Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10:15 – 13:00 on Wednesday 6 November 2019
Seminar Room, Clinical Education Centre, Southport Hospital, PR8 6PN

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration
PRELIMINARY BUSINESS			10:15
TB180/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**
TB181/19 (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**	
TB182/19 (D)	**Minutes of the Meeting held on 2 October 2019** To **approve** the minutes of the Public Board of Directors	**Chair**	
TB183/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**	
TB184/19 (D/V) **(V/P)**	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Staff Story:** Surgical Assessment Unit – How they improved the patient journey To **receive** the Staff Story and **note** lessons learnt	**NEDs EDs** **Michelle Kitson/Gemma Causer**	**30**
STRATEGIC CONTEXT			**10:55**
TB185/19 (D)	**Chief Executive's Report** To **receive** key issues and update from the CEO	**CEO**	**10**

Ref Nº.	Agenda Item	Lead	Duration
QUALITY & SAFETY			**11:05**
TB186/19 (P/D)	**Quality and Safety Reports:** a) Summary of Complaints & Compliments b) Learning from Deaths Report (formerly Monthly Mortality Report) c) Quality Improvement Plan Update d) Safe Staffing: Monthly e) CQC Inspection Update f) Freedom to Speak Up Quarterly Update To **receive** the presentation and reports	**DoN/MD**	**30**
PERFORMANCE & GOVERNANCE			**11:35**
TB187/19 (P/D)	**Integrated Performance Report (IPR)** To **receive** the report	**COO**	**15**
TB188/19 (D)	**Financial Position at Month 6, 2019/20** To **receive** the report	**DoF**	**15**
TB189/19 (D)	**Risk Management:** **Corporate Risk Register (CRR)** To **receive** the monthly reports.	**DoN**	**5**
TB190/19 (P/D)	**Single Improvement Plan Update (SIP)** To **receive** the report	**DCEO/ DoS**	**10**
ITEMS FOR APPROVAL/RATIFICATION			**12:20**
TB191/19 (V)	• To **ratify** the decision taken under Emergency Powers Section 4.3 of the Standing Orders on 25 October 2019 To **approve** application for an Uncommitted Revenue Support Loan for November 2019	**Chair**	**5**
CONCLUDING BUSINESS			**12:25**
TB192/19 (V)	**Questions from Members of the Public**	**Public**	**10**
TB193/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda, including items for forward agenda – 4 December 2019	**Chair**	**10**
TB194/19 (V)	**Message from the Board** • To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	**5**

TB195/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**	**5**
TB196/19 (V)	**Date and time of next meeting:** **10:30, Wednesday 4 December 2019** Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN	**Chair**	**13:00 CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

NHS
Southport and Ormskirk Hospital
NHS Trust

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

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

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

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
COSGROVE Mrs Juliette	Director of Nursing, Midwifery and Therapies	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Governor – Southport College**	**04 October 2019**
MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB** **NDLM Ltd** **JSSH Ltd**	**CQC Holdings Ltd** (manufacturer of textile products)	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**9 July 2019**
MORGAN Mrs Joanne	Non-Executive Director – resigned 02 October 2019 with immediate effect – to be removed	**Director of Alasdair Morgan Ltd**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 October 2019**
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**CEO Designate for Wrightington, Wigan & Leigh NHS FT**	**Nil**	**10 July 2019**
PATTEN, Ms Therese	Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Director of Human Resources	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**25 September 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother, Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust.**	**Nil**	**Nil**	**Trustee – Age Concern**	**4 October 2019**
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**	**Nil**	**9 April 2018**

Minutes of the Public Section of the Board of Directors' Meeting held on 2 October 2019

(subject to approval by the Board on 6 November 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 J Pennifold	Head of Resourcing
	Mrs Armstrong-Child	Incoming Chief Executive
	Ms J Devereaux	Communications
Apologies:	Mrs P Gibson	Associate Non Executive Director
	Mrs C Griffiths	NHS Improvement
	Mrs J Royds	Director of Human Resources & Operational Development

TB162/19 CHAIRMAN'S WELCOME AND NOTE OF APOLOGIES

The Chairman opened the meeting by welcoming members of the public who were in attendance. He reminded them that although this a meeting held in public it is not a public meeting, therefore he would give those in attendance an opportunity to ask questions at the end of the meeting.

It was noted that this will be the last Trust Board meeting attended by the outgoing Chief Executive, and the Board wished him well for the future.

The incoming Chief Executive is in attendance as an observer, the Chairman asked her to introduce herself to the group.

TB163/19 DECLARATION OF DIRECTORS' INTERESTS CONCERNING AGENDA ITEMS

Mrs Cosgrove confirmed that she had become a Governor at Southport College.

Mr Shanahan confirmed that he was now a Trustee of Age Concern.

TB164/19 MINUTES OF THE MEETING HELD ON 4 SEPTEMBER 2019

The minutes of the meeting held on 4 September were agreed as a correct record and were approved, subject to the following amendment:

- **Minute No. TB149/19 Quality Improvement Plan**: It was noted that the exercise referred to in this minute was not a mapping exercise.

TB165/19 MATTERS ARISING/ACTION LIST

January 2019, Min No. TB028/19 Monthly Mortality Report/External Mortality Review – It was confirmed that an emailed record of deferrals had been provided, which showed that deferrals were slightly less than the national average.

TB166/19 PATIENT AND ENGAGEMENT ISSUES

Non Executive and Executive Visits/Walkabouts

The Medical Director confirmed he had visited the kitchens in Southport, and reported there are ongoing problems with the dishwashers. He is happy that everything possible is being done to resolve the matter, but due to issues in obtaining the required part for the machine, remedial work is taking a long time.

Julie Gorry asked how could the Board see what was being undertaken after their visits. It would be a meaningful exercise to see positive actions.

Action: The Director of Strategy would look to compile feedback for the Board.

It was noted that good feedback had been received in respect of the Older Peoples Forum.

The COO confirmed during his liaisons with discharge staff it was becoming apparent that due to the geography of where the staff are placed handovers are proving challenging. He will be producing a report to look at centralising the discharge staff which will help during handover. This report will be brought to the Board for their attention in due course.

The Director of Nursing explained that although the Trust had not received an award at a recent NHSI/Collaborative event, the Trust had received good feedback and were commended on how the Trust continues to learn from improvement.

The Chief Executive had visited the Training Department, who are doing a marvellous job carrying out training with what is very old equipment. It was muted that some money may be released from Charitable Trust funds to update equipment.

Trust accommodation had also been visited by the Chief Executive. By and large he was happy with the standard of accommodation, although there were some small issues which needed to be carried out which will make a tangible difference to staff who use the accommodation.

The Director of Nursing explained that due to an outbreak of Klebsiella within the Spinal Unit, this led to the Unit being closed at very short notice. Although the Commissioners were concerned in respect of how the closure was communicated to them, they did agree that this was due to the speed in which the Trust needed to react to the outbreak. Board members were asked to visit the Spinal Unit when they could.

Patient Story: Representing a Trust at an Inquest
Presented by Dr Dave Snow, Medical Director

The Board were apprised of the background of the case. Dr Snow went through the presentation pointing out the differences in the Trust today as opposed to 2015. The case was a difficult one with police involvement and with the effects of the case still with the staff involved, two of whom have not returned to nursing.

After the presentation thanks were given to Dr Snow from the Chairman and Chief

Executive, the floor was then opened for questions.

Dr Snow confirmed this was a particularly difficult case, which included corridor care. It is important to remind ourselves that although the discussion on this case is in the abstract it does involve the family of the deceased as well as the staff involved.

Mr Singh reflected on the importance and value of safe staffing within A&E, it is the front face of our Trust. He was interested to know whether the points raised by Dr Snow regarding staffing and other issues had been heard, did he feel he had the support of management? Dr Snow commented that it had been a mixed response, however, pastoral support and legal and risk support had been very good. He feels that the overall management at that time does not reflect the Trust management at this time. Mr Singh asked was Dr Snow confident cases of this nature would not happen again, to which Dr Snow replied that the case was a remarkably difficult, complex and a high risk presentation and yes, it could happen again. However, the ramifications would be significantly less due to protocols which are in place within the Trust now.

The Medical Director asked whether the police involvement, which appeared to be very early into the case, was a key trigger point; Dr Snow thought that was the case.

Discussion then took place regarding support received by staff from the Trust in relation to attending inquests. It was confirmed that staff do receive support during cases which go through to inquest if they are called to attend. This is given via HR, Health & Wellbeing and colleagues who have experience.

The Chairman thanked Dr Snow for attending the meeting; although it was an emotive case it is useful for the Board to hear a mixture of patient stories.

TB167/19 CHIEF EXECUTIVE'S REPORT

The Chief Executive's Report was presented to the Board, with key issues being highlighted as follows:

The Chief Executive gave a brief précis of his report to the Board:

He welcomed Trish Armstrong-Child to the meeting, and congratulated her on her appointment as Chief Executive to the Trust. As yet the start date for Mrs Armstrong-Child has yet to be confirmed, Mrs Patten, Director of Strategy will be interim Chief Executive during that period.

Open Day, which on this occasion took place in Ormskirk, was very well attended, and he wished to extend his thanks to all those involved.

Therapy ponies have been allowed onto the Trust sites, and have delighted patients in the children's department at Ormskirk hospital and the Garden of Reflection at Southport.

The Chief Executive took time to thank the Board and every member of staff for their efforts in moving the Trust forward during his time at the Trust.

The Chairman added his thanks, along with the thanks of the Board.

