology are under review by improvement programme. Golden Patient roll-out to all specialties by the end of September	
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 was not compliant in August at 20.64% - 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	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB170/19**	**Report Title**	**Director of Finance Report – Month 5 2019/20**
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 5 performance against the plan submitted to NHSI on 4th April 2019.

Contracts have been signed except for NHS West Lancashire CCG; impact of the arbitration decision is being worked through in order to be able to sign a contract for 2019/20. The impact on the Trust is a reduction in income of £0.4m to £0.6m.

The month 5 YTD position is a deficit after PSF/FRF of £7.273 million against a plan of £6.275 million resulting in £1.0 million worse than plan. Before PSF/FRF the YTD deficit is £12.450 million

The month 5 positon is a deficit after PSF/FRF of £1.842 million against a plan of £1.394 million resulting in £448,000 worse than plan. Before PSF/FRF the in-month deficit is £3.060 million

The income budget is performing well apart from elective activity which is under performing. Expenditure levels remain unchanged from last month and are too high to enable the financial plan to be delivered.

The 2019/20 CIP programme is £636,000 behind plan at month 5; the forecast outturn is £4.8 million. The unidentified gap has increased by £200,000 to £1.5 million

Expenditure levels incurred in the first five months of the year is fairly consistent. In Quarter 1 these levels could be mitigated non-recurrently by £1.3 million. 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.

The Trust is currently forecasting to miss the financial plan by £5.2 million if expenditure cannot be reduced below current levels.

A number of business cases have been implemented recently and will create a pressure on the expenditure run rate. It is essential that further CIP schemes are able to mitigate this pressure so that the forecast position doesn't deteriorate further.

The Use of Resources metric remains unchanged from July and is a 4.

The current underlying average monthly deficit is £2.7 million excluding PSF/FRF once non recurrent issues have been removed. This indicates the Trust has an underlying annualised deficit of

£32.0 million.

The Board is asked to **receive** the Director of Finance Report – Month 5 2019/20.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

Assessment **must** accompany the report)	☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Committee)*	
Previously Presented at:	
☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

Director of Finance Report – Month 5 2019/20

1. Purpose

1.1. This report provides the Board with the financial position for Month 5 (August 2019) and the progress on delivery of the Trust's control total.

1.2. 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).

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

2. Executive Summary

2.1. This report contains the Month 5 (August 2019) performance against the plan submitted to NHSI on 4th April 2019. .

2.2. Contracts have been signed except for NHS West Lancashire CCG; impact of the arbitration decision is being worked through in order to be able to sign a contract for 2019/20. The impact on the Trust is a reduction in income of £0.5.

2.3. The month 5 YTD position is a deficit after PSF/FRF of £7.273 million against a plan of £6.275 million resulting in £1.0 million worse than plan. Before PSF/FRF the YTD deficit is £12.450 million

2.4. The month 5 positon is a deficit after PSF/FRF of £1.842 million against a plan of £1.394 million resulting in £448,000 worse than plan. Before PSF/FRF the in-month deficit is £3.060 million.

2.5. The income budget is performing well apart from elective activity which is under performing. Expenditure levels remain unchanged from last month and are too high to enable the financial plan to be delivered.

2.6. Expenditure levels incurred in the first five months of the year is fairly consistent. 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.

2.7. The 2019/20 CIP programme is £636,000 behind plan at month 5; the forecast outturn is £4.8 million leaving an unidentified gap of £1.5 million.

2.8. The Trust is currently forecasting to miss the financial plan by £5.2 million if expenditure cannot be reduced below current levels.

2.9. A number of business cases have been implemented recently and will create a pressure on the expenditure run rate. It is essential that further CIP schemes are able to mitigate this pressure so that the forecast position doesn't deteriorate further.

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

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	165,261	69,318	69,039	(279)	13,400	13,300	(100)
PP, Overseas & RTA	1,093	458	334	(124)	95	64	(31)
Other Income	12,086	5,189	5,434	245	1,283	1,062	(221)
PSF & FRF	18,271	5,177	5,177	0	1,218	1,218	0
Total Operating Income	**196,711**	**80,142**	**79,984**	(158)	**15,996**	**15,644**	(352)
PAY	(139,856)	(58,939)	(59,349)	(410)	(11,744)	(11,803)	(59)
NON PAY	(53,036)	(22,422)	(22,815)	(393)	(4,653)	(4,662)	(9)
Total Operating Expenditure	**(192,891)**	**(81,361)**	**(82,163)**	**(803)**	**(16,397)**	**(16,464)**	**(68)**
EBITDA	**3,820**	**(1,220)**	**(2,180)**	**(961)**	**(402)**	**(820)**	**(420)**
Net Financing Costs	(12,149)	(5,086)	(5,115)	(29)	(1,004)	(1,034)	(30)
Retained Surplus/Deficit	**(8,329)**	**(6,306)**	**(7,294)**	**(990)**	**(1,405)**	**(1,854)**	**(450)**
Technical Adjustments	33	31	21	(10)	11	13	2
Break Even Surplus/(Deficit)	**(8,296)**	**(6,275)**	**(7,273)**	**(1,000)**	**(1,394)**	**(1,842)**	**(448)**
Less PSF/FRF Funding	(18,271)	(5,177)	(5,177)	0	(1,218)	(1,218)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(11,452)**	**(12,450)**	**(1,000)**	**(2,612)**	**(3,060)**	**(448)**

2.11. Although the table above shows that the Trust has accounted for £1.218 million PSF/FRF funding in August this will only be received if the Quarter 2 financial plan is achieved.

2.12. The current underlying monthly deficit is in the region of £2.7 million excluding PSF/FRF once non recurrent issues have been removed.

2.13. This indicates the Trust has an underlying annualised deficit of £32.0 million.

3. 2019/20 Contract Position

3.1. Contracts have been signed except for NHS West Lancashire CCG; impact of the arbitration decision is being worked through in order to be able to sign a contract for 2019/20.

3.2. The impact on the Trust is a reduction in income of £0.5.

3.3. As reported previously the contract with Southport & Formby CCG is a “Cost based contract” which has a number of “conditional income” elements.

3.4. These conditional elements are Best Practice Tariffs above 2018/19 levels; Repatriation of elective work; 2019/20 Business cases; Contingency

3.5. All other CCG contracts are on a PbR type contract.

3.6. The commissioning income annual budget in the above table includes:-

- £51.0 million for West Lancashire CCG; based on month 5 activity performance, this is forecast to be achieved.
- £74.9 million for Southport & Formby CCG; the Trust is currently underperforming against the conditional elements of the contract.

4. **Income**

4.1. Trust activity and income performance at month 5 YTD is as follows:

- Elective – activity is 5% below plan; £570,000 loss of income
- A&E – activity 7.5% above plan; £339,000 of additional income
- Non Elective – activity is 10% below plan; but £1,520,000 additional income (see 4.2)
- Outpatients – activity is 5% above plan; £546,000 of additional income

4.2. Only a proportion of the non-elective value above is payable due to the application of the "blended tariff" adjustment.

4.3. The Trust continues to underperform against a number of areas which mainly fall within the "conditional income" section of the Southport & Formby CCG contract. The main issues are:

- Elective performance
- Best Practice Tariffs above 2018/19 levels
- Repatriation of elective work
- Business cases not implemented
- Contingency not incurred to date

4.4. The Trust's commissioning income in the month 5 YTD position assumes the following:

- Southport & Formby CCG will pay up to the month 5 value of the contract (full year £74.9 million); this results in an accrual of £425,000 for the issue in 4.3 above.
- All other commissioning income is paid in line with the agreed contract

4.5. The shortfall on commissioning income of £279,000 is the combination of a number of issues one of which is previous years' commissioning income disputes along with the current underperformance against the West Lancashire CCG plan although this is predicted to balance at year end.

4.6. Other income is adverse in month primarily due to setting the income budget for NHSI quality funding.

4.7. The £245,000 year to date favourable variance is mainly due to the non-recurrent technical adjustments which were applied in month 3 (VAT for salary sacrifice) and other income benefits.

5. Expenditure

5.1. Expenditure levels in month 5 are again consistent with previous months and remain too high to achieve the year end control total. Monthly pay expenditure has continued at the high levels experienced in Quarter 4 of 2018/19.

5.2. A number of non-recurrent expenditure reductions were applied in month 3 in order to achieve the Quarter 1 control total but no further reductions have been applied in months 4 and 5 and, therefore, the high expenditure levels have not been mitigated.

5.3. The overspend of £803,000 in the above table reflects the underperforming CIP (£668,000) as

well as the premium rates incurred on supporting vacancies and other pressures.

5.4. The Trust has spent a total of £3.695 million at month 5 YTD the breakdown of which is as follows; In tariff £1.562 million; Cancer Drug Fund £0.197 million; High Cost Drugs £1.936 million.

6. Bank/agency spend

6.1. Monthly agency spend has increased in August to £1,024,000 (8.7% of the pay bill); Medical staff £521,000; Nursing £400,000

6.2. Month 5 YTD agency spend is £4.819 million (8.1% of the pay bill); Medical staff £2.631 million; Nursing £1.791 million

6.3. An agency target cap of £4.891 million has been set by NHSI for 2019/20. The Trust's Operational Plan highlighted that the cap could not be achieved and will be breeched next month.

6.4. Total Bank spend is consistent with previous months; August is £956,000 (8% of the total pay bill) bringing YTD spend to £4.654 million (7.8% of the total pay bill).

6.5. The Trust spent almost £2.0 million in August on bank and agency staff.

6.6. This attracts a considerable premium element and is a key area of focus for the Trust to improve its financial position.

7. Cost Improvement Plan (CIP)

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

7.2. 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 5 Budget £000	Month 5 Actual £000	Month 5 Var £000	YTD Budget £000	YTD Actual £000	YTD Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	350	106	(244)	1,383	722	(661)	1,274	954
19/20 Plan - Expenditure (non pay)	1,724	1,724	149	68	(81)	586	579	(7)	1,128	970
19/20 Plan - Income (other op income)	325	325	39	11	(28)	49	186	137	312	63
19/20 Plan - Income (BPT)	1,800	300	26	0	(26)	105	0	(105)	0	0
19/20 Plan - Total	**6,314**	**6,314**	**564**	**184**	**(380)**	**2,123**	**1,487**	**(636)**	**2,714**	**1,987**

7.4. The forecast outturn against the £6.3 million target has reduced to £4.8 million leaving an unidentified gap of £1.5 million.

8. Risks

8.1. The Trust's income plan includes CQUIN at 1.25% of the contract value.

8.2. There is no risk regarding the Southport & Formby CCG element due to the nature of the contract.

8.3. In all other contracts the CQUIN element needs to be delivered in order to achieve full payment. This element is worth £815,000.

8.4. NHSE have confirmed achievement of the Quarter 1 targets. Quarter 2 may not be achieved

due to the Klebsiella infection.

8.5. The risk to Quarter 1 CQUIN income is currently estimated to be £88,000 although this will be firmed up in month 6.

9. Capital

9.1. Actual spend year to date is £1,091,000 against a planned spend year to date of £2,433,000.

9.2. Commitments remain at a similar level to last month at £706,000.

9.3. The Southport ward upgrade project has started and the first 6 wards will be completed before Christmas.

9.4. A number of contractor variations were discussed at the Ward upgrade Project Board.

9.5. A separate paper will be shared with the Board regarding the final costing of the ward upgrade project.

9.6. There are also potential additional costs arising from 2 further schemes – Spinal Isolation and spinal bathroom refurbishments due to the identification of Klebsiella.

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

9.8. Taking actual and committed spend together at £1,756,000 (excluding donated and GE radiology assets) and comparing this against the annual plan, £5,103,000, then the Trust is at 34.4% of the plan at the end of August 2019.

9.9. IM&T contingency scheme at £450,000 was originally intended for the data centre, however, this is looking unlikely to be implemented in 2019/20 and a potential re-utilisation of these monies to other IT projects which will be discussed at the next Capital Investment Group.

9.10. There is an opportunity for the Trust to receive a significant capital investment of approximately £700,000 for ePMA (electronic prescribing and medicines administration) wave 2 funding.

9.11. The Executive Team has confirmed with NHS Improvement that they are ready to proceed with this project.

10. Cash

10.1. A cashflow is attached in the appendices showing actual cash flows from April 2019 to August 2019 and forecast cashflows for the remainder of the financial year.

10.2. The Trust has worked with the main commissioners to settle debts on both sides. In addition, significant cash support was received in August from both NHS Southport & Formby CCG and NHS South Sefton CCG.

10.3. This significant cash injection is likely to give the Trust a 3 month respite from requiring Department of Health & Social Care (DHSC) interest-bearing loan funding.

10.4. The Trust continues to pay interest on its previous DHSC loans and these loans are repayable in full at the end of 3 years.

10.5. Current interest rates are 1.5% as the Trust has agreed its 2019/20 control total target.

10.6. Loan conditions include a minimum month-end cash balance of £1.0 million.

10.7. A rolling 13 week cash forecast is updated monthly and sent to NHSI/E, usually in the second

working week of the month; this forms the basis of any cash draw downs in the following month.

10.8. August's cash flow was submitted to NHSI/E on 13th August 2019.

10.9. Performance against the cash target in August was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,474	
Cash inflows	22,994	24,700	At the time the plan was done the full extent of extra monies from the CCGs was not fully known.
Cash outflows	-17,294	-19,164	Significant capital cash flows mainly connected with the anaesthetic machines plus higher than expected bills from NHS Professionals.
Closing balance	**6,700**	**7,010**	

10.10. Whilst there are variances on both cash in and out flows the Trust has managed to end the month slightly ahead of plan.

11. Recommendations

11.1. The Board is asked to receive the Director of Finance Report – Month 5 2019/20.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**PB171/19**	**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, one risk has been added onto the risk register.

- **2072** - Failure to achieve 2019/20 financial control total. This has been added to the risk register to reflect the short-term risk relating to the current financial year.

Since the last meeting, one risk has been removed from the risk register.

- **1987** - Haem / Oncology, reduction in medical capacity following resignation of consultant. This has been reduced to a high risk (12) due to commencement of locums in post. There has also been 1 expression of interest to the substantive post.

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
- **2072** - Failure to achieve 2019/20 financial control total
- **2056** - Missing Patient appointments/admissions
- **2021** - In Hospital Mortality
- **1977** - Paediatric Dietetics Band 6

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

SEPTEMBER 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 24/09/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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	20↑	=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↓	Risk Closed - replaced with Risk 2052 ↓	↓	↓	↓
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	12↓
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	=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	20↑
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	=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	16↑
2072	SO3 - Efficiently and productively provide care within agreed financial limits	Failure to achieve 2019/20 financial control total	Director of Finance						!16

TRUST RISK PROFILE AS AT 24/09/2019

	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** **2072 - Failure to achieve 2019/20 financial control total** **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** **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	13/09/2019	11/10/2019

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 31/12/2019 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	• Review of the Action Plan continues in the weekly assurance meetings. • CCG have attended one meeting to date and will continue on a fortnightly basis. • CCG are currently satisfied with the content of the action plan and the progress to date. • Tracking tool has been produced by BI. • SOP for validation and escalation has been agreed and implemented. • First interim tracker has arrived in the Trust and commenced training with Tracking team. Second one starts October 1st. • CBUs have highlighted priorities within their patient cohorts for prioritisation. • Data quality has been shown to have a major impact on process. • Substantive Directorate Manager has been appointed to Access and Bookings.				