TB168/19 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, CQC update, and Freedom to Speak Up Quarterly Update and Relaunch of Strategy) were highlighted in a presentation to the Board, as follows:

Quality Improvement Priorities

Complaints & Compliments The report shows a breakdown of the number of compliments, complaints and concerns received for the month of August and the improvements now in place following the closure of complaints in July.

Although the numbers of complaints and concerns are decreasing there are some themes which are coming through. These include clinical treatment, verbal communication, cleanliness and staff attitude/behaviour.

Care of Older People - following Business Case approval, it was confirmed that the vacant post referred to in last month's Board in relation to Older Peoples Services has now been recruited to.

Due to concerns raised recently within the Trust, it has been decided that the policy on Recognising Deteriorating patients will be relaunched to staff.

The Medical Director went through figures in relation to the increase in the number of fractured neck of femur. This increase was due to work stream issues, but it should be noted that the time to theatre has improved

Mortality – The Board was asked to receive the report for assurance. It was noted that the headline figures remain in an improved position.

The Medical Director went through figures in relation to the increase in the number of fractured neck of femur. As above the increase was noted, with the time to theatre improvement also being noted.

Non-operative rates are slightly higher, all are being analysed with a view to improve.

Medicine Management – Discussion took placed regarding the nutrition and mouth care of patients. It was agreed that although a significant amount of work is being done more is needed. This however, will have a financial implication for Estates and staffing. It was agreed that Meg Langley, Head of Older Peoples Care should be asked to undertake to look at the background of nutrition and mouth care for patients and report back to the Board in due course.

Action: Head of Older Peoples Care to produce report – via the Director of Nursing

Quality Improvement Plan – Mr Singh had concerns that mobility figures are creeping up, and questioned was there any reassurance that the Trust is going in the right direction. The Medical Director confirmed he has further information which will be brought to the Board in due course. Mr Singh asked could this also be brought to the Quality & Safety Committee.

Safe Staffing – There was some confusion over the safer staffing level. The Director of Nursing offered to bring information back to the Board on safer staffing levels.

Action: Director of Nursing clarify safer staffing levels

CQC Update – The Director of Nursing and Medical Director informed the Board that the report from the CQC was awaited and once it had arrived it would be checked for accuracy.

It was confirmed that Ward Accreditation is going well; all assessments have been welcomed by the areas involved.

It was noted that there has been a restructure within the CQC and although Lorraine Bolam, who has been appointed, is new to the Trust she does have knowledge of the Trust.

Freedom to Speak Up Quarterly Update & Relaunch of Strategy – The report identifies the number of concerns raised to the FTSU Guardian during quarter 1 2019, which shows a further increase on other quarters. At the Board's request examples of changes following concerns raised where included in the report.

Martin Abram, FTSU Guardian gave an update referring to the report and confirming that the Trust now has 10 FTSU Champions, two of whom were in attendance at the Board meeting to answer questions. It is hoped that more champions will be recruited during October which is Freedom to Speak Up month.

Through the data it could be seen that there are more collective approaches being made to the FTSU within the Trust. Although it was noted that there is still work to do, especially in some cases between managers and staff and their relationships.

The Chief Executive commented that Staff Side have mixed views on FTSU as they notice more staff are taking that route when concerned or unhappy within the workplace.

After discussion the Chairman thanked the FTSU Guardian and Champions for attending the Board meeting. The Board members endorsed the relaunch of the strategy for FTSU.

TB169/19 INTEGRATED PERFORMANCE REPORT

The COO reported on this item, giving an overview of the report shared with the Governors. It highlights the indicators that require discussion; some of these indicators require corrective action to be taken. Executive assurance and action plans have been provided in order to give assurance that corrective measures are in place. The focus for the meeting is covered in four sections which can be found in the 'Today's focus…' section of the presentation.

The COO commented that the Trusts' RTT is one of the best in the country and has maintained compliance. Although performance remains challenging, a lack of anaesthetic cover is proving a constraint.

Work is underway to lower the % of agency staff and the Trust is looking at networking with other local Trusts, with a view to include cross working, which could be beneficial to all.

At the moment the Trust is 8th out of 21 for acute trusts in the North West in relation to the number of DTA breaches.

There has been a focus on the number of stranded patients, with a view to reducing patient stays and improving patient flow.

There are three areas which can show performance at a glance; The Golden Patient, Cancellations and Utilisation. The COO went on to go through the figures which are on the path to improvement.

The Board was apprised of the plans which are being looked at in relation to Winter Planning. The work undertaken by the Venn group identified significant gaps which will need to be addressed. The Trust could be 40 beds short this winter and this is concerning.

Discussion took place on the plans the CCG have built plans around this shortfall and that they believe they have met the deficiencies. However, the Trust has raised concerns that the gap has not been met, the Trust is continuing to engage with the CCG about this issue.

The Chief Executive has written to the COO of the CCG expressing the Trust's concerns and that we are looking at what options could be put in place in case the plan the CCG has is not effective.

Mr Birrell, thanks the CCO and was pleased with the work which had been carried out, wondered had a logical step been missed; he wondered why do the CCG think capacity is covered when the Trust has concerns. Mrs Gorry added by asking where the extra beds will be placed.

The main objective will be to ensure patient experience is not compromised. Liaison has been made with clinicians and there are 'mothballed' ward environments which could be utilised. The use of these wards for some instances will mitigate, but not eradicate, the problem. If the proposal of using these wards is successful this could be aligned to the Trusts' 2020 vision.

Mr Bricknell asked whether the costs incurred in preparing the wards would be covered by the CCG. It is believed that the contents of the contract would provide for the cover of costs involved, although key negotiations may be needed between the Trust and the CCG if this step is taken.

TB170/19 FINANCIAL POSITION AT MONTH 5, 2019/20

The report for month 5 of 2019/20 was received and noted by the Board.

RECEIVED:
Noted by the Board

TB171/19 RISK MANAGEMENT: CORPORATE RISK REGISTER

The Risk Management Risk Register was received and noted by the Board.

RECEIVED:
Noted by the Board

TB172/19 SINGLE IMPROVEMENT PLAN UPDATE (SIP)

The Board received the SIP Board update.

RESOLVED:
The Board received the SIP Board update.

TB173/19 BOARD ASSURANCE FRAMEWORK

The Board received the Board Assurance Framework and were asked to note the proposed development.

RECEIVED:
The Board received the BAF and noted the proposed developments.

TB174/19 ITEMS FOR APPROVAL/RATIFICATION

a) Statement of Compliance 2019/2020, Core Standards Self-Assessment, Emergency Preparedness, Resilience and Response (COO)
This item had been brought to the Board for approval.

APPROVAL:
Approved by the Board

b) Learning Lessons to Improve our People Practices Report (DoHR)
This paper had been brought to the Board to give assurance. It was agreed that this should come back to Board in November.

Action: Director of HR to return the plan to the Board in November

c) Workforce Disability Equality Standard Information Report April 2019 – March 2020 (DoHR)

d) Workforce Race Equality Standard Information Report April 2018 – March 2019 (DoHR)
Both of the above reports were presented by Mrs Pennifold. The detailed action plan was shared with the board which covered both disability and race equality within the workplace.

Mr Birrell commented that the report was quite dense with information, with no executive summary. It was confirmed that this report would be re-presented at the November Board meeting.

Action: Director of HR to return both reports to the Board in November

e) Health & Wellbeing Strategy
This report was received and noted by the Board.

Discussion moved on to the work being undertaken via the Workforce Committee. It was asked whether success was being measured via indicators and that feedback into the Board would be useful. After which the Chairman confirmed the key subjects which will be discussed during November and December.

November: CQC report, Risk, Consultation and BAF
December: Workforce.

In relation to the awaited CQC report, it should be noted that it may be embargoed and may not be shared with the public at that time.

TB175/19 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr Johnson asked if the Board had given any thoughts to liaising with the twin city in Sweden (Lindesberg) which is mentioned on the plaque in the entrance to Southport Hospital. It was agreed that the Board would take this away for consideration.

Action: Board to consider future liaison with Lindesberg

TB176/19 ANY OTHER BUSINESS – ITEMS FOR FORWARD AGENDA

- Quality Improvement
- Older People
- Changing KPAs
- Cancer
- Theatres
- Winter Planning
- Workforce

TB177/19 MESSAGE FROM THE BOARD

- The Chief Executive's last Board meeting, and welcome to the incoming Chief Executive.
- Overview of the quality improvement work including CQC inspection update, SONAAS inspections, older people's care and mortality / fractured neck of femur report

- Freedom to speak up strategy
- IPR presented, with discussion about winter planning, theatre usage and cancer targets

The Chairman formally thanked the Chief Executive for his support and hard work whilst at the Trust, and wished him well for the future. Adding the biggest legacy he is leaving behind is the team and move forward in readiness for 2020.

TB178/19 MEETING EVALUATION

- Time Management of meeting – some items rushed, insufficient time to cover items

TB179/19 DATE AND TIME OF NEXT MEETING

08:45, Wednesday, 6 November 2019
Seminar Room, Clinical Education Centre, Southport & Formby District General Hospital, Town Lane Kew, PR8 6PN

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	✓	✓	✓	✓		✓	**A**					
Audley Charles	✓	✓	✓	✓			✓					
Steve Christian	✓	✓	✓	✓		✓	✓					
Jane Royds	✓	✓	✓	✓		✓	**A**					
Anita Davenport						✓	✓					
Jenny Pennifold							✓					
A = Apologies ✓ = In attendance												

Public Board Matters Arising Action Log
as at 2 October 2019

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB072/19	Apr 2019	**Assurance & Performance - IPR**	To provide an update via the AAA Highlight Report	**COO**	Jun 2019	Oct 2019	**October Update**: Update will be provided within the IPR agenda item.	**GREEN**
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 **November Update:** Awaiting final CQC report	**GREEN**
TB166/19	Oct 2019	**Non Executive and Executive Visits/Walkabouts**	The Director of Strategy would look to compile feedback for the Board on visits and walkabouts.	**DoS**	Oct 2019		**November Update: Tony Ellis to provide report**	**GREEN**

Public Board Matters Arising Action Log
as at 2 October 2019

Southport and Ormskirk Hospital NHS Trust

TB168/19	Oct 2019	**Quality & Safety Reports – Medicine Management**	Head of Older Peoples Care to be asked to prepare a report on the background of nutrition and mouth care for patients and report back to the Board in due course.	**DoN**	Oct 2019		**November Update:**	**GREEN**
		Staffing Levels	Director of Nursing was asked to update the Board at the next meeting with the safer staffing levels	**DoN**	Oct 2019		**November Update:**	**GREEN**
TB174/19	Oct 2019	**Items for Approval or Ratification** Learning Lessons to Improve our People Practices Report (DoHR)	All three reports are to be returned to the Board in a more user friendly format, to include an Executive Summary	**DoHR**	Oct 2019	Dec 2019	**December Update:**	**GREEN**
		Workforce Disability Equality Standard Information Report April 2019 – March 2020 (DoHR)		**DoHR**	Oct 2019	Dec 2019	**December Update:**	**GREEN**
		Workforce Race Equality Standard Information Report April 2018 – March 2019 (DoHR)		**DoHR**	Oct 2019	Dec 2019	**December Update:**	**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
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**
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	**November Update: Action complete**	**BLUE**
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 November Update: Strategy Session arranged for 6 November	**BLUE**

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.	**MD**	May 2019	Jul 2019	**October Update:** Dr Hankin to meet with Dr Goddard/Mrs Power/Mrs Flood-Jones to sign off External Mortality Review (RAM) Project. **November Update:** Meeting was held on 10th October 2019. The External Mortality Board Assurance Report (EMBAR) Action Plan underwent a full review.	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**TB185/19**	**Report Title**	**Acting 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

- Ormskirk hospital key to winter planning
- Visit by Secretary of State for Health and Social Care
- Time to Shine Awards
- Bed reopening in spinal injuries centre

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

Ormskirk hospital key role in Trust's winter planning

Like many hospitals we were under considerable pressure last winter and well into the spring.

To help we created a temporary Ward One in the Physiotherapy outpatients department at Southport hospital to provided extra capacity. However, we recognise this caused some difficulties for the therapists and their patients who needed to be relocated.

While we've been assured by the local NHS and social care that more services will be available outside hospital for patients this winter, we are proactively planning sustainable solutions of our own.

The Trust plans to make better use of the excellent facilities at Ormskirk hospital following extensive clinical consultations.

From January 1, orthopaedic patients who are likely to need an extended stay post-surgery will transfer to Ormskirk hospital for rehabilitation. This will make 16 beds available to patients needing treatment at Southport hospital.

To make this happen, improvements will be needed at Ormskirk:

- E ward will be refurbished and brought back into use. Current G ward patients and teams will be moved there. This will include an improved gynaecology assessment bay
- G and H wards will both be used for orthopaedic patients, with a therapy bay added to H ward

Additional staff are being recruited and these arrangements will initially be in place for five months. If they are successful in helping deliver better patient care, they may become part of our long-term plans.

Visit by Secretary of State for Health and Social Care

We were delighted to welcome Matt Hancock, the Secretary of State for Health and Social Care, to Southport hospital on 9 October. He was visiting at the invitation of Southport MP Damien Moore.

Mr Hancock enjoyed the opportunity to meet staff who asked him about pensions, training bursaries, funding and developing IT. He also visited the A&E department and Ward 15A.

The Secretary of State went away with a good impression of an improved hospital and engaged staff but a clear need for investment and focus on workforce.

Staff celebrate Time to Shine Awards

Nearly 250 staff and guests gathered at Formby Hall Golf Resort and Spa, near Southport, last month to celebrated our annual staff awards, the Time to Shine Awards.

This was the Trust's 11th annual staff awards. Categories are shortlisted from nominations made by staff with the exception of the People's Health Hero Award where nominations come

from the public. The shortlisted staff and teams are shown below with the winners highlighted in bold.

Team of the Year (clinical)	ACU Community Midwives **Stroke ward**
Behind the Scenes Award	Coding Team **Chris Pilkington** (Emergency Planning Officer) Transport and Stores Team
People's Health Hero Award	**Hospital Alcohol Liaison Team (HALT)** Lynn Hooton and DVT team Lynn Sugden (Medical Day Unit)
Every Day Excellence Award	Dr Khyzer Chaudhary Brenda Lovett **Roger Nicholson**
Improvement Award	**Clinical Decisions Unit** Discharge Lounge Orthopaedics
Clinical Mentor of the Year	Joy Bee Michelle Theirens **Mark Warburton**
Compassion in Action Award	Ian Challoner and Gary Monk **Dr Sharryn Gardner** Ward 15A
Apprentice of the Year Award	Gareth Ball (9A) Ami Boyd (Trainee Nurse Practitioner) **Jasmin Groom** (9B Trainee Practitioner Nurse)
Volunteer of the Year Award	Margaret Bradbury (RVS) Hilda Gates (Ormskirk hospital welcomer) **Southport hospital welcomers**
Thanks a Bunch Annual Award	Elaine Lloyd Ann McMaster (staff nurse, children's department) **Matt Parry** (Casting Manager)

Beds reopening in spinal injuries centre

North West Regional Spinal Injuries Centre at Southport hospital has begun to reopen after closing to admissions in the summer.

This was to allow essential upgrading and deep cleaning of bathrooms following an increase in the incidence of patients colonised with the Klebsiella bacteria.

The decision was taken in the best interests of patients and in accordance with guidance in our infection outbreak policy.

Klebsiella is an antibiotic-sensitive organism found in the gut. However, it sometimes develops a resistance to some antibiotics, which is what has happened on this occasion. It doesn't usually cause infections but when it does it is most likely to affect the urinary tract and people with long-term catheter use. When infections occur there are still effective antibiotics that can be used even though there is some antibiotic resistance. There is no risk to the health of the general public.

In brief …

New Chief Executive.
Trish Armstrong-Child, the Trust's new Chief Executive, will take up her role on Monday 2 December.

Flu vaccinations.
Staff are continuing their commitment to protecting themselves, each other and patients from flu this year. As we approached the end of October, 66% of frontline staff had been vaccinated – well within sight of our minimum 80% target. Many non-clinical colleagues have also been vaccinated.

Thanks a Bunch.
Each month staff nominate colleagues for our Thanks a Bunch Award for someone who's gone the extra mile and deserves recognition. In September awards were made to:

- Alison Green (senior sister in A&E)
- Communications team
- Gerry Heaton (pharmacy porter)

Therese Patten Acting Chief Executive
November 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**TB186/19a**	**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 September and the improvements put in place following closure of complaints in August 2019.

The numbers of complaints and concerns are decreasing; some of the same themes are coming through but discharge has featured this month within the themes.

- Clinical Treatment – in particularly co-ordination of medical treatment
- Staff attitude/behaviour
- Patient's being discharged who allegedly are not fit for discharge
- Misleading information given to patient

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
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☐	**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

September 2019

1.0 Introduction

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

2.0 Compliments

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

Planned care received the most compliments with 65 in total and F Ward receiving 26 compliments in the month.

The Urgent Care Business Unit received 22 Compliments, with the Cardiac Rehab team reporting 8 and the Wheelchair Service 6.

The Women & Children's Business Unit received 5 compliments, of which 4 related to Neonatal.

2.1 Complaints

The complaints data has been split in to low level concerns and formal complaints graded 3 or above using the trust grading tool. The formal complaints often include more than one area of complaint.

A total of 18 formal complaints were received in September.

Urgent Care received 8 complaints, with Ward 9B (FESS) accounting for 3 and A&E 2. Planned Care received 5 complaints, in 5 different areas. Specialist Services received 4 complaints, of which 3 related to Paediatric areas. 1 complaint was received by Estates and Facilities and related to car parking.

The following themes were identified:

- Clinical Treatment – in particularly co-ordination of medical treatment
- Staff attitude/behaviour
- Patient's allegedly not fit for discharge
- Misleading information given to patient

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

Urgent Care
Following the closure of complaints the Urgent Care Business Unit has implemented the following changes in practice:-

- During the month a review of processes has taken place with the clinicians in Urgent Care when a patient has suspected cancer.

- Following a complaint from a patient's family regarding a frequent attending patient to A & E, a documented individualised plan of care has now been agreed between, the patient, family and A & E to ensure correct processes are in place, when the patient attends. The Patient and their family are happy with this agreed approach.

- Safety huddles twice a day have been implemented in A &E; the safety huddles include patients who are deteriorating and those that are having problems with diet and fluids.

Planned care
Following the closure of complaints the Planned Care Business Unit has implemented the following changes in practice:-

- Following a complaint which detailed the length of time it takes to have buzzers answered on Ward 14A, there has been s decision to incorporate this into the SONAS inspection process for all ward areas.
- Following a complaint regarding a delay to diagnosis, a review was undertaken through the Steis process. A task and finish group is to be set up to review radiology processes throughout the Trust.
- A complaint detailed that the patient was concerned about the length of time it has taken to get a diagnosis within ENT service. A meeting was held with the patient and their family. Following the meeting the patient was happy with the explanations given.