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	13/09/2019	15/10/2019

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 QI methodology in place to support E-Roster performance 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	• Rosters aligned to NER • PAG agreed extended temporary fixed term post until Nov 2019 against the Identified HR support to enable proactive recruitment of the vacancies within the NER (24/9/19) • Recruitment Events planned across the year to support delivery against the NER • QI programme for e-roster delivery ongoing				

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

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

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

Controls	enhanced team to support DoN deliver expectations Improvement plans developed and agreed with trust Board Improvement groups developed across Trusts, including CBUs commitment to run a shadow CQC process over 12 weeks Identified Executive and management leads for Performance, quality, people and use of resources development of a shared drive to enable evidence to be uploaded development of awareness raising and preparation for key leaders at Board and CBU level identified support from PMO with project management Well-led work ongoing with AQUA CQC Programme Manager in post working to Assistant Director of Quality PIR completed and submitted 03.05.19 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	Gaps in Controls	CQC identified 96 MUST AND SHOULD DO actions following November and December 2017 inspection Lack of pace and assurance regarding progress of action plan 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	13/09/2019	15/10/2019

Assurance	committee structure regular engagement meetings assurance at quality and safety & committee CBU monthly governance meetings development of a single quality improvement action plan engage and gain support for validation from HealthWatch, CCG and other regulators Core service review identified some areas of improvement including openness of staff, Staff are caring, compassionate and there are examples of good practice, stability of leadership and no areas were considered to be 'inadequate' on both days Internal assurance panels Following submission of PIR - Preparation Plan Updated and KLOEs identified 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 Letter submitted to CQC identifying improvements made since inspections	Gaps in Assurance	Engagement of key leaders from 'ward to board' reduced understanding of expectations of regulator prior, during and after inspections A number of gaps identified during core services review, these are being addressed through Quality Improvement Plan. CQC Inspection July identified issues with Medicines Management, MCA / DoLs and other areas for further improvement Feedback received from CQC facilities focus group highlighting discontent in team and issues with culture and communication

Action Plan	Incorporate any Red Must Do Actions into CBU Risk Register Monitor facilities focus group action plan through quality assurance panels work with communications team to engage widely with staff	Action Plan Due Date	17/07/2019 28/02/2020 30/09/2019	Action Plan Rating	Completed Little or No Progress Made

	develop training for staff across the organisation Key leaders to access training with lead CQC executive/manager Establish confirm and challenge sessions for each action and core service to expedite progress against action Plan, and look at re-establishing the Quality Improvement Development (QID)Group To deliver against the 96 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.		28/06/2019 22/10/2019 29/11/2019		Completed Completed Actions Almost Completed Moderate Progress Made
Latest Month Progress	CQC inspections have been completed and the draft report is expected in October 2019. During the inspection it was noted there had been significant progress made against the action plan. Assurance panels will continue to review actions raised during unannounced inspection. This includes feedback from the Facilities Focus Group which highlighted discontent and issues with communication and culture.				

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 the Red2Green principles at board rounds across the Trust. Nutrition - New policy approved, New E-learning module provided to RNs on ward 10B with new care plans being tested - in addition to this, additional Dietetic support is being offered to this ward while they implement the new practices. Business Intelligence are working on a new collection of KPIs to measure and monitor improvement. Mouth Care- 5 staff completed Mouth Care Matters Train the Trainer programme- currently developing new policy, care plans and product availability. Dementia & Delirium - New cognitive risk assessment and care plan being trialed on 6 wards with new patient information leaflets and reporting of FAIR nationally on a new proforma as the screening tool has been changed. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Falls - 6 wards using new risk assessment, care plan and daily checklist with new e-learning module accessible to staff for completion. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Bedrails- 6 wards trialing new risk assessment, care plan and daily check - being reviewed after 1 month (end of June) for any amendments and further roll out. (Education included in falls e-learning module) Frailty Team delivering service M-F in AED and 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 e.g. dementia Lack of understanding of the impact of patients remaining in bed, in pads, with cot sides, not eating/drinking - New Training Programme to be launched end of July. Lack of pathway/service availability to support patients with enhanced needs returning home- i.e. lack of 24hour care in community to step down - Work underway with CCG, Community and LA colleagues to redesign pathway, Homefirst and Delirium/Dementia. Not yet commenced mouth care roll-out Documentation not conducive to providing person-centred care, this is to be reviewed as an entity July 2019 (particularly care plans and risk assessments) Clinical supervision for the frailty team lacking- exploring use of Leeds Buddy arrangement to support. Continence project not yet commenced- scoping session 25/6/19 to plan improvement work

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review	
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	20/09/2019	18/10/2019	
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, and 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**	03/02/2020 29/11/2019 03/02/2020 31/12/2019 31/10/2019 31/01/2020	**Action Plan Rating**	Moderate Progress Made Actions Almost Completed Moderate Progress Made Actions Almost Completed Moderate Progress Made Moderate Progress Made
Latest Month Progress	The Mouth Care Matters Group have started drafting the mouth care policy which will be sent for approval by the end of September. The products have been reviewed and a select list adhering to the guidance in the new policy and care plan have been agreed and these are all available on NHS supply chain for wards to order. The new care plan is in second draft and will be rolled out for a trial on ward 14B starting on 30th September, following this any further changes required will be made and the roll put will then continue across the trust and a roll out plan will be shared. Post-falls assessment being further developed to be trailed by September and training to be delivered. Falls documentation is on all wards except SIU, ITU and ODGH and will be in all areas except ITU by the end of September. This if applied and completed fully maps to best and evidence based practice as well as safe, high in quality and would meet the CQUIN. The falls strategy is to be created in September and October with a view to launching by November. The draft versions of the continence risk assessment and care plan are underway. The company who provide products have been contacted to plan a review of available products and these recommendations will be made with the group in the new documentation. The specialists in community are supporting this piece of work.									

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' workstream. 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	This risk was discussed at Mortality Operational Group in September 2019 and a recommendation was made to downgrade this risk to high due to the reduction in both HSMR and SHMI. The risk will be downgraded prior to next Trust Board.

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	24/09/2019	24/10/2019
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	The business case was approved in August 2019 and all posts went out to advert. Recruitment is ongoing and since the end of August 1 x Consultant,4 x PAA and 2 x Sp Dr posts have been recruited to and pre-employment checks have commenced. In September a further 3 x clinical fellows appointed.								

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**				
18/02/2019	1977	Director of Nursing & Quality	Nicola Ivanovic	Peadiatric Dietetic Service Community West Lancashire				
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	22/08/2019	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	No progress made in month. Due to meet with CCG in September with a view to suspending 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	16/09/2019	18/11/2019

Assurance	Acute Sustainability Programme Board-currently fortnightly Finance Performance & Investment Committee and Trust Board-monthly Hospital Management Board-monthly Performance Review Board-monthly People and Activities Group (PAG) process in place - meeting weekly Submit monthly workforce and finance data to NHS Improvement Cost Improvement Programme data submitted fortnightly to NHS Improvement	**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. Obtaining relevant information, financial and activity from the Trust Confirmation of Scenarios Initial Assumptions Development and Confirmation with the Trust Agree specialty cost structure for scenario development Produce Demand and Capacity (Activity) model Produce detailed Travel Analysis Produce Financial and Economic models Alignment of models Prepare and share draft report Final Report	**Action Plan Due Date**	31/12/2019 31/01/2019 30/09/2019 28/10/2019	**Action Plan Rating**	Actions Almost Completed Completed Completed Moderate Progress Made
Latest Month Progress	System recovery plan submitted 2nd August; System partners and Regulator met 6th August; further submission made on 13 August, submitted a detailed project and resourcing plan for developing and implementing the schemes that will make up your System Financial Recovery Plan. NHSE/NHSI Director of Performance and Improvement advised, that in late September (26th) there will be a whole system meeting that replaces the current IAF and QRM meetings for commissioners and providers respectively. This will be used to review both operational and financial performance. For the finance element, this will effectively be used as to monitor the progress of the financial recovery plan. A written update on the progress of the System Financial Recovery Plan to be provided by noon on 13 September that will demonstrate delivery of the aggregate control total.				

Strategic Objective		SO3 - Efficiently and productively provide care within agreed financial limits						Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
22/07/2019	2072	Steve Shanahan	Steve Shanahan	Failure to achieve 2019/20 financial control total					
Description	If the Trust fails to achieve its 2019/20 financial control (a deficit of £8.296 million) then the Trust could be put into financial special measures and it would lose non-recurrent PSF (Provider Sustainability Fund) and FRF (Financial Recovery Fund) funding of up to £18.271 million. This risk is linked to Risk ID 1942 - eradicating the Trust's deficit by 2023/24. This new risk is the short-term risk and 1942 is the long-term risk.								
Controls	People and Activities Group (PAG) Hospital Management Board (HMB) Project Management Office (PMO) Southport & Formby CCG contract signed with maximum earnings of £74.9 million						**Gaps in Controls**	Signed contract with West Lancashire CCG outstanding following outcome of arbitration Further update required for regulator following System Financial Recovery plan submitted 2nd Aug 2019	
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	16/09/2019	21/10/2019
Assurance	People and Activities Group (PAG) process in place - meeting weekly Hospital Management Board (HMB) monthly Finance Performance & Investment Committee and Trust Board - monthly Submit monthly workforce and finance data to NHS Improvement Cost Improvement Programme data submitted fortnightly to NHS Improvement Acute Sustainability Programme Board - currently fortnightly Performance Review Board - monthly						**Gaps in Assurance**	Agency spend continues significantly in excess of NHS Improvement agency ceiling Recruitment and retention issues resulting in high vacancy rates Unidentified Cost Improvement Plans Non-recurrent measures used to deliver Q1 position not sustainable going into further quarters.	
Action Plan	Regulator will require monthly updates on delivery of the system recovery plan. 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. 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 A System Recovery Plan submitted on 02.08.19 to the Regulators. It was discussed with NHSI/NHSE on 06.08.19						**Action Plan Due Date**	31/03/2020 31/03/2019 30/09/2019 31/12/2019 02/08/2019	**Action Plan Rating**	Moderate Progress Made Completed Completed Actions Almost Completed Completed
Latest Month Progress	System recovery plan submitted 2nd August; System partners and Regulator met 6th August; further submission made on 13 August, submitted a detailed project and resourcing plan for developing and implementing the schemes that will make up your System Financial Recovery Plan. NHSE/NHSI Director of Performance and Improvement advised, that in late September (26th) there will be a whole system meeting that replaces the current IAF and QRM meetings for commissioners and providers respectively. This will be used to review both operational and financial performance. For the finance element, this will effectively be used as to monitor the progress of the financial recovery plan. A written update on the progress of the System Financial Recovery Plan to be provided by noon on 13 September that will demonstrate delivery of the aggregate control total.								

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB172/19**	**Report Title**	**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

The principle of developing a Single Improvement Plan (SIP) was agreed with the Southport and Ormskirk Improvement Board (SOIB) to ensure there is consistency and continuity in how it takes assurance against the Trust improvement journey. In April 2018 the Trust developed a SIP as a consolidated plan for describing all the improvement activities conducted during the year that will ultimately enable the Trust to exit the Challenged Provider (Sector 3) status and the remove the conditions on its Provider Licence.

The SIP is used as a reporting tool to assure SOIB that the Trust is making the required progress, and the ratings below relate to the levels of assurance the Trust feels able to give SOIB. There are eight risks rated as red with a further seven rated as amber, after mitigation is in place. The SIP priorities for 2019/20 are:

Quality: September rating - Amber

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

Operations: September rating - Amber

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

Workforce: September rating - Amber

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

Finance: September rating - Red

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

Strategy: September rating - Amber

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

The attached presentation has a deep dive into one of the operational areas; Theatre Turnaround times and explores further the work undertaken as a result of the NHSI/E (Southport & Ormskirk Quality Improvement) SOQI Programme which was undertaken by the Trust from June to September.

It is anticipated that this report will provide a deep dive into other areas within the report on an on-going basis.

The executive assurance reports are included in the paper for information purposes. Preceding Board reports will have picked up key areas described in these reports, with the exception of Acute Sustainability.

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Single Improvement Plan

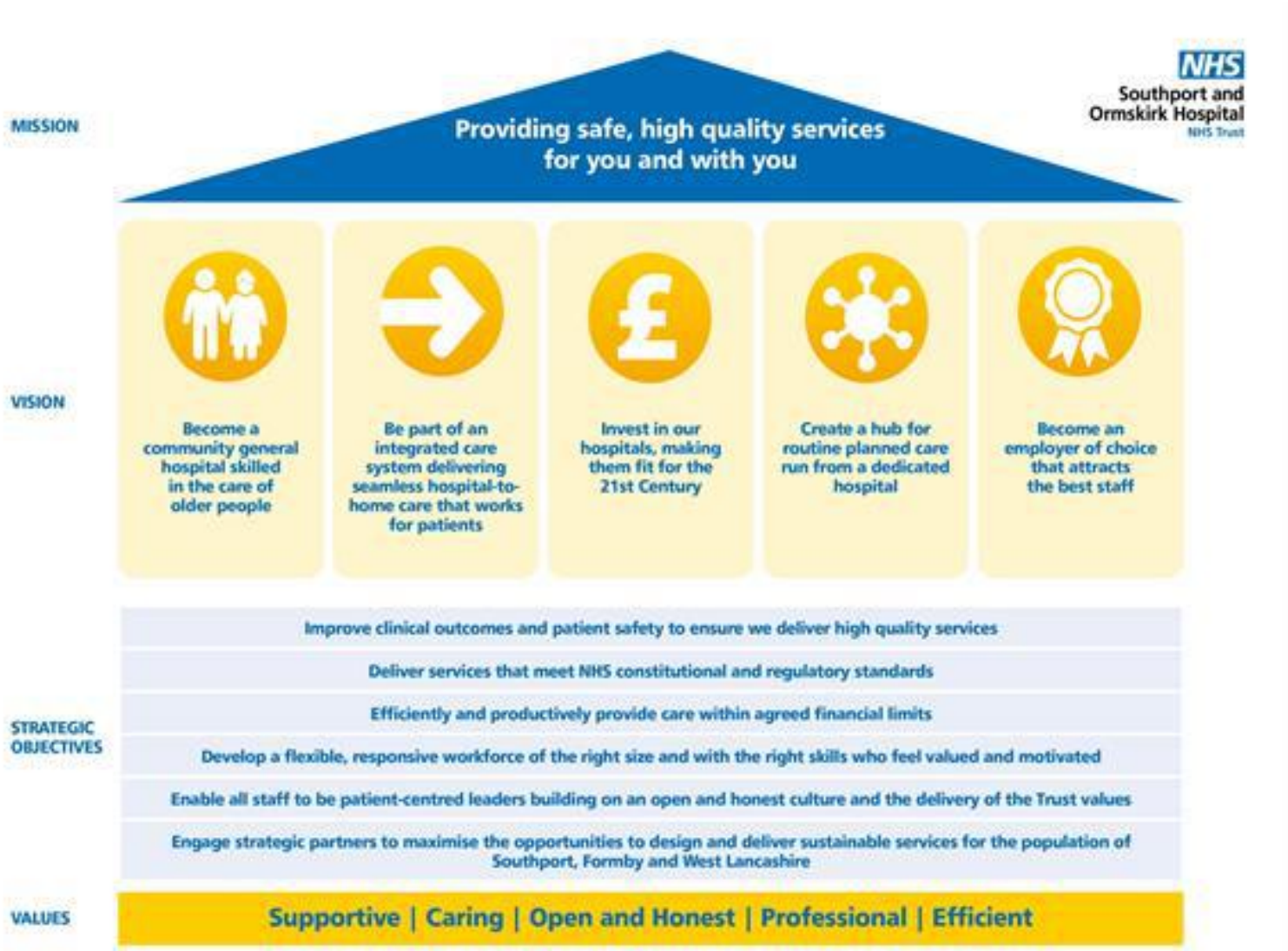
Board Update

October 2019

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

Single Improvement Plan - Background

NHS
Southport and Ormskirk Hospital
NHS Trust



Single Improvement Plan – Priorities & Trajectories

NHS
Southport and Ormskirk Hospital
NHS Trust

we have a dream	*what is important*	*how we will do it*
Trust Vision	**Priorities**	**Strategic Objectives**
Become a district general hospital with specialist skills in the care of older people Be part of an integrated care system delivering seamless hospital-to-home care that works for patients Invest in our hospitals, making them fit for the 21st Century Create a hub for routine planned care run from a dedicated hospital We will become an employer of choice that attracts the best staff	**Quality Priority 1** - Recognition and care of the deteriorating patient **Quality Priority 2** - Care of the older person **Quality Priority 3** - Infection prevention and control **Quality Priority 4** -Medicines management	SO 1- Improve clinical outcomes and patient safety to ensure we deliver high quality services
	Operations Priority 1 - Achievement of quality targets for ED, RTT, cancer and diagnostics **Operations Priority 2** - Clinical documentation focus on accuracy, completion and safe storage	SO 2 - Deliver services that meet NHS constitutional and regulatory standards
	Finance Priority 1 - Deliver our control total **Finance Priority 2** - Maximize capacity using transformative efficiency and productivity tools	SO 3- Efficiently and productively provide care within agreed financial limits
	Workforce Priority 1 - Culture – organisational development, staff engagement and Freedom to Speak Up **Workforce Priority 2** - Clinical workforce strategy to ensure the right numbers of skilled staff	SO 4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO 5 - Enable all staff to be patient-centred leaders building on an open and honest
	Strategy Priority 1 - Engage with partners to develop opportunities for joint working **Strategy Priority 2** - Develop an affordable, sustainable acute services model	culture and the delivery of the Trust values SO 6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Progress to date – September 2019

Southport and Ormskirk Hospital NHS Trust

Priorities	Progress to date
Quality Priority 1- Recognition and care of the deteriorating patient **Quality Priority 2**- Care of the older person **Quality Priority 3**- Infection prevention and control **Quality Priority 4** -Medicines management	**Amber**
Operations Priority 1- Achievement of quality targets for ED, RTT, cancer and diagnostics **Operations Priority 2**- Clinical documentation focus on accuracy, completion and safe storage	**Amber**
Finance Priority 1- Deliver our control total **Finance Priority 2**- Maximize capacity using transformative efficiency and productivity tools	**Red**
Workforce Priority 1 - Culture – organisational development, staff engagement and Freedom to Speak Up **Workforce Priority 2** - Clinical workforce strategy to ensure the right numbers of skilled staff	**Amber**
Strategy Priority 1 - Engage with partners to develop opportunities for joint working **Strategy Priority 2** - Develop an affordable, sustainable acute services model	**Amber**

Key	
Blue	Activity completed
Red	Significantly delayed and/or of high
Amber	Slightly delayed and / or of low risk - can be recovered
Green	Progressing on schedule

Progress to date – Risks September 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Priorities	Risks (after mitigation)			
	Amber	Red	Narrative	Mitigation
Quality Priorities	1	2	Medicine Mgt Business Case Winter Pressures	Corporate input to business case Participate in the development of the system winter plan
Operations Priorities	0	2	Workforce – gaps impacting on current performance and being able to sustain a consistent level of performance Increased demand and worsened performance in MOFD and super-stranded metric	Workforce Improvement Board established CCG Commissioner discussions
Finance Priorities	1	2	Underlying expenditure levels will not reduce to pre Q4 2018/19 levels Income plan has been revised down following contract discussions. There is a risk that the BPT and repatriation of activity will not be achieved.	Further analysis of overspends and recovery actions established Best Practice Tariff opportunities of £1.1 million have been shared with CBU's. Repatriation £0.5 million of this should be available from T&O.
Workforce Priorities	5	1	Capacity of the HR Business Services Team	Temporary funding secured from E&F
Strategy Priorities		1	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	Alignment within the Acute Sustainability programme with the Sefton workforce workstream and wider C&M workforce agenda. HEE North is supporting the acute sustainability workstream

Deep Dive – Operations Priority 1

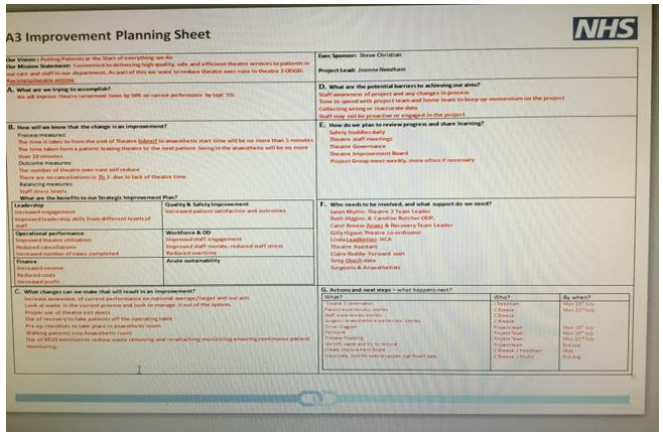
Achievement of quality targets for ED, RTT, cancer and diagnostics

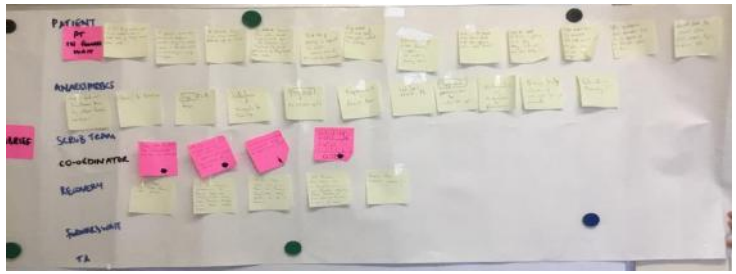
Southport and Ormskirk Hospital NHS Trust

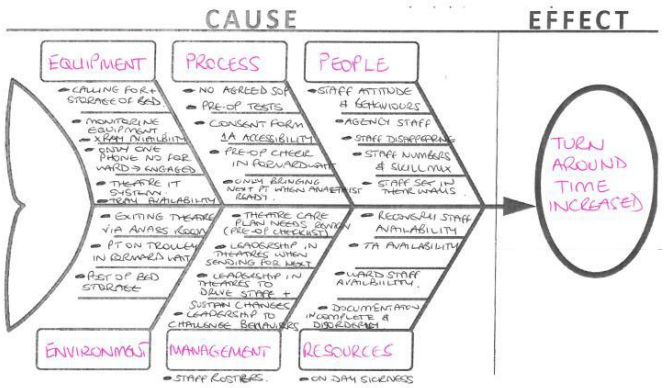
QI Project: Improving Theatre Turnaround Times.

Vision: Putting patients at the start of everything we do.

Mission statement: Committed to delivering high quality, safe and efficient theatres to patients in our care and staff in our department. As part of this we want to improve theatre turnaround times thus reducing theatre over-runs in Theatre 3 (Gynae) at ODGH.







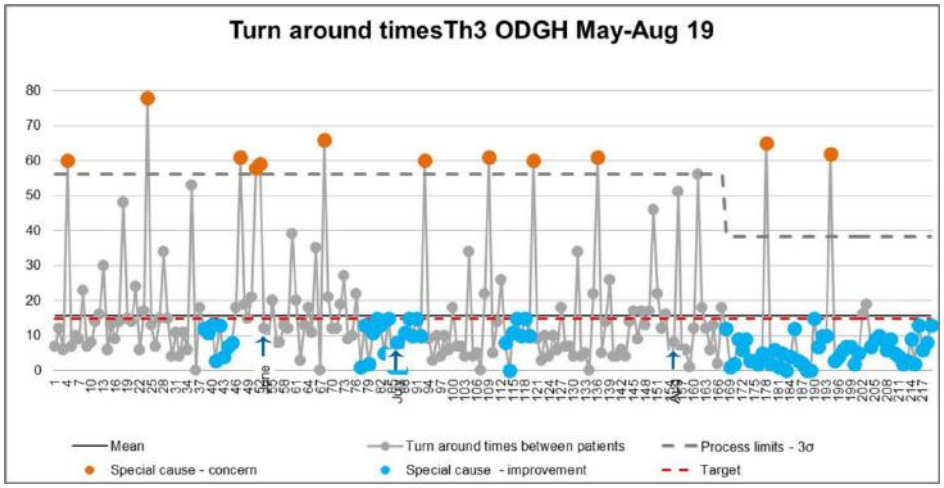
Tools used

- A3 planning sheet
- Process mapping-identifying waste
- Waste wheel
- Driver Diagram
- PDSA cycles

Result – What's different now

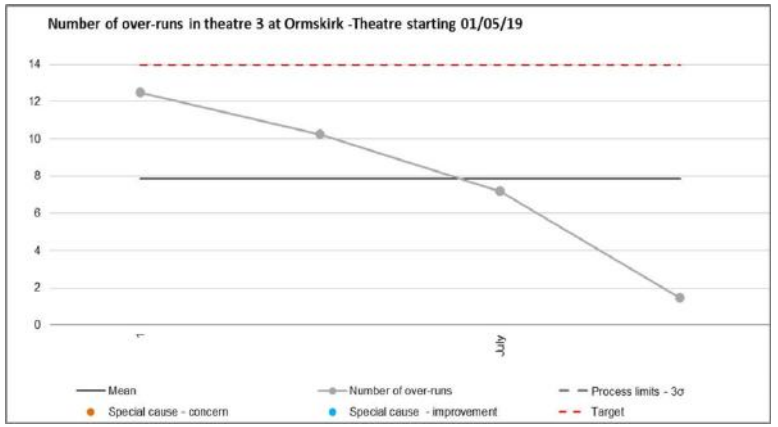
Southport and Ormskirk Hospital NHS Trust

Theatre 3 Turnaround times have improved from an average of 15 minutes to 10 minutes



- general spread of datapoints is getting better, with less variability and a general trend below the dataset mean.
- the role of special cause points to act against this trend. The number of special cause events decreases.

Theatre 3 over-runs have reduced – 12 to 2



Moving quickly into the anaesthetic room alleviated my anxiety
Patient comment

the anaesthetic room it is more private and patients can talk more freely about personal issues.
Staff comment

What our patients think…….

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY STANDARDS

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.

The Medicines Development Plan has been developed, all immediate actions have been completed in relation to 30 day plan only one action remains amber in relation to Quality Impact Assessment, however this will be completed w/c 16 September. The roll out of electronic checklists monitoring out of date medicines on the resus trolleys is due to be completed end of September 2019. The 3 month action plan is on track and monitored and updated on a weekly basis.

A business case is currently being developed and is due to go to BDISC October 2019

SONAAS - The formal assessment programme commenced 21st August 2019, 2 areas to date have been assessed, their overall ratings were bronze . Initial feedback was provided to the ward manager on the day of assessment, with a written report and formal meeting the following day. The formal feedback process has been reviewed and will involve both the ward manager and matron following future assessments. Both areas will be reassessed according to the criteria above (after a period of 8 weeks). Improvement plans have been developed based on issues identified, along with weekly meetings chaired by the relevant matron, supported by the quality team. This will be a continual process until date of reassessment, utilising the expertise of relevant subject matter experts.

Klebsiella outbreak within the Spinal unit is on going and weekly internal meetings continue with external stakeholder involvement. the unit remains closed and from recent screening no new cases have been identified.

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 in September there are 20 policies out of date, all outstanding policies have been reviewed and are awaiting update
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
Approval and implementation of Medicines Management Business Case	Corporate input to business case particularly from Finance, Project Management support and HR capacity for recruitment	R
Winter pressures - Clear impact access and flow on Quality & Safety Winter pressures - Clear impact access and flow on Quality & Safety	Participate in the development of the system winter plan	R

1.1 Operational Performance (Exec Lead: Steve Christian)

RAG Rating

Progress

18 Week RTT Performance

- August 18-week RTT performance was 92.5% and is still well above the 92% target despite some challenging operational/staffing issues.
- Predictions for September show performance will remain above the 92% threshold.
- There are currently 6 patients waiting over 40 weeks a slight reduction , the number of 30+ week waiters has also dropped to 99 , these figures are largely due to the continuing challenges in Community Paediatrics, Gynaecology and General Surgery.
- Despite the overall performance level being above 92% there are still significant challenges in Oral Surgery (42%), Community Paediatrics (55%), Clinical Haematology (78%), Rheumatology (84%) and Gynaecology (88%).

Length of Stay

- Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 7.38 days in August, with patients on assessment wards staying an average of 6 hours. This is slightly decreased on previous months.
- There were 173 stranded patients in August 2019, continuing the reducing trend of the past 4 months, however Super Stranded remained the same as July at 63 despite the ongoing #Long Stay Tuesday reviews.

Ambulance Handover Times

- The Trust had only 20 ambulance handovers greater than 1 hour in August 2019. The lowest number since June 2018 and further evidence of the sustained improvement in this area.
- Since July 2018 the Trust had made steady improvements of ambulance handovers over 1 hour as the new ambulance hand over bays at the front door of A&E are helping to facilitate a more rapid turnaround.

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.

Cancer 62 Day

- Performance for July 2019 was 78.9% a slight increase on June's position of 78%.
- The Trust has challenges in workforce across a number of tumour groups and Medical Director with COO are meeting with clinical & service leads to determine issues and critical interventions

1.2 Operational Efficiency (Exec lead: Steve Christian)

RAG Rating

Progress

Theatre Utilization (reporting to July)

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.

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%

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.

Outpatient Productivity (reporting to July)

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 (reporting to July)

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)	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.	R
• 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.	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.	

2019/20 FINANCIAL PLAN (1)

RAG Rating

Key Achievements/Progress

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

Current performance

The month 5 YTD position after PSF and FRF is a deficit of £7.273 million against a plan of £6.275 million resulting in £1.0 million worse than plan. For the month the deficit was £1.842 million against a plan of £1.394 million resulting in £448,000 worse than plan.

Contract have been signed except for NHS West Lancashire CCG; impact of the arbitration decision is been worked through in order to be able to sign a contract for 2019/20. The impact on the Trust is a reduction in income of £0.4m to £0.6m.

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 dental 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 5 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 5 YTD agency spend is £4.819 million; spend has increased in August; total spend in month was £1.024 million. 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 £956,000, £14,000 more than July; YTD spend is £4.654 million.
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 5, the Trust had transacted £2.714 million of CIPs.
The Trust is forecasting delivery of £5.8 million, a gap of £1.5 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 £1.082 million (planned spend year to date of £2.4 million) with a further £706,000 committed expenditure. Comparing this against the annual plan, £5,103,000 excluded donated and GE radiology assets, then the Trust is at 35% of the plan at the end of August 2019.

The Southport ward upgrade project which started 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 was £600,000.

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

WORKFORCE — AMBER

Key Achievements/Progress (1)

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. YTD Sickness absence rates have consistently decreased since December 2018, monthly sickness absence had reduced to below 5% for a number of months but has increased to above 5% in June 19 to 5.05% and to 5.28% in July.

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 on – early increase in responses seen
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. Consultation process completed and amendments to strategy completed, using diagnostic tool to inform action plan (NHS employer 'Workforce Health and Wellbeing Framework).
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, further work to promote role.
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.

WORKFORCE	AMBER

Key Achievements/Progress (2)

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 April 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 early adopter group (report by Oct 2019)
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 at 87.08%
- 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 – 10 delegates confirmed
- Communications plan in place for Staff Survey to commence Sept 2019
- Relocation of HR consultation has concluded. 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 for review at WFC (Sept 2019)
- In-house coaching service being finalised ready for launch end of Sept 2019
- Leadership Development Strategy approved at WFC – to Board for sign off Sept 2019
- "Introduction to QI" - 1st cohort delivered by NHSi June-Sept 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
- 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.
- Bespoke SOProud 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'	Meeting scheduled with COO & Head of PMO to develop next steps	A
HR resource lacking in order to deliver on the key workforce priorities as the HR Business Case has not been approved	Business case approved at Hospital Management Board, team now able to progress with transformation plans	G

ACUTE SUSTAINABILITY	RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

There has been good progress throughout the summer months in refining the clinical care models including testing them through statutory organisations governance groups, undertaking the review into fragile services for acute care, and securing expertise to progress the production of the draft business case.