Specialist Services

Following the closure of a complaint the Specialist Service Business Unit has implemented the following changes in practice:-

- Training has been put in place for the clinicians in paediatrics' regarding a missed diagnosis within paediatric outpatients department.

2.2 Concerns

There have been a total number of 47 concerns raised this month. 13 were requests for information, 8 related to staff attitude and 7 related to appointment dates.

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

TRUST BOARD
6 November 2019

Agenda Item	**TB186/19c**	**Report Title**	**Quality Improvement Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	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 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
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✓	**SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐	**SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*Absence of clear direction, engagement and leadership across the system is a risk to the sustainability of the Trust and will lead to declining clinical standards.*

Linked to Regulation & Governance

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

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

QUALITY IMPROVEMENT PLAN UPDATE OCTOBER 2019

1. PURPOSE OF REPORT

This paper provides the 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), the 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
- Patient Safety (complaints and Risk Management)
- Safeguarding (Improve training compliance and documentation regarding MCA and DoLs)

Following the October 2019 Quality and Safety Group, two additional work streams were identified including Safe and Effective Discharge and Documentation, the work streams will be reviewed again following publication of the 2019 CQC Report.

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.

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 approximately 170 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.
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. The roll-out of the ward-level training and introduction to the care plan has been placed on hold due to the lack of ability to release Dietitians from clinical duties in the absence of a Dietetic lead – the new lead is due to start November 2019, the Matrons have agreed roll-out at ward level regardless of Dietetic presence.
New NOF Pathway approved and has been sent to print including the provision of Ensure Plus Advance post-operatively (needs to be reviewed and audited)
The Mouth Care Matters Group have created the final version of the Mouth Care Plan to start trialling on ward 14B. Products have been decided on and ordered by ward 14B to trial, these are due to be delivered week commencing 21/10/2019. This will be trialled for 3-4 weeks and any amendments required will be changed. Following the roll out will then continue across the Trust and the roll out plan will be shared. Due to the difficulties in releasing staff to deliver the training, three further places have been secured to get three more members of staff trained ad train-the-trainers by HEE in order to increase ability to sustain and spread this piece of work, these will attend the training on 15th November.
Hydration management education is delivered on the 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 which is yet to be established.
The NG Feeding Group is established, the process has been mapped for best practice, wider stakeholder group have been invited to check and challenge on the proposed new process. Suppliers were invited into the next session in October to demonstrate their offerings however none have been able to provide the required packs therefore procurement are working with the suppliers to see if they could meet the request. The meeting is yet to take place..

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 has been rolled out to all wards at SDGH and ODGH except Spinal Injuries and Intensive Care who are reviewing the specialist elements required. 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, the first data has been reported and is being reviewed, the plan will be to take the module from vitalpac at the end of November 2019.
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 can launch the pathway and test it with other patients who do not have a delirium. 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 relaunch the pathway.
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, the Admiral Nurse is due to start on 16/12/19 and one of the two Band 6's has a start date of 04/11/19, while a start date is awaited for the other. Ward resource pack developed in draft now being costed up and charitable funds bid will be submitted in October 2019 once IPC approve the ward resource packs.
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, the reps will be presenting these at the meeting in October.
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.
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 confirmed and trialled on two wards before the end of October with a view to launching fully and removing the old documentation form the intranet by the end of November.
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:

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. 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.

Fractured neck of femur (NOF) update - The Trust remains an outlier for mortality on the National Hip fracture database and action plan in place an external review of NOF is planned. Fractured NOF time to surgery remains variable and constantly monitored by Medical Director.

Urinary tract infection is a 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.

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.

Mortality Screening - Screening rate for July has increased to 88.14%, the screening tool is intranet based and triggers SJR process automatically, screening rates have improved, process reviewed with addition of i-pads made available.

Infection Prevention and Control (IPC):

Programme PID requires further development a date in diary is planned for November 2019. A core service review (CSR) is currently being planned led by an external reviewer (there has been a slight delay as due to prioritising a review for Spinal Centre) the Deputy Director of Nursing is liaising with external lead.

Priorities in relation to policy updates is ongoing

MRSA bacteraemia reported in August 2019 on ward 9B 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 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 Spinal Centre refurbishments and deep cleaning - work has been completed in acute respiratory care area to provide 2 isolation cubicles and a bathroom, these areas are now in use, as part of the improvement programme, 6 beds have reopened w/c 30 September
Medicines Management: Medicine management development plan (MMDP) – the 30 day plan was completed 25 August 2019 and 3 month plan on course for completion 25 October 2019. An assurance template has been developed to ensure improvement actions are embedded and sustained. Business case for staffing has been completed for additional 13 staff to address 'extreme risk'. This will now go to Board of Directors 6 November 2019 Serious Incident RCA in relation to the CQC concern has been completed and recommendations have been incorporated into Medicine management development plan following review by SIRG Focus remains on improving 7 day working, staffing and Electronic prescribing

4. CONCLUSION

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

5. 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

6 November 2019

Agenda Item	**TB186/19b**	**Report Title**	**Learning from Deaths Monthly Report** (Formerly The Mortality Report)
Executive Lead	**Dr Terry Hankin,** Medical Director		
Lead Officer	**Dr. Chris Goddard**, Associate Medical Director of Patient Safety		
Authors	**Rachel Flood-Jones,** Project Delivery Manager **Mike Lightfoot,** Head of Information		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

1.0 Executive Summary
2.0 Mortality Indicators

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

3.0 Mortality Improvement Activity
4.0 Learning from Deaths: Structured Judgement Reviews (SJRs)
5.0 Learning from Deaths: Lessons Learned- Process & Activity
6. 0 Appendices

Appendix 1: The External Mortality Review Board Assurance Action Plan: October 2019
Appendix 2: Recognition and Care of the Deteriorating Patient Project Highlight Report
Appendix 3: Mortality Dashboard.(Dr Foster Mortality Data) October 2019
Appendix 4: Distribution Performance Graph, April 2019
Appendix 5: Mortality Indicators

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 Executive Summary

- The monthly HSMR for April shot up to 118.0 from 82.8 the previous month.
- The Rolling 12 Month HSMR for April remains within confidence intervals at 96.3 against the target of 100.
- Mortality screening rates have increased in September to an all-time high of 90.5%
- 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.

2.0 Mortality indicators

2.1 Performance Indicator Chart: Key National and Local Mortality Indicators

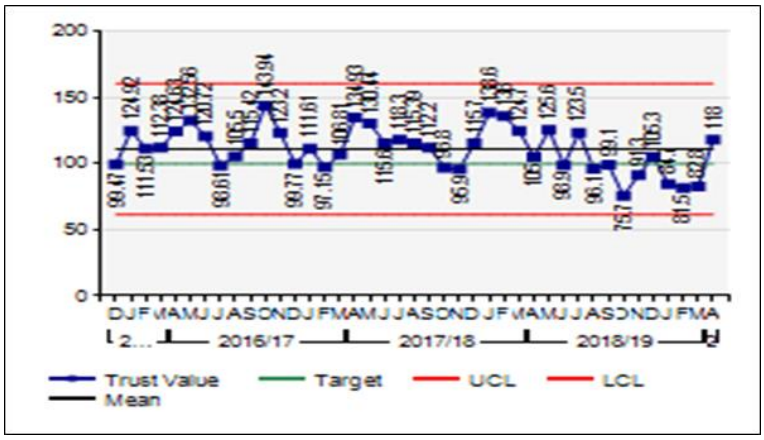
	2018/19							2019/20					Target
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
Rolling 12 Month HSMR	114.8	112.8	112.3	112.0	102.9	98.7	94.8	96.3					*100.0*
Monthly HSMR	99.1	75.7	91.3	105.3	84.7	81.5	82.8	118.0					*100.0*
SHMI	113.2			111.1			101.9						*100.0*
Local HSMR Bronchitis	152.8	136.6	136.6	138.1	133.0	118.4	105.9	116.2					*100.0*
Local HSMR LRTI	154.0	137.6	137.4	138.9	134.1	119.5	106.8	117.2					*100.0*
Local HSMR Pneumonia	128.8	121.7	122.1	120.1	112.6	104.8	103.7	107.4					*100.0*
Local HSMR Septicemia	87.7	89.9	89.7	90.2	81.1	79.1	80.0	77.1					*100.0*
Local HSMR Stroke	114.8	107.9	110.1	112.0	100.3	100.2	103.5	102.5					*100.0*
Local HSMR UTI	116.4	114.9	123.5	120.0	106.2	109.0	80.0	80.5					*100.0*
Local HSMR Acute Renal Failure	96.8	96.1	107.4	128.8	126.8	115.0	101.3	108.4					*100.0*
Mortality Screens - %	58.90%	53.45%	58.82%	50.62%	64.52%	61.67%	44.44%	35.16%	31.71%	56.25%	88.14%	84.62%	*90.00%*
SJRs	33.0	21.0	13.0	7.0	13.0	4.0	9.0	6.0	4.0	10.0	11.0	13.0	*0.0*
2nd Review	0.0	2.0	2.0	0.0	2.0	1.0	0.0	0.0	0.0	1.0	1.0	1.0	*0.0*
In Hospital Deaths	72.0	59.0	69.0	81.0	94.0	60.0	72.0	91.0	82.0	48.0	60.0	52.0	*77.0*
In Hospital Deaths Crude Rate	22.2	17.4	20.6	24.4	27.4	19.2	21.5	30.1	25.6	16.0	17.7	15.3	*31.0*
LD Deaths	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0	*1.0*
Steis Incidents	1.0	10.0	2.0	3.0	4.0	6.0	3.0	4.0	5.0	5.0	6.0	8.0	*5.0*

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

2.2 SHMI

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.