CLINICAL SCENARIOS

A strategy for acute clinical services is in development based on the work of the care models and the fragile service review which will form the basis of the draft PCBC due at the end of October. There are five emerging scenarios for delivering the clinical strategy predicated on the potential capital investment available ranging from a brand new hospital with all acute and sub-acute services collocated through to no capital investment leading to a do nothing 'catastrophic case'.

ESTATES SOLUTIONS

GB Partnerships have commenced the modelling work aligned with the activity and financial modelling work

FINANCE SOLUTIONS

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

Key Achievements/Progress in Month

An alignment review has commenced to ensure that previous work exploring the challenges and opportunities with Southport and Ormskirk Hospitals are fully understood and incorporated into the emerging business case. With the funding secured from Cheshire & Merseyside Health & Care Partnership, expertise is now in place to develop the draft PCBC within the tight timescales with expected outputs emerging from mid-September onwards.
A critical path of the development of the PCBC has been developed which will be further refined over the next period to ensure the effective review and approval in principle of the draft PCBC after October and the development of a full PCBC by the end of March 2020.

Key Risks/Issues	Mitigating Actions	RAG
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

2 October 2019

Agenda Item	**TB173/19**	**Report Title**	**Board Assurance Framework Report (BAF)**
Executive Lead	Silas Nicholls,Chief Executive Officer		
Lead Officer	Anita Davenport, Interim Associate Director Corporate Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

Background

The BAF provides assurance on the extent to which the trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. Following consultation, some improvements have been made to the structure of the BAF report and the mapping of gaps in controls and assurance to enable the development of a clear remedial action plan. Further improvements are in the pipeline as the development of the content of the BAF is somewhat iterative. This should enable a comprehensive BAF report to enable the Board to ensure focus is maintained towards the optimum areas of activity and risk management.

Next Steps

- Development of the BAF report structure to enable clarity and simplicity, and a logical mapping of relevant information

- Continued self assessment of the evidence of and effectiveness of controls and assurance, and remedial actions to ensure demonstration of full and comprehensive assurance to the Board. Assurance is sought from 3 lines of defence:

  1. First line – Service delivery and day to day management of risk and control
  2. Second line – Specialist support, policy and procedure setting, oversight responsibility
  3. Third line – Independent challenge on levels of assurance, risk and control

For each of the controls identified, the BAF report should identify where the controls and assurances meet the levels required to be assured by each line of defence. A RAG rating on the BAF report will identify progress against this

- Ensuring the BAF drives the Board agenda
- Establishing an integrated BAF report, aligning the strategic risks of the BAF with tactical/operational risk

- **Recommendation** The Board is asked to **receive** the report and note the proposed development.

Strategic Objective(s) and Principal Risks(s) (*The content provides evidence for the following Trust's strategic objectives for 2019/20)*	
Strategic Objective	**Principal Risk**
☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
☐ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*
Continue to development the content of the framework and develop the BAF report

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

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

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

Risk Appetite:	**CAUTIOUS**	**Risk Scores:**	**Initial/Raw** ***(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF***	**16** **4x4** **(Likelihood x Consequence)**	**Current** ***(Showing the current position after considering controls and assurances in place)***	**12** **3x4** **(L x C)**	**Target** ***(A desired score after actions have been taken to reduce the score)***	**8** **2x4** **(L x C)**
DATIX Code:	**2094**	**Risk Rating Tracker**	(***A brief outline of the treatment, journey/movement of the risk and any changes proposed)*** Risk remains high (12)					
Executive Director	Director of Nursing/Medical Director							
Assurance Committee	Quality & Safety Committee							
Strategic Objective	**SO1** – Improve clinical outcomes and patient safety to ensure we deliver high quality services							

Controls	**Gaps in Controls**	**Remedial Actions**
Quality Improvement Plan in place identifying four priorities for 2019/20	High bed occupancy and reduced patient flow	Action 1 - Delivery against the Trust Patient Flow Improvement Programme (PFIP)
Reducing Avoidable Mortality Project including compliance with the National Structured Judgement Review method designed by the Royal College of Physicians	Issues with the quality of documentation	Action 2 - Establishing Documentation Programme with support from the PMO. Scope of programme currently being defined, timescales to be agreed.
Training programme (mandatory and non-mandatory)	Additional work required against 4 key quality improvement areas (Care of the Deteriorating Patient, Care of Older People, Infection Prevention &	Action 3 - Delivery against Care of the Deteriorating Patient Improvement Programme.

	Control and Medicines Management)	
Clinical Policies in place.		Action 4 - Deliver the External Mortality Review Action Plan.
Governance processes around policies and guidelines		Action 5 - Delivery against Care of Older People Improvement Programme
Management of NICE guidance and clinical audit	Availability of allocated time and people to undertake and provide clinical and educational supervision. (indicated time is allocated in Consultant job plans for this activity)	Action 6 - Establishing Infection Prevention Control Improvement Programme
Engagement with the GIRFT programme	Clinical workforce plan not fully developed.	Action 7 - Establishing Medicines Management Improvement Programme
All medical staff have work plans agreed with CDs and MD.	Limited support for clinical teams to be involved in clinical audit	Action 8 - Medical job plans to be finalised (including allocated time for clinical and educational supervision and clinical audit)
Application of Patient Safety and other safety alerts.	Evidence of lessons learned from incidents, complaints and audit	Action 9 - Further enhance the shared learning across relevant Business Units from incidents, complaints and audits through CBU training, dissemination of lessons learned bulletins.
Analysis of incidents, complaints and claims to identify areas of risk.		Action 10 - Ward Accreditation Programme (SONAS) to be rolled out across the Trust.
Supervision and education of clinical staff across all professions.		Action 11 - Implement recommendations from Nurse Establishment Review.
Application of clinical pathways and guidelines.		Action 12 - Delivery against Must and Should Do CQC Actions Please see update and progress in Risk 1902 on the Corporate Risk Register).
Increasing R&D involvement across the organisation		
Regulatory information provided to staff in update sessions.		
An integrated approach between corporate, operational and governance teams.		
Quality Impact Assessments for all service changes and CIPs that are considered		
Professional standard		
Risk Management Strategy and culture		
Quality and independence of QIAs by DoN and MD		
Freedom to Speak Up Champions in place across the Trust		
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance gained at operational tier - LEVEL 1,	Difficult to gain consistent assurance that clinicians are following best practice	
Local and National Audit Programme/Audit Strategy	Lack of available benchmarking data across all services	
MDT approach to patient management	Lack of testing of action plans following audits to ensure they lead to embedded change.	Action 9 - Further enhance the shared learning across relevant Business Units from incidents, complaints and audits through CBU training, dissemination of lessons learned bulletins.
Directorate performance reviews		
Monthly and Annual Mortality Reports to Mortality Operational Group and Trust Board		
StEIS and Incident Reporting		
Monthly CBU Quality and Safety Reports		
Reports to Patient Flow Improvement Board		
Clinical Revalidation		
Patient feedback (FFT/Patient Surveys)		
Quality Visits/Senior Walkabouts including focus on Patient Safety		
Maintenance of CQC registration		
Reports and Metrics monitored at monthly Assurance Committees and/or Board - LEVEL 2		
Monthly Mortality Reports to Q&S and Board		
Mortality metrics		
Never events		
Incident data		
Quality Strategy metrics		

CQUINS		
Performance data		
Internal audit metrics		
High level performance metrics		
Serious Incident Reporting Group		
Freedom to Speak Up		
Speak Up Champion (NED appointed by Board)		
Integrated Performance Report		
Quality Improvement Plan		
Monthly Safe Staffing Report		
Mortality Report		
Quarterly and Annual Guardian of Safe Working Report		
Independent / semi-independent - LEVEL 3		
External Audit Plan (Mazars)		
Internal Audit Plan (MIAA)		
GMC / NMC Reports		
Royal College Reports / Visits.		
SHMI / RAMI		
CQC Outlier Alerts		
National Audits		
Peer Reviews and accreditation.		
R&D Performance		
CQC inspection visits		
Regular meetings with NHSI/E/CQC		
Engagement meetings with CQC		
Weekly Catch-up conversations with CQC		
CCG monthly quality and performance meetings		
Internal Audit Report		
Quality Account		

BAF Summary Report September 2019

Action 1 – Patient Flow Improvement Programme (PFIP) Workstream 2 continues to work on its actions to improve efficiency and leadership of patient management on the ward with an aspiration of established reduce all Emergency ALOS by 0.5 days.
Action 2 - Scoping exercise to be undertaken prior to commencement of project. Need to confirm Project lead and PMO support.
Action 3 - The trend for improvement in national mortality indicators continues. The SHMI has reduced to within the expected range.
Monthly performance based on HSMR continues to be improved, although this is yet to include the spring period which in previous years has been challenging to flow and mortality. The Trust remains an outlier for deaths from FNOF. A review of these deaths is planned.
Mortality screening has increased and structured judgement reviews continue to be undertaken with themes fed back through Mortality & Morbidity meetings. Outreach Team recruited to fulfil 24/7 service.
Action 5 – Considerable progress has been made on this action and progress is reflected in operational risk 2052
Action 6 - Project still being scoped and requires further development.
Action 7 - Medicines Management plan developed. All immediate actions completed. In relation to 30 day action plan only 1 action remains amber. The roll out of electronic checklists monitoring for out of date medicines on resus trolleys due to be completed end Sept 2019. Business case due to go to BDISC in Oct 2019
Action 9 - An Integrated Governance Improvement Plan is in place until 2020, progress so far includes weekly complaints meeting, CBUs to review all open incidents and risk registers currently being cleansed.
Action 10 - Formal assessment programme commenced Aug 2019. Two areas assessed - overall assessment bronze. Formal feedback provided on identified issues and action plans in place. Timetable for inspections in place and re-inspections for bronze areas will take place 8 weeks after the inspection.
Action 11 - Implementation plan being rolled out – ongoing. New E-Roster Manager in post, new budgets uploaded, Ward managers & matrons informed of increase in establishments and new roster patterns. Recruitment ongoing.
Action 12 - 2019 CQC inspection process now complete. Draft report for factual accuracy checking expected Oct 2019. Key themes from the inspection have been circulated to the relevant leads to incorporate into their improvement plans. This includes Safeguarding where work on MCA and DOLS documentation has been undertaken and there is an increased focus on level 3 training to ensure compliance for all relevant staff.

Number of linked Risks	1987: Haematology/Oncology service 1862: Nursing/HCA vacancies 1688: Anaesthetic Staffing 2052: Older Peoples Care 1902: CQC Compliance 2056 – Missing Patient appointments/admissions	**Number of linked Incidents**	**Add:** 14 incidents reported to StEIS July-Aug	**Last Review Date**	**Next Review Date**
				September 2019	December 2019

Board Assurance Framework (BAF) Report

NHS Southport and Ormskirk Hospital NHS Trust

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

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial/Raw** ***(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF***	**16** **4x4** **(Likelihood x Consequence)**	**Current** ***(Showing the current position after considering controls and assurances in place)***	**16** **4x4** **(LxC)**	**Target** ***(A desired score after actions have been taken to reduce the score)***	**12** **3x4** **(LxC)**
DATIX Code:	**2095**	**Risk Rating Tracker**	***(A brief outline of the treatment, journey/movement of the risk and any changes proposed)*** Risk reviewed September 2019 and remains extreme.					
Executive Director	Chief Operating Officer							
Assurance Committee	Finance, Performance & Investment Committee							
Strategic Objective	**SO2** - Deliver services that meet NHS constitutional and regulatory standards							

Controls	**Gaps in Controls**	**Remedial Actions**
Regulatory information provided to staff in update sessions.	Lack of strategy to counter benchmarking data can make the Trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention	Action 1 - Delivery of the diagnostic trajectory set within the Trust Integrated Performance Report (IPR)
Committee structures in place to monitor compliance.	Workforce strategy - recruitment of key delivery posts	Action 2 - Work with HR and Clinical team to develop sustainable workforce plans
Finance, Performance & Investment Committee		
Improvement Group	System partnership working	Action 3 - Deliver 95% against the 4 hour standard against a backdrop of rising demand

		Action 4 - Patient Flow Improvement Programme (PFIP) Workstream 2 continues to work on its actions to improve efficiency and leadership of patient management on the ward with an aspiration of established reduce all Emergency ALOS by 0.5 days.
Performance Review Board		
An integrated approach between corporate, operational and governance teams.		
Quality Impact Assessments for all service changes and CIPs that are considered		
Professional standards		
Trust policies and procedures		
Risk Management Strategy and culture		
Ward accreditation scheme pilot commencing in April		
Quality and independence of QIA's by DoN and MD		
External peer reviews		
Completion and Submission of Annual Quality Report		
Exec and NED leads in place for key CQC areas		
Patient Safety included in Exec , NED and senior staff walk rounds		
Trust policies and procedures		
Risk Management Strategy and culture		
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance		
For Clinical CBUs an Integrated Performance Report and slide pack presented at monthly Performance Review Boards	Mixed sex accommodation – due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready to be moved to a general ward.	Action 4 - Patient Flow Improvement Programme (PFIP) Workstream 2 continues to work on its actions to improve efficiency and leadership of patient management on the ward with an aspiration of established reduce all Emergency ALOS by 0.5 days.
For the Corporate CBU a slide pack presented at Quarterly Performance Review Board for Estates & Facilities, Finance and HR		
Programme and Project Highlight reports presented to Vision 2020 Improvement Boards for Operational Efficiency, Quality and Safety and Workforce		
Performance Management and Accountability Framework		Action 7 - Development of accountability and assurance
Sickness Absence Policy approved.		
Monitoring of the Activity Plan for 2019/20 with regulatory functions		
Reports to Improvement Group		
Reports to Performance Review Board		
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
Constitutional Standard: Accident & Emergency - 4 hour compliance	A&E 4 hour target/trolley waits/ambulance handovers	Action 3 - Deliver 95% against the 4 hour standard against a backdrop of rising demand
Constitutional Standard: Accident & Emergency - 12+hour trolley waits		
Constitutional Standard: Ambulance Handovers <=15 mins		
Constitutional Standard: Diagnostic Waits	Diagnostic waiting times not met	Action 1 - Delivery of the diagnostic trajectory set within the Trust Integrated Performance Report (IPR)
Constitutional Standard: 14 day GP referral to Outpatients		
Constitutional Standard: 62 day GP referral to treatment (and associated Cancer Standard measures)	62 day cancer performance-some improvements have been realised but underlying issues within certain tumour groups remain	Action 5 – Cancer Improvement plans with deliverable KPIs for each area
Constitutional Standard: 18 week RTT	Some specialities failing 18 week RTT target	Action 6 - Enhanced scrutiny and oversight through the development of the weekly Senior Operational Leadership Team (SOLT) meetings chaired by

		the COO to review each CBU PTLs though adoption of the Trusts 3A reporting.
Integrated Performance Report		
Vision 2020 Priority Area Highlight Reports to Hospital Improvement Board		
Internal audit metrics		
High level performance metrics		
Result of Local Audits		
Board assurance visits		
Independent / semi-independent		
Regular meetings with NHS Improvement		
CQC Inspection Report (2018) Good' for the Trust		
Maintenance of CQC Registration		
CQC Visit		
CCG Meetings monthly		
NHS Improvement monthly returns		
Result of National Audits		

BAF Summary Report September 2019

Action1 - The actions relating to diagnostic waiting times continue to make good progress and remain on-track against agreed timelines.
Action 2 - A medium term solution has been reached regarding the Haematology service but there remains a national recruitment crisis in Haematology. Inadequate staffing levels in anaesthesia, with 10 vacancies, heavily dependent on locums for emergency cover. WLI's to maintain elective capacity. Consultant vacancies in Radiology, currently c 60% of establishment. Using agency locums. National recruitment issue.
Action 3 – over 56% of ambulance handovers completed within 15mins in Aug, highest level in 2 years. ED continues to work with NWAS to identify further opportunities to improve. The number of patients streamed from ED to ambulatory pathways increased in August as the use of ACU as an overnight escalation area reduced. ACU have plans in place to run a perfect week model week commencing 30 September, which will test an extended service across the week and there are early discussions about some weekend working. A new medical referral proforma is being launched in September 2019, which will enable real time handover of information from ED to Medicine, improve the quality of the information being handed over, and release valuable medical registrar time to deliver direct patient care. Substantive medical staffing in ED has increased.
Action 4 – Patient Flow Improvement Programme (PFIP) Workstream 2 continues to work on its actions to improve efficiency and leadership of patient management on the ward with an aspiration of established reduce all Emergency ALOS by 0.5 days.
Action 5 - Cancer Improvement plans with deliverable KPIs for each area that has a direct impact on the cancer patient's pathway have been completed. This work is led by the PMO and Operational Service teams, with oversight from the Cancer Management team and ADO for cancer.
The Cancer Improvement Group continues to meet twice monthly and have oversight of all the improvement works geared towards to general improvement of compliance against the National Cancer Waiting time targets.
Action 6 - Enhanced scrutiny and oversight through the development of the weekly Senior Operational Leadership Team (SOLT) meetings chaired by the COO to review each CBU PTLs though adoption of the Trusts 3A reporting. Each ADO provides assurance / escalation to ensure the Trust delivers the required or best possible performance.
Action 7 - The CBUs have well defined PRBs that take place monthly. The PRBs have Executive representation and act as the forum to assess CBU performance against critical measures across quality / safety and financial and operational performance.

Number of linked Risks	1987-Haematology/Oncology service 1688-Anaesthetic staffing 2056 – Missing Patient appointments/admissions	**Number of linked Incidents**	**Add:** 6 (issues with Outpatient appointments)	**Last Review Date** September 2019	**Next Review Date** December 2019

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

Risk ID:	**3**	**Risk Description** ***(What could prevent the objective from being achieved)***	***If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*** **Cause:** • Being able to deliver the required levels of CIP. • Being able to control agency costs. • Ability to service outstanding historic debt • Being able to agree sufficient income to support cost base **Potential Effect:** • Misses its control total • Additional CIPs may need to be identified and delivered. • Lack of financial stability • Inability to invest in services and new technologies • Continued borrowing to meet operational expenses resulting in significant debt **Potential Impact:** • No non-recurrent funding (PSF/FRF) • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention. • External interventions and financial special measures.

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial/Raw** ***(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF***	**16** **4x4** **(Likelihood x Consequence)**	**Current** ***(Showing the current position after considering controls and assurances in place)***	**16** **4x4** **(L x C)**	**Target** ***(A desired score after actions have been taken to reduce the score)***	**12** **3x4** **(L x C)**
DATIX Code:	**2096**	**Risk Rating Tracker**	***(A brief outline of the treatment, journey/movement of the risk and any changes proposed)*** Risk updated September 2019 and remains extreme.					
Executive Director	Director of Finance							
Assurance Committee	Finance, Performance & Investment Committee							
Strategic Objective	**SO3** - Efficiently and productively provide care within agreed financial limits							

Controls	Gaps in Controls	Remedial Actions
Financial model produced giving early indication of issues	Future Clinical Model not finalised	Action 1 - Delivery of control total in 2019/20 at end of financial year
Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger	5 Year long term financial model (LTFM) to be updated to reflect current financial performance and future financial plan	Action 2 - Delivery of CIP for 2019/20 at end of financial year
Early and continuing dialogue with NHS Improvement and NHS England	2018/19 CIP plan underachieving	Action 3 - Achieve NHSI Use of Resources Risk Rating – 3
PMO Governance improved with roles and responsibilities CIP lead appointed	Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate	Action 4 - Manage Agency Spend vis a vis NHSI cap
Cash support through agreed loan arrangements	Modelling of Acute Sustainability into 5 year LTFM to provide savings from any reconfiguration in line with Sefton Transformation Board Strategy	

Annual Financial Plan including target to reduce underlying deficit within Vision 2020		
Financial governance arrangements in place at a number of levels: FP&I Committee/CBU's		
Monthly governance meeting and performance meetings with Execs		
Monthly Directorate Meetings (budget scrutiny at this level)		
Revised CIP planning processes and PMO co-ordination of planning and delivery.		
Weekly CIP review meetings		
Turnaround Director in post with Trust governance, grip and control measures implemented, including Discretionary Spend Policy, CQUIN Group, Business Development Group & Investment sub-Committee (BDISC), People & Activity Group (PAG)		
CIP plan for 2019/20 in place		
Internal Audit Plan		
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance		
Operational Plan approval (Board (BoD) – Nov 2014	Agency costs exceed the NHSI cap	Action 4 - Manage Agency Spend vis a vis NHSI cap
Future Generations Clinical Strategy and Business Plan	Financial Recovery Plan that delivers break-even	Action 1, Action 2 & Action 4
Sustainability Plan	I&E positon by 2023/24	
SOC for preferred option proved by Board – Sep 17		
2019/20 budget approval (BoD – May' 2018)		
Budget holder training manual and attendance records		
Performance & Finance Report (monthly to FP&I and BoD)		
Finance & CIP achievement (monthly to FP&I)		
Executive Team & Board oversight		
Internal audit report provides assurance		
Hospital Management Board		
Trust Board		
Fortnightly Acute Sustainability Programme Board		
Finance, Performance & Investment Committee		
Southport & Ormskirk Improvement Board meets monthly		
BAF-Quarterly to Board and Audit Committee		
13 week rolling cash flow forecast agreed by NHSE		
CIP Reviews through fortnightly Sustainability Scrutiny Meetings		
Internal and External audit reports and opinion at Audit Committee		
Monthly Performance Review Boards		
Executive Team Meeting Weekly Update		
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
Monthly formal data submission		
Long term financial projections		
Independent / semi-independent		
CCG Pre Consultation Business Case, approved by CCG Committees in Common		
Northern Clinical Senate Report recommendations		
Monthly reports to NHSI with feedback		

Internal audit review of budgetary controls		
External audit opinion		

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Progress against actions as below:

- Action 1 - Updated System recovery plan submitted 17 September 2019. Recovery plan highlights that the trust will miss its control total by £5.2 million. Trust meeting with Regulators on 26 September 2019.
- Action 2 - At month 5 Trust has identified £5.907 million of schemes against a target of £6.314 million. When risk adjusted the identified schemes is expected to deliver £4.840 million a gap of £1.474 million.
- Action 3 - At month 5 Trust rating is a 4 as the Trust is £1.0 million worse than plan.
- Action 4 - The Trust will breech NHSI Agency cap set at £4.891 by month 6. At moth 5 Trust has spent to date £4.819 million: medical staff £2.631 million; Nursing £1.791 million; £0.303 million on non-clinical staff Focus on eliminating non clinical staff agency following changes to agency rules 16 September 2019

Number of linked Risks	1942: Eradicating Trust deficit by 2023/24 2072: Failure to achieve 2019/20 financial control total 1688: Anaesthetic staffing	**Number of linked Incidents**	**Add:** None	**Last Review Date** September 2019	**Next Review Date** December 2019

Board Assurance Framework (BAF) Report

NHS Southport and Ormskirk Hospital NHS Trust

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

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial/Raw** ***(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF***	**12** **3x4** **(Likelihood x Consequence)**	**Current** ***(Showing the current position after considering controls and assurances in place)***	**12** **3x4** **(L x C)**	**Target** ***(A desired score after actions have been taken to reduce the score)***	**8** **2x4** **(L x C)**

DATIX Code:	**2097**	**Risk Rating Tracker**	(***A brief outline of the treatment, journey/movement of the risk and any changes proposed)*** This risk remains high (12)
Executive Director	Director of Human Resources & Organisational Development		
Assurance Committee	Workforce Committee		
Strategic Objective	**SO4** - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated		

Controls	Gaps in Controls	Remedial Actions
Annually agreed funding contract with HEN	Gaps in junior doctor workforce	Action 1 - During 2019/20 the Trust will develop and enhance Clinical & nursing roles to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANPs, Consultant Nurses, ER Practitioners.
Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.	Regional Training Programme Directors manage the junior doctor rotation programme and do not highlight shortages to the Lead Employer	Action 2 - During 2019 a new programme for recruitment of Drs from India for Gynaecology will be developed
Effective electronic rota management system implemented in 2015.	Rota management system not fully utilised	Action 3 - The 2019 Operational Plan will include the requirement for increased number of consultants
New Guardian of Safe Working Hours appointed in 2019	Training requirements are not always met	Action 4 – Establish a process to get early notification of shortages in the junior doctor rotation programme from the Lead Employer
Monitoring exercises undertaken on annual basis to ensure compliance on junior doctor rotas	Delays in recruitment of staff	Action 5 - Deliver against Quality Improvement Programme to maximise utilisation of E-Rostering by the end of 2019.
Annual Workforce Planning exercise with operational and clinical teams	Lack of local in year feedback in relation to staff views / staff surveys	Action 6 - During 2019/20 the Director of Medical Education (DME) will ensure training requirements are met and will report to the Trust Medical Director and externally to HEN
Shared decision making and review of risks with Joint Local Negotiating Committee	Lack of focused resource for staff engagement	Action 7 - Deliver against Quality Improvement Programme to reduce Time to Hire to 8 weeks (advert-offer) by the end of 2019.
Organisational Development Strategy	Recruitment and retention strategy	Action 8 - Improve the response rate for the annual Staff Survey
Health and Wellbeing strategy and action plan	Low attendance at Essential Skills Training Programmes	Action 9 - The Trust will develop Meeting Place – Live which is facilitated by NHS Elect in order to engage the workforce and seek views on the S&O way, values and behaviours with meetings and focus groups from June to December 2019.
Staff engagement and awareness programme in place		Action 10 - Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019.
CBU Staff induction		Action 11 - Development of a Recruitment and Retention Strategy by the end of 2019.
Corporate staff Induction		
Mandatory training		
PDR process and training		
Robust employment checks (FPPT)		
Disclosure Barring Service		
Professional Bodies Checks and Balances for clinicians (NMC/GMC)		
Duty of Candour/Safe Care		
Sickness Absence Policy		
Speak Up Champion & Guardian		
Recruitment Strategy		
Retention Strategy		
Annual staff Appraisal		
Freedom to Speak Up Guardian in post		
Equality & Diversity Lead in post		
OD Manager in post and Workforce and OD Strategy in place		
NHS Elect support for staff engagement, values and behaviour		
NHSI Nursing Retention Programme		
NHSI Health and Wellbeing Project		
Nursing Retention Improvement Plan		
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance		
Quarterly reporting by Guardian of Safe Working to JLNC, PPF and the Lead Employer.	Sickness absence above target but improved to 4.8%	

Annual report to Board by the Guardian of Safe Working.	Appraisal Rates below target	
Escalation process in place for Exception Reporting to the Medical Director	Time to hire is longer than expectations	Action 7 - Deliver against Quality Improvement Programme to reduce Time to Hire to 8 weeks (advert-offer) by the end of 2019.
DME reports to HEN on an annual basis in relation to junior doctor training	Lack of talent pipeline for nursing and specialist medical roles	Action 1 - During 2019/20 the Trust will develop and enhance Clinical & nursing roles to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANPs, Consultant Nurses, ER Practitioners.
Jr Dr work plans	Overall staff engagement scores are lower than average which impacts on Trust reputation.	Action 8 - Improve the response rate for the annual Staff Survey
Junior Medical Staff – annual internal staff survey	Reliance on agency staff to fill gaps in rotas for nursing and medical staff	Action 3 - The 2019 Operational Plan will include the requirement for increased number of consultants
Annual GMC Survey	Low completion rates for Exit interviews	
~~Annual Staff Survey~~		
~~Friends and Family Test~~		
Junior Doctor Forum held quarterly for concerns to be raised.		.
Education and development processes in place		
Appraisal compliance and training attendance monitored		
Staff Survey & Quarterly Staff FFT/Survey		
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
Exception reporting data		
FTSUG reports		
Absence Data		
Turnover Data		
Vacancy Rate		
National Medical Revalidation process ensuring competent doctors		
Quality Visits by NEDs and EDs		
Time to Hire		
Independent / semi-independent		
GMC Revalidation process.		
HEN visit – regular		
GMC Medical Staff survey – annual		
Winter Planning and Length of Stay discussed at weekly Performance Improvement Board (PFIB)		
Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board		
Weekly activity data reported to CBUs		
Endoscopy Project in place to deliver endoscopy diagnostic targets		
Finance Performance and Investment Committee		
Southport & Ormskirk Improvement Board (SOIB)		
Monthly Mortality Operational Group		
Monthly Performance Review Board (PRB) for each CBU		
CBU Governance meetings		
QIA process to approve all CIPs		
Monthly contract meeting with Commissioners		
Engagement of EY to address patient flow		
Monthly Report to FP&I committee		
Monthly Report to Q&S Committee		
Monthly report to Workforce Committee		

Report to Mortality Operational Group (MOG)		
Reports to Workforce Improvement Board (WIG)		
Monthly Trust-level and CBU-level dashboard for performance forum		
Monthly Reports presented to CBU governance meetings		
Performance against A&E 4 hour target report to Board monthly		
Hospital Management Board		
Improvement Board		
Performance Review Boards		
IPR indicators demonstrate compliance against 14 day cancer target, 31 day cancer treatment target and RTT		

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Action 1 - Recruitment of additional Physician Associates to support Junior Doctors. ANP's currently being trained.
Action 3 - Review of Consultant workforce being planned
Action 5 - QI initiate in place working with wards/depts on utilisation of rotas across the Trust. Particular focus on ward 14A which has highest use of bank/agency.
Action 7 - High levels of recruitment activity impacting ability to deliver reduced Time to hire in addition to vacancies in the recruitment team. New starters Oct 2019 will improve data. Steady progress has been made despite these challenges.
Action 8 - Completed June 2019. Action plan monitored weekly with weekly plan in place for next staff survey.
Action 9 - Meeting Place live in place. Developed a plan for engagement, Big Conversations/Walkabouts in place. So Proud conversations. Positive feedback from staff. Progress monitored through Workforce improvement group.
Action 10 – Engagement Strategy completed and ratified at Workforce Committee and Board.
Action 11 – Recruitment & retention Strategy is in draft.

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

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

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

Risk Appetite:	**OPEN**	**Risk Scores:**	**Initial/Raw** ***(Showing the likelihood of a risk & its consequence when the risk was first put on the BAF***	**12** **3x4** **(Likelihood x Consequence)**	**Current** ***(Showing the current position after considering controls and assurances in place)***	**12** **3x4** **(L x C)**	**Target** ***(A desired score after actions have been taken to reduce the score)***	**8** **2x4** **(L x C)**
DATIX Code:	**2099**	**Risk Rating Tracker**	(***A brief outline of the treatment, journey/movement of the risk and any changes proposed)*** Risk remains high.					
Executive Director	Director of Human Resources & Organisational Development (other Executives)							
Assurance Committee	Workforce Committee							
Strategic Objective	**SO5** - Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values							

Controls	Gaps in Controls	Remedial Actions
Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff	Succession Planning – not fully in place	Action 1 - By the end of 2019 the Aspirant Managers programme will be rolled out via Shadow Board
Consultant revalidation process	Insufficient visibility of Executive Team and Non-Executive Directors	Action 2 - During 2019/20 the Executive Team and Non-Executive Directors will participate in quality visits/walkabouts
Reward and recognition processes to be reviewed	Talent management programme – not fully developed	Action 3 - A Talent Management Programme will be developed by Q4 2019/20
Retirement Intentions annual exercise to be explored	Ongoing challenges of engaging effectively with all staffing groups due to rota patterns	Action 6 - The Trust will develop Meeting Place – Live which is facilitated by NHS Elect in order to engage the workforce and seek views on the S&O way, values and behaviours with meetings and focus groups from June to December 2019.