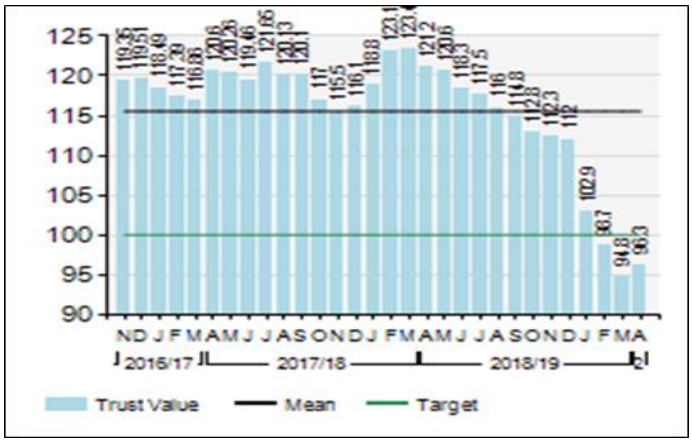
2.3 HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



In April our HSMR was 118 which is significantly higher than the national target of 100. We had 91 deaths in this month which was 19 (26%) more than the previous month and 17 (23%) more than April in the previous year. There were no significant spikes in any disease specific areas and the main primary diagnoses of these patients were similar to previous months.

The performance distribution chart (Appendix 2) used in the mortality operational group highlights key areas which may have contributed to this increase in mortality; namely key Accident & Emergency indicators around waiting times and an increased acuity of patients who died. There were 5000 plus attendances in A&E and the highest demand in Urgent Care for some time. There was increase in Sepsis and Pneumonia with a decrease indicated in June/ July. The Average Length of Stay Dashboard is beginning to populate and a more comprehensive report which will be available for November's Mortality Operational Group. There was also a marginal drop in performance of harm free care in this month.

2.4 HSMR - Hospital Standardised Mortality Ratio (*Rolling)*



Rolling HSMR is affected by the same factors as the in-month HSMR and remains within confidence levels.

2.5 Diagnostic Group Risk – Future Priorities

Increases are reported for all three respiratory illness mortality ratios in April 2019. As detailed in the External Mortality Review Board Assurance Report (EMBAR), work is on-going to embed the Pneumonia Pathway, with a particular focus in the Emergency Ambulatory Unit.

3.0 Mortality Improvement Activity

The Deteriorating Patient Project is the second phase of the Reducing Avoidable Mortality Project and is one of the Trust's four key Quality Priorities in line with Vision 2020.

A more detailed update on the project can be found under Appendix 1 in the form of the monthly project highlight report.

3.1 Update on Recognition and Care of the Deteriorating Patient Programme

Primary Driver	Progress and achievements this month
Appropriate Assessment & Admission	Strata Networking solutions have been working with members of the Emergency Department to create a GP referral system to the Ambulatory Care Unit. The Surgical Ambulatory Emergency Care Project Group are also developing a pathway for improved, appropriate GP referrals to the Surgical Assessment Unit.
Senior Ownership	The Electronic Board Round is in the final iteration of the PDSA cycle. The pilot has been well received by the Consultants and Drs on Ward 10A (Gastro). The tool captures the level of escalation (ward care, critical care or end of life care) for each patient and records the direct or remote senior review of all Daily Board Rounds.

Primary Driver	Progress and achievements this month
Correct Pathways of Care	The AKI Steering Group is now driving the required activity to improve compliance to best practice. Linking into the Deteriorating Patient Group ensures the triangulation with business intelligence and the Critical Care Outreach Team.
Observations & Escalations	The Observations QI Project continues on Ward 9A (Short Stay Unit). Iterations of the PDSA cycle are continuing with the use of business intelligence to identify when and why patients are being taken off protocol for observations and how compliance with the Trust Track and Trigger Policy can be improved.
Future Care Planning	Strata Networking Solutions have undertaken process mapping with key stakeholders from the Trust, Queenscourt Hospice and community service providers to design a tool with which Anticipatory Clinical Management Plans can be shared. This will ensure that there is one version of the truth and a single plan that can be accessed for each relevant patient at any access point.
Learning from Deaths	The Monthly Mortality Report to the Board is now a Learning from Deaths report. This along with high level fortnightly Mortality Meetings will support the delivery of a responsive and learning focused approach to the screening of deaths and the findings of the Structured Judgement Review.

4.0 Learning from Deaths: Structured Judgement Reviews (SJR)

4.1 Mortality Screening

Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review
Sep-18	72	43	59.7%	33	77%
Oct-18	59	31	52.5%	22	71%
Nov-18 (change of criteria for review)	68	40	58.8%	13	33%
Dec-18	81	41	50.6%	7	17%
Jan-19	94	60	63.8%	13	22%
Feb-19	60	38	63.3%	4	11%
Mar-19	72	32	44.4%	9	28%
Apr-19	91	33	36.3%	6	18%
May-19	82	27	32.9%	6	22%
Jun-19	48	26	54.2%	9	35%
Jul-19	59	53	89.8%	11	21%
Aug-19	52	44	84.6%	13	30%
Sep-19	63	57	90.5%	18	32%

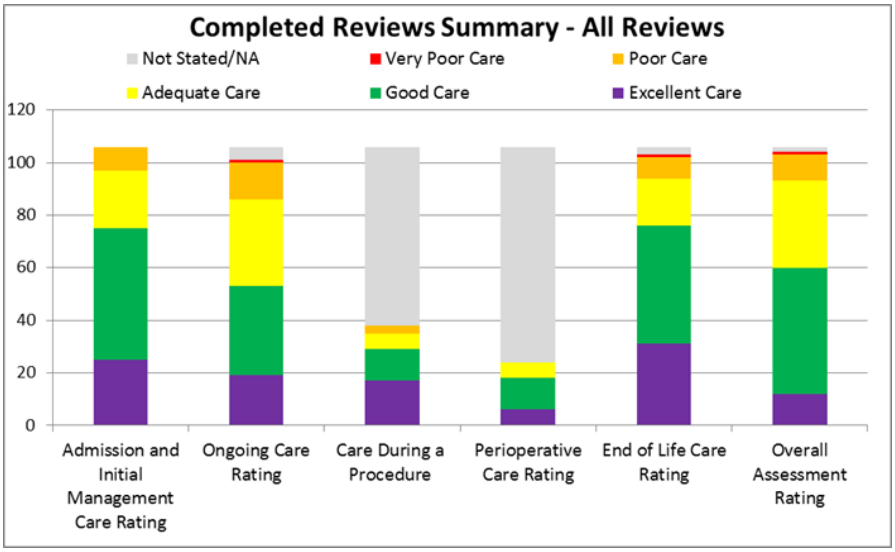
4.2 Screening by Specialty

	July			August			September		
	No of Deaths	No of Deaths Screened	Screening Rate	No of Deaths	No of Deaths Screened	Screening Rate	No of Deaths	No of Deaths Screened	Screening Rate
General Medicine	32	32	100%	42	35	83%	27	23	85%
Frail Elderley Medicine	6	6	100%	1	1	100%	4	4	100%
Cardiology	2	2	100%	0		N/A	5	5	100%
General Surgery	1	1	100%	3	3	100%	11	10	91%
Trauma & Orthopaedics	5	4	80%	2	1	50%	2	2	100%
Stroke Medicine	8	6	75%	3	3	100%	7	6	86%
Gastroenterology	1	1	100%	0		N/A	3	3	100%
Respiratory Medicine	0	0	N/A	0		N/A	1	1	100%
Rehabilitation	0	0	N/A	0		N/A	2	2	100%
Spinal Injuries	0	0	N/A	1	1	100%			N/A
Endocrinology	1	1	100%	0		N/A	1	1	N/A
Grand Total	**56**	**53**	**95%**	**52**	**44**	**85%**	**63**	**57**	**90%**

4.3 Completed First Structured Judgement Reviews

	2018						2019									Grand Total
Completed First SJR's	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
General Medicine				**4**	**4**	**1**	**1**	**1**	**3**	**2**				**2**	**5**	**23**
Geriatric Medicine			**1**	**3**	**1**	**2**	**1**	**3**	**2**		**1**		**1**	**1**	**3**	**19**
Intensive Care/Coronary Care/High Dependency	**1**	**2**	**1**	**3**	**1**	**1**			**3**		**1**	**2**	**1**		**2**	**18**
Respiratory Medicine/Thoracic Medicine				**1**	**1**				**2**	**2**		**1**		**2**	**3**	**12**
Trauma & Orthopaedics		**1**	**1**	**1**									**1**		**5**	**9**
Cardiology				**2**	**1**							**2**	**1**	**1**	**2**	**9**
Stroke						**2**								**1**	**1**	**4**
Urology								**1**				**1**			**1**	**3**
Cardiology																**0**
Gastroenterology							**1**			**1**						**2**
A&E														**1**	**1**	**2**
Urgent Care														**1**		**1**
Endocrinology														**1**		**1**
Grand Total	**1**	**3**	**3**	**14**	**8**	**6**	**3**	**5**	**10**	**5**	**2**	**6**	**4**	**10**	**23**	**103**