Pay progression for AFC to be developed by end of 2019	Lack of quality of appraisals being carried out and insufficient numbers.	Action 7 - Implement a programme of appraisals to ensure quality and compliance to meet 85% by September 2019.
Targeted OD intervention for areas in need of support	Lower than expected attendance at non-mandatory training e.g. leadership training	
Management Development Training Programme	Requirement for further development of middle managers	Action 8 - Development of Core Leadership Development Programmes
Aspirant Talent Programme for aspiring ward managers and matrons	Poor response rates in relation to staff views / staff surveys performed quarterly	
Programme of health and wellbeing initiatives	Recruitment & retention of staff remains a problem	Action 9 - Develop a Recruitment & Retention Strategy by December 2019.
All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Some processes need embedding within CBUs and across the organisation to ensure robust Ward to Board communication and escalation	Action 10 - Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019.
Extensive mandatory training programme available	Staff Engagement Strategy	
Value-based recruitment & induction planned now that recruitment is now in house.		
Workforce planning processes to be reviewed in line with delivery of safe staffing		
Quality Strategy 2017-2020		
Staff engagement programmes via NHS Elect		
Freedom to Speak Up Guardian and Champions		
Whistleblowing Policy/Raising Concerns		
Guardian of Safe Working in post		
Trust's Vision 20/20 and promotion of Trust values.		
Single Leadership Plan accepted by NHSI		
Substantive Board appointments in 2018.		
Training, education and development (TED) strategy & programmes based on training needs analysis.		
Leadership and people management policies, processes & professional support (including management training & toolkits)		
Staff support and occupational health and wellbeing arrangements at Trust, CBU and Service levels		
Monthly and quarterly monitoring of workforce performance		
Deep dive reports to Committee investigating specific issues when required		
Staff communication via meeting place on Facebook, Trust news and Trust magazine, Town Events, Breakfast with Execs etc.		
Grievance & Disciplinary Policies		
Data Protection Policy (General Data Protection Regulations)		
Staff Survey		
Employment checks		
FPPT & Code of Conduct		
PDRs		
Non-Executive directors' (NED) Skills mix - academic & professional qualifications		
Unitary Board: Non-Executive and Executive directors are jointly responsible for decisions taken by board		
Governance Structure		
Board Development Sessions planned throughout the year.		
Board Timeout Sessions planned throughout the year		
HR Governance Meetings		
Valuing our People meetings		
Workforce and OD Committee		
Healthcare Leadership Model (-self-assessment tool 360 degree appraisals/- Edward Jenner online leadership programme/Management & Leadership Apprenticeships)		

Essential HR skills for managers provided on a rolling basis		
Substantive E&D Manager in post		
Substantive OD posts in post		
Trust wide staff survey action plan		
CBU staff survey action plans		
Staff friends and family test + pulse check questions		
Workforce and OD Strategy		
Model Hospital support		
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance	Staff Survey Engagement score not significantly improved in year	Action 5 - Engagement sessions with a cross section of staff to ask for feedback and priorities in relation to staff survey will take place during June 2019.
National Staff surrey (annual)		Action 6 - The Trust will develop Meeting Place – Live which is facilitated by NHS Elect in order to engage the workforce and seek views on the S&O way, values and behaviours with meetings and focus groups from June to December 2019.
Quarterly Staff Friends and Family survey		
Monthly KPIs for controls		
Performance Reports (monthly)		
Quarterly Speak up Guardian Reports		
Report from Guardian of Safe Working – Quarterly to Board		
PDR training on-going	PDR compliance currently below target	Action 7 - Implement a programme of appraisals to ensure quality and compliance to meet 85% by September 2019.
Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board		
Monthly reporting to Workforce Committee		
CBU Governance meetings		
Workforce Improvement Board (WIB)		
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
Increase in managers attending training programmes		
Mandatory training data		
Absence data	Sickness absence above target but reducing	Action 4 - The Trust will continually monitor sickness absence on a monthly basis during 2019/20
Turnover data		
FTSU Guardian data		
Staff Engagement Scores		
Guardian for Safe Working Exception Reports		
Independent / semi-independent		
CQC regulatory inspection		
National Workforce and Wellbeing Charter - 2018		
NHS Staff Survey 2018		
NAVAJO Chartermark		
Health Watch Sefton		
Workforce Race Equality Scheme Reporting		
Workforce Disability Equality Scheme		
Annual ED&I Report		
BAF Summary Report September 2019		

Action 1 – Aspirant Managers programme rolled out and has met twice Action 2 – Monthly Quality Visits/walkabouts in place Action 3 - Signed up to NHS Leadership Academy Talent Management Diagnostic Assessment Tool to allow us to rate ourselves and develop a plan going forward. Report expected Oct 2019 Action 4 – Sickness absence monitored through Workforce Committee and Board Action 5 - Engagement sessions taken place with feedback received and incorporated into weekly plan prior to next staff survey. Action 6 - Meeting Place live in place. Developed a plan for engagement, Big Conversations/Walkabouts in place. So Proud conversations. Positive feedback from staff. Progress monitored through Workforce improvement group. Action 7 – Current compliance 72.4% (July) Action 8 - The Southport & Ormskirk Way currently being developed to equip Operational and Clinical Managers with the skills to perform their roles well. Middle Management programme being reviewed by Head of Education & Training but issues with funding. Action 9 – Recruitment & retention strategy currently in draft Action 10 – Engagement strategy completed and ratified at Workforce Committee and Board.

Number of linked Risks	None	**Number of linked Incidents**	**Add:** None	**Last Review Date** September 2019	**Next Review Date** December 2019

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

Risk ID:	**6**	**Risk Description** (*What could prevent the objective from being achieved)*	**There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services** 6a) By October 2019 develop a robust partnering strategy to enable development of a range of clinical and non-clinical joint working opportunities 6b) By October 2019 develop a blueprint and roadmap for the acute sustainability programme					
Risk Appetite:	**HUNGRY**	**Risk Scores:**	**Initial/Raw** (*Showing the likelihood of a risk & its consequence when the risk was first put on the BAF*)	**15** **3x5** **(Likelihood x Consequence)**	**Current** (*Showing the current position after considering controls and assurances in place)*	**15** **3x5** **(L x C)**	**Target** (*A desired score after actions have been taken to reduce the score)*	**9** **3x3** **(L x C)**
DATIX Code:	**TBC**	**Risk Rating Tracker**	(*A brief outline of the treatment, journey/movement of the risk and any changes proposed)*					
Executive Director	**Deputy CEO/Director of Strategy**		This BAF risk has been to HMB as part of the new BAF. Risk remains extreme.					
Assurance Committee	Finance, Performance & Investment Committee							
Strategic Objective	**SO6** - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire							

Controls	**Gaps in Controls**	**Remedial Actions**
Robust system governance in place, including: -Sefton Transformation Board -Cheshire & Mersey STP (includes acute sustainability) -Provider Alliance -SOIB - leading Vision 2020	Financial constraints for delivery of facilities improvements	Develop, implement and deliver the agreed organisational transformational CIP Schemes. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to HOIB.
Robust internal governance in place, including: -Acute Sustainability Programme Board -HIB - leading Vision 2020 and Single Improvement Plan	Delay in delivering Transformational CIP Schemes	Recruitment to substantive positions to reduce agency spend.
Documentation in place; -S&O Operational Plan 2019/20. -STP 5 year plan in development for submission summer 2019 (date TBC	Whole system engagement - support from key health and social care partners to address increased demand on the non-elective pathway and helping reduce LoS for patients not requiring acute hospital care	Action 1 - Establish a Strategic Task and Finish group with executive and non-executive membership to provide assurance to the Trust Board on the robustness of the development and delivery of the Acute Sustainability Programme. To commence in June 2019 and meet monthly.
	Operational plan in development	Action 2 - Report progress on the delivery of the Operational Plan using the Single Improvement Plan. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to SOIB.

	Communication and Engagement Strategy	Action 3 - Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019 and monitored by the Acute Sustainability Programme Delivery Group.
Assurance	**Gaps in Assurance**	**Remedial Actions**
External assurance		Develop, implement and deliver the agreed organisational transformational CIP Schemes. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to HOIB.
Programme of work in development to align partners - chaired by Merseycare CEO	Trust significantly adverse from financial plan (June 2019)	Recruitment to substantive positions to reduce agency spend.
Clinical Leadership Group development of clinical models across four work streams		
Clinical Senate Report in place - confirming the case for change and clinical direction		
Internal Assurance		
Vision 2020 updated and agreed at Board		
Single Improvement Plan in development to be signed off by Board		
Minutes of Monthly Contract Review Meetings		
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
Performance monitoring of patient experience and clinical outcomes		
Incident Data (including SIs / Never Events)		
CEO's reports to Board		
Deputy CEO reports to Board		
Single Improvement Plan reports to Improvement Board		
Single Improvement Plan reports within IPR		
Finance Reports include contractual and commissioning issues, where relevant reported to Board		
Progress of agreeing contracts reported via Finance to Board		
Business Cases involving commissioners reported, where these occur, reported to Board		
Independent / semi-independent		
CQC Inspection Report (2017)		
Clinical Senate Reports		
Minutes of Network/Alliance meetings		
Update reports from Community Partnership Network		
Quarterly review against plan (Titration system)		
Monthly meetings with CCGs		

BAF Summary Report September 2019					
Action 1 – Strategic Task & Finish group established Action 2 – Completed Action 3 – Engagement Strategy completed and ratified and Workforce Committee and Board.					
Number of linked Risks	1942: Eradicating the Trust's deficit	**Number of linked Incidents**	**Add:**	**Last Review Date**	**Next Review Date**

	by 2023/24 1987: Haematology/Oncology service		None	September 2019	December 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB174/19a**	**Report Title**	**Statement of Compliance 2019/2020 Core Standards Self-Assessment Emergency Preparedness, Resilience and Response (EPRR)**
Executive Lead	Steven 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

NHS England and NHS Improvement has a statutory requirement to formally assure both itself and the NHS in England of EPRR readiness. This is provided through the EPRR Core Standards self-assessment annual assurance process.

There is a requirement that this Statement of Compliance is noted annually at Trust Board.

Following self-assessment, and in line with the definitions of compliance, the organisation declares itself as demonstrating **Substantial** compliance against the EPRR Core Standards.

There is an action plan supporting further improvement with timescales.

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 Board is asked to take assurance that the Trust is prepared for an emergency and approve the Statement of Compliance.

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

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2019-2020

STATEMENT OF COMPLIANCE

Southport and Ormskirk Hospital NHS Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards (same as last year)	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
64	**0**	**2**	**62**
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43**			

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan.

_____ _____

Sign Name Print Name

The organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

Ref	Domain	Standard	Detail		Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale
59	CBRN	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	We have a limited number of staff trained as PRPS wearers however, currently we are not in the position to provide enough trained staff to allow a continuous process for the decomtamination of self-presenters for longer than approximately 1 hour	Partially compliant	There is a plan in place to recruit and train staff to become part of the CBRN Response Team.	Steve Christian Chris Pilkington	Mar-20
61	CBRN	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	We have the required number of PRPS which is 24 in total. 12 suits on each site. Currently, there is no finance plan in place to revalidate or replace suits that are reaching their expiration date.	Partially compliant	EPRR does not have a designated budget. A Statement of Case is being completed and submitted to BDISC for approval.	Steve Christian Chris Pilkington	Dec-19

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB174/19b**	**Report Title**	**Learning lessons to improve Our People Practices**
Executive Lead	Jane Royds, Director of HR and OD		
Lead Officer	Laura Hilton, Head of HR		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Committee's highlight report for September 2019 is set out below:

Alert
N/A

Advise
There are a number of recommendations in the attached paper that need to be agreed in order to strengthen the Trusts compliance with investigation findings and recommendations.

Assure
The board can take assurance that many of the recommendations set out by Baroness Harding are already in place at S&O.

Recommendation: This paper is to **assure** the Board.

Strategic Objective(s) and Principal Risks(s)

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

	Strategic Objective	Principal Risk
☐	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
✓	**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	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*

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	*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)*

A further update paper to be provided to Workforce Committee in October 2019.

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

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For Information: Literally, to inform the Board

Learning lessons to improve our people practices

1. Introduction

This paper is to advise the Trust Board about the content of a letter sent to Provider chief executives and chairs on the 24th May 2019 from Baroness Dido Harding, Chair, NHS England and NHS Improvement about why Trusts need to learn lessons to improve our people practices. The letter shares the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago. This paper will provide details of the case of Amin Abdullah who was the subject of an investigation and disciplinary procedure in late 2015 and includes additional guidance relating to the management and oversight of local investigation and disciplinary procedures.

2. Background

In the case of Amin Abdullah the protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' advisory group to consider to what extent the failings identified in Amin's case are either unique to that Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

This paper aims to outline where S&O's current processes and procedures are against the 7 areas of focus set out in Baroness Harding's guidance and the Business HR team's commitment to further improve and strengthen our people practice in relation to the management of employee relations cases.

3. Guidance relating to the management and oversight of local investigation and disciplinary procedures

3.1. Adhering to best practice

The Trusts key disciplinary and grievance policies are in the process of being significantly reviewed to ensure that they maintain keeping in line with current best practice as advised in the Arbitration Conciliation Advisory Service (ACAS) Code of practice on disciplinary and grievance procedures. The Trusts Managing High Professional Standards policy applicable to the management of our medical workforce has also recently been reviewed.

The recommendation of Baroness Harding suggests that procedures should also follow the principles of the NMCs best practice guidance on local investigations (when published). The Business HR team

in partnership with staff side will ensure review of this once published and make any amendments to our process if required.

All formal employee relations cases have an assigned HR representative to advise and support the management of procedures. Through this the Business HR team ensure that independence and objectivity is applied throughout the process and action is taken to prevent any perceived conflicts of interest. This is supported by our policies and procedures and also applicable to the HR representative assigned to the differing steps of the process.

Where required advisors to disciplinary and appeal panels may also be assigned as subject matters experts to ensure objectivity.

All employee relations policies and procedures 'owned' by the Business HR team have recently been reviewed or are currently going through review and will be reviewed in accordance with the recommendations following this independent investigation.

3.2. Applying rigorous decision making

Trust processes can be considered to be in line with the application of just culture principles. Policies have been drafted to ensure that preliminary investigative work is undertaken before any process progresses to a formal procedure.

Within the Trusts revised disciplinary policy the usage of the NHS Incident Decision tree (Just Culture Guide) is proposed to be used on the outset of any employee relations case to guide and inform the appropriate next steps, for example when considering the suspension of an employee where a serious allegation has come to light.

If following a preliminary investigation the senior manager in possession of the allegation recommends suspension, the Business HR team ensure that this is escalated to the respective Director of the Trust, Deputy Director, Assistant Director of Operations, Head of Nursing or equivalent. By adopting this practice ensures plurality and informed decisions are made on the outset.

The Trust has significantly invested into their mediation service within the last 3 years and now has 27 trained mediators available throughout the Organisation. Where mediation is deemed appropriate, this is an enabler for cases to be managed at a local and informal stage of the process.

3.3. Ensuring people are trained and competent to carry out their role

The appointment of investigating officers is decided in collaboration of the case manager/commissioning manager (revised policy) and the assigned HR representative. When appointing investigating officers this will be dependent on the seniority, neutrality and experience of the individual. As all employee relations cases will be assigned a HR representative, it is their role to guide, advise and coach that investigating officer as the process progresses.

To support the competence of investigating officers, hearing and appeal boards, the Trust has guides and training established which are available on the Trusts intranet. The Business HR team will also review those guides and training programmes to ensure consistency with the revised policies.

3.4. Assigning sufficient resources

Within the Business HR team monthly case reviews are held as a team which allows capacity and demand oversight and appropriate delegation to ensure the timeliness of investigations internal to the Business HR team. Any concerns regarding resource will be escalated to the appropriate senior member of the management team to ensure resolution.

Additionally the Trust has invested in the development and resourced a bank of investigating officers to ensure that the Trust has access to independent investigating officers should resourcing be of concern.

3.5. Decisions relating to the implementation of suspensions / exclusions

When a suspension is likely, the Business HR team ensure that the decision to suspend is escalated to the Director of the Trust, Deputy Director, Assistant Director of Operations, Head of Nursing or equivalent. The revised policy will ensure that the escalation of a decision to suspend ensures preliminary investigative work has been undertaken, that decisions to suspend are informed, safe and alternatives to suspensions are considered.

3.6. Safeguarding people health and wellbeing

On the outset of an employee relations case the individual is reminded of the support services available to them through the Trusts health and wellbeing service and employee assistance provider. The individual is advised that a self-referral to those services can be made or alternatively a management referral will be made on their behalf. In some circumstances a case manager/commissioning manager may automatically refer an individual to support services dependent on the nature of the allegations or individuals circumstances.

Once an employee relations case has been commissioned a terms of reference will be drafted by the case manager/commissioning manager that includes timeframes for the completion of the investigatory process and also when the individual will be informed of the outcome of the process. This timeframe will be shared with the individual by the investigating officer through the course of their investigation.

The case manager/commissioning manager is responsible for keeping the individual informed on the progress of the investigation and any delays to the originally anticipated timeframe of completion.

3.7. Board level oversight

Going forward the board will receive data relating to employee relations cases via a dashboard presented at Workforce Committee held on a monthly basis. This group is chaired via the Director of HR and OD and the minutes and papers of that group are shared with the Board via the Corporate Governance structure. The board will also receive data relating to employee relations cases directly via the CBU Performance Review meetings chaired by the Chief Executive Officer.

Detailed discussions relating to employee relations cases are shared during the monthly one to one meetings held between the Head of HR and HR Business Partners.

4. Recommendations

It is recommended that the board can take assurance that many of the recommendations set out by Baroness Harding are already in place at S&O. There are however areas that can be strengthened and the Business HR team will commit to improve those in the coming months, and will provide an assurance at regular intervals. .

Actions to be taken:

- Review the contents of the NMCs ‘best practice guidance on local investigations’ when published, making any necessary amendments to process where needed.
- The team will develop a suspension pro-forma in order to record the process of escalation and informed decisions when the need to suspend arises. Whilst this can be evidenced at present this will ensure consistency and a central record of this information. Once developed a recommendation for this suspension pro-forma to be added as an appendices within the disciplinary policy to encourage its usage.
- The Business HR team to ensure evidence that a preliminary investigation has been undertaken prior to commencement of a formal process. Currently this can be difficult to evidence the separation of a preliminary and formal process.
- The Business HR team to will refresh a local training programme for investigations of employee relation cases.
- Continue to develop and review toolkits and guides to ensure they are fit for purpose.

- Add to terms of reference templates that the requirement for the commissioning manager to ensure wellbeing support is offered at regular intervals and a communication plan is established on the outset of an employee relations process.
- Develop and establish a governance framework in relation to the reporting of cases.
- Business Case funding will implement an employee relations case management system to ensure timeliness of case management. This system has shown much improvement when implemented in other Trusts.

This paper is to **assure** the Board that an action plan is in place.

NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. **Was there any intention to cause harm?**

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

No go to next question - **Q2. health test**

2a. **Are there indications of substance abuse?**

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

3c. **Did the individual knowingly depart from these protocols?**

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

4c. **Did more senior members of the team fail to provide supervision that normally should be provided?**

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. **Were there any significant mitigating circumstances?**

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

collaboration trust respect innovation courage compassion

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB174/19c**	**Report Title**	**Workforce Disability Equality Standard Report**
Executive Lead	Jane Royds: Director of Human Resources and OD		
Lead Officer	Bob Davies: Equality Lead		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Committee's highlight report for August 2019 is set out below:

Alert

30.48% of the workforce have not disclosed if they do or do not have a disability. The Trust needs to promote to staff the purpose of self-reporting and self-reporting process on ESR.

Advise

The WDES report highlights that staff with a disability have poorer experiences in areas such as bullying and harassment and attending work when ill.

Assure

The WDES action plan will be monitored and updated. Updates will be provided to the various Trust groups / committees and the report and updates are also a requirement of the equality section of the quality contract with the CCG's.

Recommendation

The Workforce Committee is asked to **receive** the report

	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	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right*

skills who feel valued and motivated	*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 Committee)*

The Trust has compiled a WDES report and action plan that will be monitored at various Trust committees and groups i.e. Workforce Committee Valuing Our People Group, reporting is also a requirement in the CCG equality section of the quality contract, the Trust will set up a disability staff network to obtain the views of staff with a disability or long-term medical condition, the WDES action plan highlights areas for development i.e. Reporting a disability on ESR, Recruitment, Staff Bandings, Bullying and Harassment

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 Workforce Disability Equality Standard Information Report April 2019 – March 2020

1. Executive Summary

This paper provides a general overview of the Workforce Disability Equality Standard (WDES) and the metrics against the nine indicators within the Workforce Disability Equality Standard (WDES). It also provides analysis of the metrics and outlines actions (Appendix 1 WDES Action Plan) to address the gaps between the experience of Disabled and Non-disabled staff.

2. Introduction

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and will apply to all NHS Trusts and Foundation Trusts from April 2019. The WDES is a data-based standard that uses a series of measures (Metrics) to improve the experiences of Disabled staff in the NHS.

The WDES comprises ten Metrics. All of the Metrics draw from existing data sources (recruitment dataset, ESR, NHS Staff Survey, HR data) with the exception of one; Metric 9b asks for narrative evidence of actions taken, to be written into the WDES annual report

The Metrics have been developed to capture information relating to the experience of Disabled staff in the NHS. Research has shown that Disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The ten Metrics have been informed by research by Middlesex and Bedford Universities, conducted on behalf of NHS England, and by Disability Rights UK on behalf of NHS Employers.

The annual collection of the WDES Metrics will allow NHS Trusts and Foundation Trusts to better understand and improve the employment experiences of Disabled staff in the NHS.

The WDES Metrics have been designed to be as simple and straightforward as possible. The development of the WDES owes a great deal to the consultation and engagement with NHS key stakeholders, including Disabled staff, trade unions and senior leaders.

3. Staff Profile

As of March 2019 Southport and Ormskirk Hospital NHS Trust employed 2986 people of which 2.55% disclosed they have a disability.

Disability – Non Disabled Staff Information: 2.55% of the Workforce has disclosed that they consider themselves to have a Disability, 66.97% of staff have told us they don't consider themselves to have a Disability with the remainder 30.48% either not declaring, preferring not to say and the others unspecified

Disability	Headcount	Percentage %
No	2000	66.97% of staff don't consider themselves to have a disability
Not Declared	127	
Prefer Not To Answer	1	
Unspecified	782	30.48% not disclosed
Yes	76	2.55% of staff consider themselves to have a disability
Grand Total	**2986**	**100%**

4. Workforce Metrics

Three workforce Metrics, compares the data for both Disabled and non-disabled staff.
Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

Workforce Disability Equality Standard Indicators:
For each of workforce indicators, the standard compares the metrics for disabled and non-disabled staff were the figures don't equate to 100% this is due to the information not stated / not given

Workforce Metrics

For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff.

Metric:

1

Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Cluster 1 (Bands 1 - 4)
Cluster 2 (Band 5 - 7)
Cluster 3 (Bands 8a - 8b)
Cluster 4 (Bands 8c - 9 & VSM
Cluster 5 (Medical & Dental Staff, Consultants)
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)

Note: Definitions are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.

Data for reporting year

Non – Clinical

2018-19

Cluster	Disabled	Non-Disabled
Cluster 1	4%	58%
Cluster 2	4%	67%
Cluster 3	0%	69%
Cluster 4	0%	89%

Clinical

2018-19

Cluster	Disabled	Non-Disabled
Cluster 1	2%	70%
Cluster 2	2%	71%
Cluster 3	3%	64%
Cluster 4	0%	86%

Cluster 5: Med & Dental Consultant

2018-19

Disabled	Non-Disabled
0%	58%

Cluster 6: Med & Dental Consultant Non –Consultant Career Grade

2018-19

Disabled	Non-Disabled
2%	64%

Cluster 7: Medical & Dental Trainee Grades

2018-19
2017-18

Disabled	Non-Disabled
1%	94%

Metric 2:

2 Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.

Recruitment: The information below highlights the ratio of Disabled and Non-Disabled staff being appointed from short listing; please note this refers to both internal and external posts

2018-19

	Head Count		Ratio	
WDES Category	Shortlisted	Hired	Shortlisted	Ratio
Disabled	432	16	0.96	0.04
Non-Disabled	2515	150	0.94	0.06
NULL	31	8	0.79	0.21
Not Stated / Not Given	49	1	0.98	0.02

Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts: 1.6,

A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting

Metric 3:

3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note:
i) This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii) This Metric is voluntary in year one.

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process

2018-19

WDES Category	Head Count
Disabled	0
Non-Disabled	0
Not Stated	1
Total	1

Figure for disabled and none disabled staff is the same 0%

National NHS Staff Survey Metrics
For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff

Metric 4:

4	**a/** Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	
	i/ Patients/service users, their relatives or other members of the public in the last 12 months	**i/** Patients/service users, their relatives or other members of the public:

		Disabled : 37.3 % **Non-Disabled** 26.7%
	ii/ Managers	**ii/** Managers: **Disabled** 24.4% **Non-Disabled** 11.5%
	iii/ Other colleagues	**iii/** Other colleagues: **Disabled** 30.8% **Non-Disabled** 15.9 %
	b/ Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	**b/** % of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **Disabled** 52.8% **Non-Disabled** 46.5%
Metric 5: Q14		
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	**Disabled** 78.5% **Non-Disabled** 80.9 %
Metric 6: Q11		
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Disabled** 31.8% **Non-Disabled** 19.7%
Metric 7: Q5		
7	Percentage of Disabled staff compared to non – disabled staff saying that they are satisfied with the extent to which their organisation values their work	**Disabled** 26.9% **Non-Disabled** 37.8%
The following NHS Staff Survey Metric only includes the responses of Disabled staff		
Metric 8: Q28b		
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	**Disabled** 76.2%
NHS Staff Survey and the engagement of Disabled staff For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score For part b) add evidence to the Trust's WDES Annual Report		
Metric 9:		
9	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) **Note:** For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report.	**Disabled** 6.2 **Non-Disabled** 6.6 **Yes:** Staff & Family Friends Test NHS Staff Survey Big Brew / Conversation Setting Up of a Disability Staff Network So Proud Pulse Check

	Examples are listed in the WDES technical guidance.	
Board Representation Metric For this Metric, compare the difference for Disabled and non-disabled staff		
Metric 10:		
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:	• Trust board headcount • Executive and Non-executive • Workforce • Please note were figures don't equate to 100% this is due to staff responses unknown or null response

	Non-Disabled	Disabled
Trust board members – Headcount:	14	0
of which: Voting Board Members	11	0
:Non-Voting Board Members	3	0
Trust Board Members		
of which: Exec Board Members	11	0
:Non Exec Board Members	3	0
Workforce		
Overall workforce % by disability	67%	2%
Differences		
Total Board –overall workforce	33%	-2%
Voting membership –Overall workforce	33%	-2%
Executive-Overall Workforce	33%	-2%

5. Trust Actions taken to be compliant with the WDES

- WDES Reporting template completed and sent to NHS England
- WDES Report completed and will be uploaded onto the Trust website
- WDES Action plan completed and to be reviewed and updates to be provided at each Valuing Our Peoples Assurance Group and Workforce Committee meeting

6. Recommendations

- WDES paper to be presented to the appropriate Trust Valuing Our Peoples Assurance Group and Workforce Committee meeting

The Valuing Our Peoples Assurance Group and Workforce Committee meeting to:

- Note that the NHS Workforce Disability Equality Standard (WDES) came into effect on the 1st April 2019 and will be completed by the Trust on an annual basis.
- Note that the Trust will put in place WDES action plan and agree that the performance against the plan will be reported through the various Trustwide Valuing Our Peoples Assurance Group and Workforce Committee meeting
- An annual report will be complied for submission to the NHS England Co-ordinator, Commissioner outlining progress on the Workforce Disability Equality Standards.
- Workforce Disability Equality Standard report will be published on the Trust website
- A copy of the WDES Indicators has been sent to NHS England

Appendix 1:

Workforce Disability Equality Standard (WDES) Action Plan

WDES ACTION PLAN 2019-20 Final.doc

Appendix 2:

WDES Technical guidance

wdes-technical-guidance-v1.pdf

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB174/19d**	**Report Title**	**Workforce Race Equality Standard Report**
Executive Lead	Jane Royds: Director of Human Resources and OD		
Lead Officer	Bob Davies: Equality Lead		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Committee's highlight report for August 2019 is set out below:

Alert

To highlight the Trusts compliance to NHS England to complete the Workforce Race Equality Standard (WRES) report and action plan, the report highlights the comparisons between BME and white staff across a number of indicators.

Advise

Ensure that the Trust data for the WRES has been uploaded onto NHS England site and will be published on the Trust website and sent to the CCG as part of the equality section of the quality contract.

Assure

The WRES action plan will be monitored and updated. Updates will be provided to the various Trust groups / committees and the report and updates are also a requirement of the equality section of the quality contract with the CCG's.

Recommendation

The Workforce Committee is asked to **receive** the report

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

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✓ 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

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The Trust has compiled a WDES report and action plan that will be monitored at various Trust committees and groups i.e. Workforce Committee Valuing Our People Group, reporting is also a requirement in the CCG equality section of the quality contract, the Trust will set up a disability staff network to obtain the views of staff with a disability or long-term medical condition, the WDES action plan highlights areas for development i.e. Reporting a disability on ESR, Recruitment, Staff Bandings, Bullying and Harassment

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

Southport and Ormskirk Hospital NHS Trust Workforce Race Equality Standard Information Report April 2018 – March 2019

1. Executive Summary

This paper provides a general overview of the Workforce Race Equality Standard (WRES) and the Trust's metrics against the nine indicators within the Workforce Race Equality Standard (WRES). It also provides analysis of the metrics and outlines actions (Appendix 1 WRES Action Plan) to address the gaps between the experience of BME and White staff.

2. Introduction

The NHS Equality and Diversity Council agreed in July 2014 that action across the NHS needs to be taken to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The move follows recent reports which have highlighted disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst the BME population.

Following a period of consultation, the NHS Equality and Diversity Council agreed two measures that compliment each other whilst being distinct to improve equality across the NHS and these would be mandatory requirements embedded within the NHS Contract from April 2015.

1. The Workforce Race Equality Standard (WRES)
2. NHS Equality Delivery System 2 (EDS2)

There are nine metrics. Four of the metrics are specifically on workforce data and four of the metrics are based on data derived from the national NHS Staff Survey indicators. The latter will highlight any differences between the experience and treatment of White staff and BME staff in the NHS, with a view to closing the gaps highlighted by those metrics. The final metric requires provider organisations to ensure that their Boards are broadly representative of the communities they serve.

The CQC will take this into account within the 'Well Led' domain.