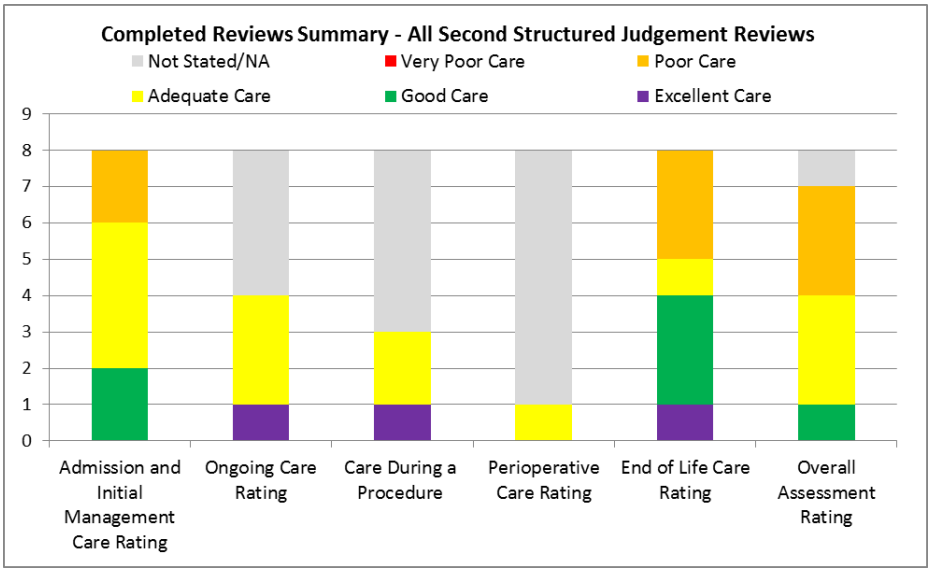
Outcomes of First Structure Judgement Reviews (since July 2018)



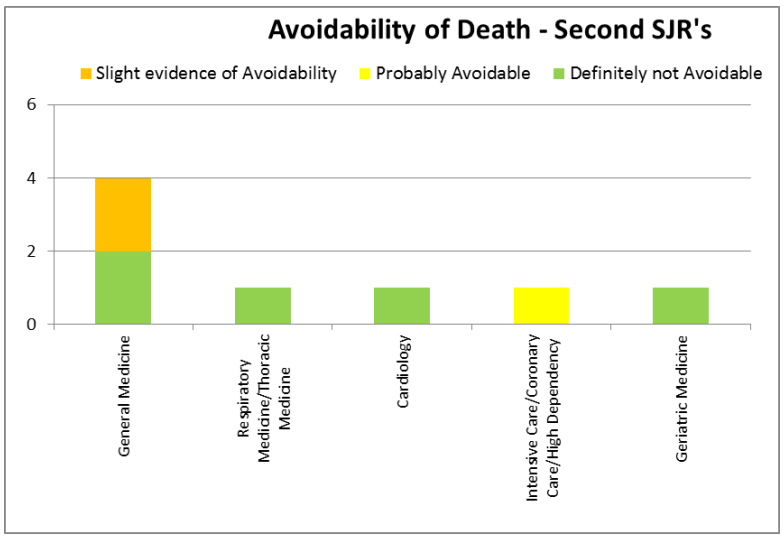
4.4 Second Level Structured Judgement Reviews

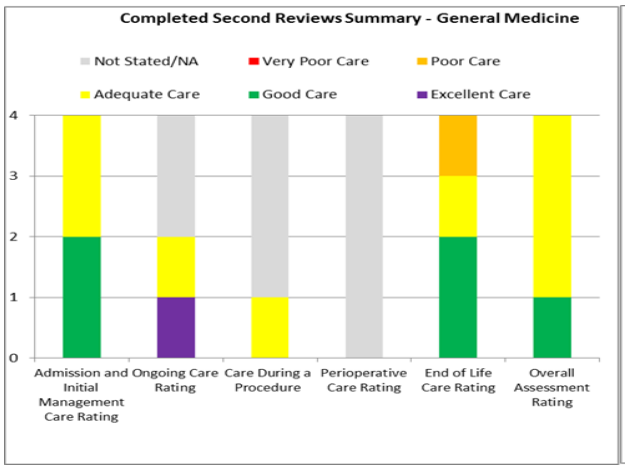
	Number of completed First SJR's	Number requiring a second SJR	Number of completed Second SJR's
General Medicine	23	6	4
Intensive Care/Coronary Care/High Dependency	18	2	1
Geriatric Medicine	19	1	1
Respiratory Medicine/Thoracic Medicine	12	1	1
Trauma & Orthopaedics	9	2	
Cardiology	9	1	1

Outcomes of Second Structure Judgement Reviews by Specialty



4.5 Avoidability of Death (Second Structured judgement reviews)





5.0 Learning from Deaths: Lessons Learned - Process & Activity

A Learning Event has been organised for the Grand Round on 29th November to be presented by Dr Paddy McDonald. The event will discuss the SJR findings on end of life Care. Thematic review of findings are discussed at the monthly Mortality Operational Group. The Learning from Deaths process triangulates themes with serious incidents and mortality data.

A monthly Lessons Learned newsletter is produced by Clinical Audit from the discussions at the Mortality Operational Group. The Newsletter is shared on Trust News and the Meeting Place via Facebook and has proved extremely useful in cascading Lessons Learned messages to Medics.

6.0 Appendices

Appendix 1 - External Mortality Action Plan (including 7 RCA Cases) – Board Progress Assurance Report (EMBAR)

EMBAR

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

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

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 21st October 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 (Deteriorating Patient Project: 'Appropriate Assessment & Admission')	Executive Lead: Chief Operating Officer	Nov-18	Mar-20	50%	G	The Patient Flow Improvement Programme (PFIP) consists of 4 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. Strata Electronic Networking Solutions to improve Patient Flow pathways The Programme drives the implementation of the NHSI SAFER Patient Flow Improvement bundle; the five elements of the SAFER patient flow bundle are: S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting. F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am. E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday. R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.
		a. **Alternative to admission**	Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams					20%	G	The Patient Flow Improvement Programme (PFIP) is currently reviewing Dr Foster and Model Hospital data to identify pathways requiring modification to avoid inappropriate attendances at A&E and inappropriate admissions. Length of Stay targets and reporting are being reviewed in the context of a significant increase in year on year A&E attendances. Work is ongoing with Strata Networking Solutions and community partners to design pathways to support the implement IT functionality for: 1. GP referrals into Ambulatory Care 2. Frailty Pathway: shared Patient Anticipatory Clinical Management Plans (ACMP) 3. Discharge to Assess 4. Electronic Referral to Social Care
		b. **Criteria led discharge**	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.					50%	G	Improving Criteria Led Discharge to support flow and reduce length of stay is a key deliverable of the Work Stream 2 (of PFIP). Criteria Led Discharge is driven by clear medical documentation and planning and starts with the Expected Date of Discharge (EDD) which is allocated by a clinician at the outset of the patient's time in hopsital. The patient is to know their EDD with answers to 4 other key questions: 1. What is wrong with me or what are you trying to exclude? 2. What have we agreed that will be done and when to 'sort me out'? 3. What do I need to achieve to get me home? 4. Assuming my recovery is 'ideal' and there is no unnecessary waiting, when should I expect to go home? The Red to Green multi-disciplinary approach supports patient flow by ensuring that all patients have a 'green day' where it is possible (a day of value for the patient's progress towards discharge) as opposed to a 'red day' (a day where there is little or no value adding care).
		c. **Proactive escalation planning**	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.					80%	G	The Electronic Board Round requires confirmation for each daily patient review of the level of escalation required (whether the patient requires Ward Care, Intensive Care or End of Life Care). The Trust's latest DNACPR Audit results were published in July 2019 and showed an 100% of patient records reviewed had a reason code, 92% had a originator date and 95% had appropriate information regarding why the decision has been made.

External Mortality Action Plan, Board Assurance Report – Page 2

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 21st October 2019
Patient Flow	EMR Action 1	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.	Patient Flow Improvement Programme (Deteriorating Patient Project: 'Appropriate Assessment & Admission')	Executive Lead: Chief Operating Officer	Nov-18	Mar-20	90%	G	A multi-disciplinary team (MDT) approach is the cornerstone of the daily Red to Green Board Rounds. Mini audits are currently being undertaken for two weeks to ensure the correct and complete MDT attendance in line with new 'Red to Green Board Round' Standard Operating Procedure. Wards are being asked to focus on key activity: • Ensuring board rounds happen - with a firm focus on agreeing the necessary actions to ensure every patient has a plan to progress their care towards discharge • Early senior review of all inpatient care plans – clearly communicated and documented with the ward MDT on the required criteria for discharge • Use the discharge lounge to create flow and work hard to get those patients that can go home today away as soon as possible • Early completion of TTOs and booking of transport for discharge • Referrals made by ward MDT teams are actioned promptly (e.g. therapy, radiology, pharmacy) • Delays to discharge to be escalated to the Bed Management Team Long Stay Tuesdays: 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 are ongoing.
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.	Deteriorating Patient Project: 'Correct Pathways of Care'	Associate Medical Director of Patient Safety	Mar-18	Ongoing until end of project March 2020	40%	A	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. It is expected that improvements will be visible in November 2019 reporting on October data.
	EMR Action 2	**Improve awareness of Sepsis**	Improve awareness of Sepsis 6 guidelines and monitor adherence.			Apr-18	Jul-18	100%	B	Compliance with of the Sepsis Six (three diagnostic and three therapeutic steps to be delivered within one hour of the initial diagnosis of sepsis) is ingrained across the Trust. In line with the AQUA AQ data set; we are performing well in relation to our peers however ongoing areas of challenge include: performance of blood cultures within an hour of diagnosis and senior review within two hours. The most up to date AQ data reports on acitvity up to February 2019; we expect to see improvement going forward reflecting the impact of the increased cover of the 24/7 Critical Care Outreach Team. The Trust's Consultant Microbiologist has produced guidance on best practice for taking blood cultures to reduce contamination rates. This has recently been signed off and is now being embedded through training.
		Improve compliance with Sepsis 6 Guidelines / Monitor Complaince With Sepsis Pathway					Mar-20	60%	A	
	EMR Action 3	**Establish Pneumonia Pathway**	Review and/or establish a pneumonia pathway to ensure that it meets national guidelines.	Deteriorating Patient Project		Nov-18	May-19	90%	G	The Pneumonia Care Pathway is readily available across the Trust and has been given additional focus by the Consultant in Acute Medicine in the Emergency Ambulatory Unit. The Associate Director for Patient Safety and the Trust's Clinical Education Lead are incorporating the Pneumonia Care Pathway into the junior doctors' training programme.