3. Drivers for WRES implementation

The research Snowy White Peaks by Roger Kline (2013) showed:

- Unfair treatment of BME staff adversely affects the care and treatment of patients
- Talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
- Precious staff resources are being wasted through the impact of such treatment on morale and discretionary effort
- Diverse teams and leaderships are more likely to show the innovation and increased organisational effectiveness the NHS needs.
- Organisations whose leadership composition bears little relationship to the communities they serve will be less likely to deliver the patient focussed care that is needed
- Nationally there has been a decrease in the proportion of BME Board members, Senior Managers and Nurse Managers in recent years; there are less BME Leaders and Managers in 2013 than in 2003 (Kline 2015).
- Statistically White staff are 1.74 times more likely to be appointed once shortlisted than BME staff (Kline, 2013);
- BME staff are twice as likely to enter formal disciplinary processes and be disciplined for similar offences than white staff (Archibong et al, 2010);
- Black nurses take 50% longer to be promoted and are less likely to access national training programmes (NHSLA);
- BME staff experiences correlate to the staff survey results on bullying, career progression, promotion and discrimination.
- 2014 Francis found BME Whistle-blowers are treated less favourably than white whistle-

blowers.

4 Staff Profile
As of March 2019 Southport and Ormskirk Hospital NHS Trust employed 2986 people of which Workforce

Ethnicity: The Trust workforce consists of 10.95% from Black Minority and Ethnic groups 82.65% White staff and 6.40% not stated unspecified prefer not to answer.

5. Workforce Race Equality Standard Indicators:
5.1 Workforce: For each of these four workforce indicators, the standard compares the metrics for White and BME staff were the figures don't equate to 100% this is due to the information not stated / not given.

Indicator		Data for reporting year			
		2018-19		2017-18	
1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • • Non-Clinical staff • • Clinical staff - of which • - Non-Medical staff • - Medical and Dental staff Note: Definitions are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.	**Non - Clinical**			
		Band	**BME**	**White**	**BME**	**White**
		Band 1	7.17%	84.75%	7.0%	84.7%
		Band 2	1.29%	93.89%	1.3%	93.7%
		Band 3	4.0%	86.40%	4.3%	84.5%
		Band 4	0.61%	95.09%	0.6%	95.8%
		Band 5	1.96%	90.20%	1.9%	90.4%
		Band 6	1.96%	94.12%	2.2%	93.5%
		Band 7	3.45%	86.21%	3.3%	90.0%
		Band 8a	4.76%	90.48%	5.0%	95.0%
		Band 8b	0.00%	100%	0%	100%
		Band 8c	0.00%	100%	0%	100%
		Band 8d	14.29%	85.71%	14.3%	66.7%
		Band 9	0.00%	100%	0%	100%
		2017-18				
		VSM	16.67%	83.33%	33.3%	66.7%
		CQIR	0.00%	100%	0%	100%
		IRPM	0.00%	100%	0%	100%
		WCOO	0.00%	100%	0%	100%
		Clinical				
			2018-19		**2017-18**	
		Band	**BME**	**White**	**BME**	**White**
		Band 2	9.68%	80.24%	9%	80.2%
		Band 3	2.97%	91.82%	3.2%	92.2%
		Band 4	0.00%	96.08%	0%	98.1%
		Band 5	7.10%	87.33%	7.5%	87.2%
		Band 6	5.32%	90.05%	4.8%	90.6%
		Band 7	1.35%	91.89%	2.0%	91.2%
		Band 8a	8.62%	86.21%	8.9%	85.7%
		Band 8b	0.00%	91.30%	0.00%	90.5%
		Band 8c	0.00%	100%	0.00%	100%
		Band 8d	0.00%	100%	0.00%	100%
		VSM	0.00%	100%	0.00%	100%
		FMWC	0.00%	100%	0.00%	100%
		MT02	80%	0.00%	N/A	N/A
		WHO3	0.00%	100%	0.00%	100%
		WHO7	16.67%	66.67%	16.67%	66.67 %
		Med & Dental Consultant				

		2018-19		**2017-18**	
		BME 42.06%	**White** 42.99%	**BME** 45.9%	**White** 40.5%
		Med & Dental Consultant Non –Consultant Career Grade			
		2018-19		**2017-18**	
		BME 56.38%	**White** 28.72%	**BME** 54.2%	**White** 30.1%
		Medical & Dental Trainee Grades			
		2018-19		**2017-18**	
		BME 23.91%	**White** 66.30%	**BME** 24.7%	**White** 65.6%
		Board- Ex- Non Exec			
		BME 18.18%	**White** 84.62%	**BME** 33.3%	**White** 66.67%

2 Relative likelihood of staff being appointed from shortlisting across all posts

Note: This refers to both external and internal posts

Recruitment: The information below highlights the ratio of BME and White Staff being appointed from short listing; please note this refers to both internal and external posts 2018-19 & 2017-18

2018-19

	Head Count		**Ratio**	
WRES Category	Shortlisted	Hired	Shortlisted	Ratio
BME	432	16	0.96	0.04
White	2515	150	0.94	0.06
NULL	31	8	0.79	0.21
Not Stated / Not Given	49	1	0.98	0.02

2017-18

	Head Count		**Ratio**	
WRES Category	Shortlisted	Hired	Shortlisted	Ratio
BME	393	7	0.98	0.02
White	2289	98	0.96	0.04
NULL	10	2	0.83	0.17
Not Stated / Not Given	47		1.00	

3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year. For consistency, organisations should use the same methodology as they

Disciplinary Process: Overall breakdown of cases by ethnic origin categorised in line with WRES requirements as at 31.3.2019

2018-19

WRES Category	Head Count
BME	1
White	23
Not Stated	1
Total	25

2017-18

WRES Category	Head Count
BME	1

	have always used.	White: 38 Not Stated: 4 Total: 43
4	Relative likelihood of staff accessing non-mandatory training and CPD	Training: The information below highlights the ratio of BME and White staff accessing training in 2018-19 and 2017-18

2018-19

WRES Category	Head Count	Enrolment Headcount	Ratio
BME	244	226	0.93
White	2551	2219	0.87
NULL	12	8	0.67
Not Stated / Not Given	178	160	0.89

2017-18

WRES Category	Head Count	Enrolment Headcount	Ratio
BME	242	223	0.92
White	2603	2447	0.94
NULL	12	10	0.83
Not Stated / Not Given	206	191	0.93

5.2 NHS Staff Survey:
The 2018 NHS Staff Survey was completed by 1,147 staff this is a response rate of 40% which is average for combined acute and community trusts in England (43%) and compares with a response rate in the Trust in 2017 of (45%) ,
For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff.

Key Findings KF25, KF26, and KF21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.
Note that for question Q17, the percentage featured is that of "Yes" responses to the question.

Key Finding and question numbers are the same in 2018 as 2017.
Figures in bold highlight BME figures

	Indicator	**Data for reporting year 2018**	**Data for previous year 2017**
5	**15a:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Experiences of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has seen the figures for white staff decrease by 0.1% and a **9.2% increase for BME staff**.	White staff 28.4 % BME staff : 29.4% Average (median) for combined Acute and Community Trusts White staff– 28.2% BME staff- 29.8%	White staff: 28.5% BME staff: 20.2%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months Experiences of experiencing harassment, bullying or abuse from staff in last 12 months has seen a 1.8% increase for white staff and a **decrease of 6.5% for BME staff**.	White staff: 25.7% BME staff: 26.5% Average (median) for combined Acute and Community Trusts White staff– 26.4% BME staff- 28.6%	White staff: 23.9% BME staff: 33%

7	Percentage believing that trust provides equal opportunities for career progression or promotion Experience of white staff has seen an increase of 1.2% for white staff and an **increase of 5.4% for BME staff.**	White staff: 80.5% BME staff: 80.4% Average (median) for combined Acute and Community Trusts White staff: 86.5% BME staff: 72.3%	White staff:79.3% BME staff: 75%
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues Experience of white staff has seen a 0.3% increase from 2017 and there has been an **increase of 3.5% from 2017 for BME staff.**	White staff: 7% BME staff: 13.6% Average (median) for combined MH/LD and Community Trusts White staff: 6.6% BME staff: 14.6%	White staff: 6.7% BME staff: 10.1%

5.3 Board Representation Indicator:
For this indicator, compare the difference for white and BME staff

	Indicator	**Data for reporting year**
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board Note: This is an amended version of the previous definition of Indicator 9	The information below provides information on the headcount and percentage difference between the organisations board membership and its overall workforce for BME and White Staff By executive and non-executive board membership = BME: 14.29% White:78.57% Not Stated: 7.14%

2018-19

WRES Category	Head Count	Head count %	Board Head Count	Board Headcount %
BME	258	8.18%	2	14.29%
White	2679	84.97%	11	78.57%
Null	23	0.73%	0	0.00
Not Stated /Not Given	193	6.12%	1	7.14%

2017-18

WRES Category	Head Count	Head count %	Board Head Count	Board Headcount %
BME	242	7.9%	3	30%
White	2603	85.01%	6	60%
Null	12	0.39%	0	0.00
Not Stated /Not Given	206	6.7%	1	10%

6. Trust Actions taken to be compliant with the WRES

- WRES Reporting template completed and sent to NHS England
- WRES Report completed and will be uploaded onto the Trust website
- WRES Action plan completed and to be reviewed and updates to be provided at each Valuing Our Peoples Assurance Group and Workforce Committee meeting

7. Recommendations

- WRES paper to be presented to the appropriate Trust Valuing Our Peoples Assurance Group and Workforce Committee meeting

The Valuing Our Peoples Assurance Group and Workforce Committee meeting to:

- Note that the NHS Workforce Race Equality Standard came into effect on the 1st April 2015 and is completed by the Trust on an annual basis.
- Note that the Trust has put in place WRES action plan and agree that the performance against the plan will be reported through the various Trustwide Valuing Our Peoples Assurance Group and Workforce Committee meeting
- An annual report will be compiled for submission to the NHS England Co-ordinator, Commissioner outlining progress on the Workforce Race Equality Standards.
- Workforce Race Equality Standard report will be published on the Trust website
- A copy of the WRES Indicators has been sent to NHS England

Appendix 1:

Workforce Race Equality Standard (WRES) Action Plan

WRES ACTION PLAN 2019-20 Final.doc

Appendix 2:

wres-technical-guidance-2017 (1).pdf

Appendix 3:

wres-nhs-board-bulletin.pdf

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 October 2019

Agenda Item	**TB174/19e**	**Report Title**	**Health and Wellbeing Strategy**
Executive Lead	Jane Royds, Director of HR and OD		
Lead Officer	Linda Lewis, Assistant Director of Health and Wellbeing		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Committee's highlight report for July 2019 is set out below:

Alert

- N/A

Advise

- The next Health and Wellbeing report will be provided in December and include the action plan that will be produced from a comprehensive diagnostic tool (NHS Employers 'Workforce Health and Wellbeing Framework').

Assure

- This report provides the Committee members with an oversight of the Health and Wellbeing strategy. The strategy is aligned to the Workforce and OD strategy to ensure a consistent approach to 'creating a healthy culture'.
- In recognition of the importance of getting the delivery of the outcomes of this strategy right, the Valuing our People Group will become the Steering Group for the action plan to ensure that momentum is increased throughout 2020.

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

	resources the sustainability of services will be in question.
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services*

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

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

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

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

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

Complete diagnostic tool to develop action plan – Linda Lewis

Previously Presented at:

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

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

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

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

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

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

For Information: Literally, to inform the Board

NHS
Southport and Ormskirk Hospital
NHS Trust

Staff Health and Wellbeing Strategy

2019 - 2021

Contents

1. Introduction

This document describes our Health and Wellbeing Strategy 2019-2021. It sets out our vision, ambitions and plans for the health and wellbeing of our staff, drawing together strategically all that the Trust does to attract, retain, support and reward its people to meet its priorities.

Delivery of NHS services involves one of the world's largest workforces and the health and wellbeing of this significant proportion of the UK working population is crucial to the delivery of continued improvement to patient care.

Our vision is to have a healthy organisational culture, a sustainable and capable workforce, working in an integrated manner with partners and where leadership is effective and conducted in a manner that improves staff experience and lets us demonstrate that we have put our values into action. Our success will be delivered through our people and in collaboration with our staff side colleagues.

Strong evidence shows that NHS organisations that support the health and wellbeing of their staff achieve a range of positive outcomes. The level of health and wellbeing of the workforce is a key indicator of organisational performance and patient outcomes. The evidence makes it clear that cultures of engagement, mutuality, caring, compassion and respect for all staff, patients and the public, provide the ideal environment within which to care for the health of the nation. When we care for staff, they can provide outstanding professional care for patients. We know that "it is the experience of healthcare staff that shapes patient experiences of care for good or ill, not the other way around (Maben et al, 2013). The health and wellbeing of our staff is everyone's responsibility.

Silas Nicholls
Chief Executive Officer

Jane Royds
Director of HR and OD

2. Our vision for our workforce

Our workforce has been commended for its care of our patients. We value and are proud of the commitment and contribution of every member of staff. We want our staff to be equally proud to work for us as a provider of trusted acute services and as a desirable employer.

We want our staff to feel fulfilled, fairly treated, valued in their roles and recognised for the important contribution they make each day. We also want our staff to be engaged, positively shaping the services they provide and the culture of the environment they work in. Great leadership is fundamental to delivering this, so we attract, develop and retain staff who do their very best for our patients and their carers', and live our values through their actions.

3. Our aim

Our workforce and OD strategy has three strategic pillars:

1. **Create a healthy culture** – develop a leadership culture where our staff feel they are included, valued 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.

The aim of this strategy is to support these strategic pillars creating a working environment that optimises staff health and wellbeing and enables staff to enjoy work and perform at their best.

This is a two year strategy that will focus on the three areas:

- Promoting an active and healthy lifestyle (in both workplace and home)
- Staying well (preventing avoidable illness and infection)
- Mental wellbeing (creating an open and supportive culture for our employees)

4. How will we do this?

4.1: our health and wellbeing initiatives are backed with strong leadership and visible support at board level. The health and wellbeing service is integrated with the organisation and involved in the wider project work being undertaken within the Trust.

4.2: to continue to provide a proactive safe effective quality occupational health service (SEQOHS accreditation)

4.3: we will build the capacity and capability of management at all levels to improve the health and wellbeing of our staff. This will be supported by the 'leading healthy workplaces' framework.

4.4: we will use a diagnostic tool (NHS employers 'Workforce Health and Wellbeing Framework) to inform our health and wellbeing action plan.

4.5: we will continue to promote 'Making Every Contact Count (MECC)' encouraging and helping people to make a healthier choice to achieve positive long-term behaviour change.

5. Responsibility for delivery

Our Trust Strategy 2018 - 2020 sets out the operating model and accountability framework. This means while Executive Directors have accountability for the overall strategy implementation, day to day accountability for delivery sits with everyone in a management and leadership role. However, every member of staff has an essential role to play; as we can only achieve this Strategy and make our Trust a great place to work and a great place to receive care by working collaboratively.

With overall leadership from the Director of Human Resources and Organisational Development, this Strategy will be managed as a transformational programme of work through the Workforce Committee and monitored by the Trust Board.

The lead for this strategy is the Assistant Director of Health & Wellbeing enabling strategies and supporting implementation plans will be led by the Head of Education and Training, the Head of Human Resources, the Deputy Director of Nursing and Deputy Medical Director plus others, as appropriate, on a day to day basis. The implementation leads will work collaboratively with our staff side colleagues to ensure effective delivery of the programmes of work.

The annual operation implementations plans will feed into our Trust's Annual Plan.

6. Measuring success

The true success of this strategy will be evidenced by our Trust meeting its strategic goals. It will be seen, by all stakeholders, as a safe, effective, caring, responsive and well led organisation, operating within financial balance.

A set of detailed quantitative and qualitative indicators will be developed which will be used to assess performance and success in line with the implementation plans.

7. Heath & Wellbeing Strategy on a page