External Mortality Action Plan, Board Assurance Report – Page 3

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

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 21st October 2019
Senior Ownership	EMR Action 4	**Doctors' Rotas to be Reviewed (to ensure sufficient daily senior cover & junior doctor support)**	Review doctors' rotas to ensure sufficient daily senior cover and that junior doctors are not unsupported or working beyond their capabilities.	Deteriorating Patient Project ('Senior Ownership')	AMDs of Clinical Business Units	Mar-19	Mar-20	20%	A	The requirement to review doctors rotas to ensure daily senior cover originated from reports that junior doctors were working unsupervised on wards. Audits to assess staffing levels have showed that the issue is not a shortage of doctors but the poor management of rotas and the misallocation of staff (for example cohorts of staff all attending training at the same time). The audit is to be rerun in November to ascertain whether changes in job planning and the modification of junior doctor rotas in August has improved cover and support for junior doctors.
	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	25%	G	The Electronic Ward Board Pilot has entered into its final PDSA iteration. The tool has been well received by Consultants and Drs on Ward 10A (Gastro) and is successfully recording senior ownership / involvement (in response to External Mortality Review 2018 and the Health Education England report which stated that Junior Drs weren't being supported. Although we were undertaking Daily Board Rounds or reviews after Jnr Dr Board Rounds, evidence was required to prove this). The Electronic Board Round requires an escalation level to be identified for each patient (as stipulated in the NEWS2 Policy): ward care, critical care or end of life care. The benefits of the system are that: we can correlate NEWS2 Scores against the Escalation status / plan, we will be able to produce a list of patients who need to be seen by the Transform Team and we will have a list of patients who are at risk. The pilot has however shown that the allocated consultant for each patient is often unclear, (The responsible consultant should be documented above the patient's bed, in the nursing handover notes and on Medway. The standardised nursing documentation that was used to capture this information is no longer in consistent use and needs to be factored into the Documentation Project.)
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 Deteriorating Patient Project ('Observations & Documentation')	Deputy Director of Nursing	Apr-19	Mar-21	7%	R	Dedicated Programme Management support is now allocated 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%	R	Update as per 'Review Standards of Documentation' above.

External Mortality Action Plan, Board Assurance Report – Page 4

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

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 21st October 2019
Documentation & Observations	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.	Documentation' Project Deteriorating Patient Project ('Observations & Documentation')	Deputy Director of Nursing	Apr-19	Mar-20	15%	R	The Gosport audits completed within Southport and Ormskirk Hospital Trust showed 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. The Trust is dedicated to a Medicines Management Improvement and Optimisation Project which is currently being driven by a detailed action plan which is subject to weekly scrutiny and planning meetings. Clear and legible documentation in line with national guidelines is to be incorporated 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. Work is continuing to reduce observation breaches and to improve observations compliance against the Trust's The Trust's NEWS2 Policy (CLIN CORP 81 Early Warning Track & Trigger System Operational Policy.) The Trust has invested in a Fluid Balance module on VitalPac (System C) which will electronically record fluid balance checks and provide reporting by ward to measure compliance levels against standards. The roll out of the product is expected in the near future with a start date to be confirmed.
Appropirate Escalation	EMR Action 8	**Review Escalation and Ceilings of Care Policies**	Review escalation and ceilings of care policies to include timely access to critical care and end of life care. Include a focus on training of all staff in accurate calculations of Early Warning Scores (EWS), interpretation and contextualisation of EWS and a shared understanding of when to escalate care and consider a structured communication approach such as Situation, Background, Assessment, Recommendation (SBAR).	Deteriorating Patient Project ('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 plans for every inpatient as an integral part of every ward and board round. All clinical staff should be aware of the NEWS 2 score for escalation, who to, and what should be expected from the senior decision maker.			Jan-19	Jun-19	80%	G	

External Mortality Action Plan, Board Assurance Report – Page 5

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

	Origin	Area Requiring Improvement	Recommendation Detail	Programme / Project	Lead(s)	Start Date	Projected Completion Date	Completion %	BRAG	Update 21st October 2019
Future Care	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.	Deteriorating Patient Project ('Future Care Planning')	Medical & Education Director, Queenscourt Hospice	Sep-18	Mar-21	30%	G	Strata Healthcare has presented an electronic solution to support the delivery of a single Patient Anticipatory Clinical Management Plan (ACMP) across all local health care providers. 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.	Deteriorating Patient Project ('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 90.5% in September. 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%	A	The Trust's Mortality Report has been redesigned to provide monthly assurance around Learning from Deaths. Learning from Deaths is also 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	RCA Action 7	**Management of Diabetes**	Review and update the trusts policy and approach to the management of inpatient diabetes. Ensure available, clear guidance	Tbc	CD Medicine / AMD of	Apr-19	Mar-21	50%	A	Recruitment for Diabetes and Endocronology Consultant cover is now underway and will address the long term gap left when the community services were contracted out in 2017. The Medical Director is organising a review of diabetes service.
	RCA Action 8	**Acute Pain Services**	Review and update the trusts approach to the provision of acute pain services, to include the available guidance to non-specialist	Tbc	Acute Pain Lead / CD Anaesthetic	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.

Appendix 2: Recognition and Care of the Deteriorating Patient Project Highlight Report

Programme Highlight Report

Recognition and Care of the Deteriorating Patient (RCDP)

(Formerly 'Reducing Avoidable Mortality' Project)

Programme	Recognition and Care of the Deteriorating Patient
Start Date	1st April 2019
End Date	31st March 2021

Executive Sponsor	Dr Terry Hankin, Medical Director
Clinical Lead	Dr Chris Goddard, AMD Patient Safety
Project Manager	Rachel Flood-Jones, Project Manager
Information Lead	Mike Lightfoot, Head of Information / Amanda Halsall Information Analyst
Reporting To	Mortality Operational Group / Quality & Safety (Improvement Board) Group
Report Date	1st October 2019

BRAG for KPI actual versus in month target	R
BRAG for progress of activity against projected timeframes	A

BRAG	
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

EXECUTIVE SUMMARY
(What we are trying to achieve and where we are to target)

Recognition and Care of the Deteriorating Patient Programme (RCDP) is 1 of 4 of the Trust's Quality Priorities for Vision 2020 - Single Improvement Plan 2019/20
It is a continuation of the Reducing Avoidable Mortality Project (2018/19) the aim of which was to reduce the Summary Hospital-level Mortality Indicator [NHSI's SHMI] to within confidence intervals - achieved for December 2018 at 1.1)

The work streams for the programme are:
Appropriate Assessment & Admission
Senior Ownership
Correct Pathways of Care
Observations & Escalations
Future Care Planning
Learning from Deaths

SMART OBJECTIVES
(Specific-Measurable-Attainable-Relevant-Time bound)

To devise continuous self- improvement structures which proactively identify clinical deterioration within our community so that by March 2021:
Mortality indictors sit premanently within confidence intervals (SHMI, HSMR & Local SMR)
All end of life patients have an Anticipatory Clinical Management Plan
Advance Care Planning is business as usual with staff confident to have conversations with patients and families
Joined up working and seemless collaboration between primary care, acute care, community service providers and care homes to deliver the most appropriate care for patients in line with ACP, ACMP and GSF.

PROGRAMME KPIs 2019/20

			Apr-19		May-19		Jun-19		Jul-19		Aug-19		Sep-19		Oct-19		Nov-19		Dec-19		Jan-20		Feb-20		Mar-20		Projected Trajectory	Actual Trajectory
	Baseline (March 2019)	End Target	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual		
Percentage of Mortality Screened	44.40%	100%	100%	36.30%	100%	23.90%	100%	54.20%	100%	89.80%	100%	84.60%	100%	90.50%	100%		100%		100%		100%		100%		100%			
Number of Outstanding First Reviews	44			37		42		45		51		66																
% of Overdue Early Warning Score Observations (with EWS 5-6)	18%	5%		18.11%		14.50%		16.51%		17.30%		19.41%																
% of Breached Early Warning Score Observations (with EWS 5-6)	39%	5%		42.28%		48.28%		46.55%		46.00%		44.06%																
Patients reviewed by the Critical Care Outreach Team (CCOT)	156	450	450	589	450	486	450	486	450	514	450	367																
AKI Level 3 Patients reviewed by Critical Care Outreach Team	Not Avail	30	Data not available						30	30	30	65																
Patients discharged from ICU/HDU	Tbc		Awaiting Data																									
HCAs & Nurses trained in Track and Trigger Policy	229	20 PCM		236		251		272		317		338		354														

MILESTONE / WORK STREAM / KEY ACTIVITY	Start date	End date	Owner / Lead	Completion %	BRAG	LATEST UPDATE FOR HIGHLIGHT REPORT
1. Governance, Reporting and Data						
Performance Reporting to Quality and Safety (Programme Board) Group Meetings	01/07/2019	12/08/2019	Project Manager	100%	B	Highlight Reports for the Mortality Project are now to be submitted monthly to the **Quality and Safety Group** (the official line of reporting is into the Quality & Safety Programme Board). The Project (which was formerly Reducing Avoidable Mortality) is now called **"Recognition and Care of the Deteriorating Patient (RCDP)"** and is one of the four main quality Priority 1 of the Trust's Vision 2020 - Single Improvement Plan 2019/20
2. Appropriate Assessment & Admission						
Outpatients Antibiotics Therapy OPAT at Cleveland House	01/05/2019	31/12/2019	AMD Patient Safety	20%	G	AMD for Patient Safety in conversation with Community GP for Cleveland House regarding the trial of Outpatients Antibiotics Therapy OPAT at Cleveland House - Success of this initiative will ultimately pave the way for roll out of a model which will reduce the requirement for patients to be admitted for those with an agreed ACMP
Joint Record Sharing *Sharing of Anticipatory Clinical Management Plans (ACMPs) and patient records to support a more informed assessment of patients on presentation at A&E.*	01/03/2019	31/03/2021	Interim IT Director	15%	A	Strata Healthcare (Patient Flow Networking Solutions) are working with the Trust and Community Service Providers to provide paperless, integrated solution which would support a single, real time electronic ACMP record that would be shared across the health economy. The timeframe for delivery will be dependent upon sharing agreements, system integration and the funding for any supporting costs.
Anticipatory Clinical Management Planning for Care Home Patients	01/06/2019	30/03/2020	Frailty Practitioner	5%	A	Meetings have been organised with the Project Lead for Older People's Care Programme (OPCP), Transform, Consultant for Palliative Care, Resus Nurses and Frailty Practitioners to review the plan for activity required to deliver the Trust's objectives for ACMP. (Strata plans for electronic Care Plans are currently at CCG and Trust level, further consultation will be required to incorporate individual Care Homes.)
3. Senior Ownership & Appropriate Escalation						
Electronic Ward Board Round *PDSA Pilot on Gastro Ward*	03/06/2019	30/03/2020	AMD Patient Safety	20%	A	AMD for Patient Safety, Chief Clinical Information Officer, Clincal Quality Lead, PMO and PDSA Clinical Lead (on Ward 11B - Medicine) met on 27th September to evaluate the pilot which has proved extremely successful in recording the Clinical Board Round and ensuring the remote senior review when the Board Round has been undertaken by a junior doctor. IT fixes required to move the pilot forward are on hold at the time of reporting due to staffing levels in the IT development team. (Cf Risk Log). A screen is being secured for the final cycle of the pilot on Ward 11B which will last for a further 2 weeks. The pilot is also to be extended to ward 14A (Orthopaedic Ward - Surgery). 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).
Consultant Review (Documentation)	23/07/2019	30/10/2019	Lead Tbc	10%	A	Concerns raised at Deteriorating Patient Operational Group regarding identification of Consultant review in medical notes – Consultants are to be encouraged to carry and use name stamps. An update is expected at the next Group Meeting on 15th October. The Trust's Documentation Project is being revisited by a new Programme Office Lead.
4. Correct Pathways of Care						
Pneumonia	01/04/2019	30/03/2019	Project Manager	15%	R	The HSMR for pneumonia is on a continual improving trajectory. This as 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. The next session for Correct Care Pathways is set for 1st November and will be attended by key Trust stakeholders and by AQUA. The Trust will also be represented at the Advancing Quality Detection & Response Collaborative sharing best practice and learning from different areas and healthcare for the recofnition and treatment of Acute Kidney Injury, Sepsis, Pneumonia (Community & Hospital Acquired).
Sepsis	01/04/2019	30/03/2020	AMD Patient Safety	90%	G	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. The most recent AQ data was reviewed demonstrating continued good performance in respect of sepsis where our overall position is third in the region overall.
AKI	01/04/2019	30/03/2020	Consultant of Urgent Care / AKI Lead	25%	A	AKI mortality has risen from a previously controlled baseline. AQ process data is also currently poor. Work is ongoing through the AKI steering group to address this; changes already put in place will not be reflected in the data for 2-3 months. 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. Fluid balance module is to be introduced beginning of October with the next 4.1 version of vital Pac. AKI stickers now being used for all AKI 3s, they are placed in patient records following assessment to highlight treatment given and considered (IV fluids, ultrasound, medication review, bloods ordered, date and time).

MILESTONE / WORK STREAM / KEY ACTIVITY	Start date	End date	Owner / Lead	Completion %	BRAG	LATEST UPDATE FOR HIGHLIGHT REPORT
5. Observations and Escalation						
Track and Trigger Policy (NEWS2, Observations and Escalation)	01/04/2019	30/08/2019	Clinical Quality Lead	75%	G	There has been an 154% increase in the numbers of nursing and HCA staff trained since March. Training is ongoing in a ad hoc manner on the wards. The enhanced 24/7Critical Care Outreach Team have been instrumental in training staff on the wards in the policy (which supports best practice for the use of VitalPac and NEWS2). Link Nurses were also trained with the purpose of cascade training but have not (in the main) had capacity to do this.
Timely Observations (PDSA - Ward 9A) (95 % of patients on Ward 9A to have their observations performed as per Trust Policy by September 2019 (model to be designed, trialled and then to be rolled out across other wards)	12/06/2019	30/09/2019	Clinical Quality Lead	25%	R	Observation Breaches for the Trust require immediate attention. The PDSA cycle on Ward 9A is taking the lead which can then be rolled out. The findings of the PDSA cycle on Ward 9A presented at the NHSI QI Event 12th September reported success through the following changes: Move from bedside discussion of patients observations to organised group Handover meeitngs (with access to the electronic data on Ipads). Increased education and visibility of Observations compliance levels for the ward to drive correct activty. Discuss NEWS2 Scores in R2G Board Rounds to increase universal awareness of high scoring patients. Set times for observations to be taken 6 times every 24 hours. **(Cf "Additional Information" Section below for supporting data on PDSA)**
6. Future Care Planning						
Advance Care Planning: supporting discussions with Patients and Families	01/04/2019	30/09/2019	Project Manager / Frailty Practitioner	5%	R	As detailed above, a further meeting is required with the Project Leads for Older People's Care Programme to scope the split of activity required to deliver the Trust's objectives for Future Care Planning. The focus for this project is to develop a culture to support end of life conversations with patients and families from the earliest possible point.
7. Learning from Deaths						
Structure Judgement Review Method	01/04/2019	30/03/2020	AMD Patient Safety	70%	R	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 . There is an increasing backlog of SJR reviews in surgery and orthopaedics, medicine and ICU are currently performing well. This is mainly being driven by clinical capacity (reviews take 1-2 hours) and the impasse caused by the lack of clarity over job planning. Reviewers do not have this work recognised in the current job planning structure. A meeting of mortality leads is to be arranged to address the issues. (See Appendix: Mortality Screening appendix).
Lessons Learned	01/04/2019	30/03/020	AMD Patient Safety / Director of Medical Education / ADO Integrated Governance	40%	A	The topic for the Grand Round on the 29th November 2019 is based upon the Structured Judgement Review findings for End of Life Deaths. This thematic approach will continue to underpin Learning from Deaths lessons learned. The monthly Mortality Report to the Quality and Safety Committee and the Trust Board is changing to a Learning from Deaths Report which will demonstrate the increased of focus of Lessons Learned. Clinical Audit Lead is producing a monthly newsletter from the Mortality Operational Group (MOG) called 'Lessons to be Learned' which is being circulated to Foundation, Specialty and GP doctors in training as well as being posted on Trust News and on the Meeting Place (the Trust's closed Facebook page).

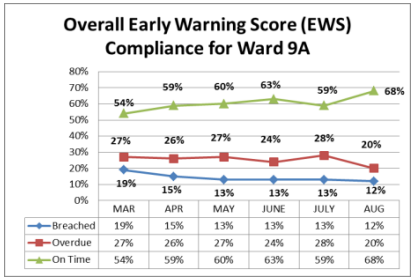
Current PDSA Cycles	Lead	Detail	Iteration End Date	Next Steps
Electronic Ward Board Pilot (Ward 11B)	AMD Patient Safety	Electronic standardisation of Board Round to ensure documented senior input and consistent practice.	**17/10/2019**	Trial to join up with Red to Green did not work. Trial has overall gone well. Awaiting IT fixes and a screen. To start on ward 14A.
95% Timely Observations PDSA (Ward 9A)	Clinical Quality Lead	95 % of patients on Ward 9A to have their observations performed as per Trust Policy by September 2019 (then to be rolled out across other wards)	**17/10/2019**	Updates to come from the PDSA Team for Ward 9A. Measures taken as below from VItalPac reports. Timeline for roll out to be discussed at 'Observations and Escalation' Meeting in October.

RISKS (Potential risk which will impact the project; has not yet occurred)	RAG	Mitigation Activity	RAG After Mitigation	Comments
Electronic Ward Boards - IT Development	R	At time of reporting all IT support for the Electronic Ward Board PSDA has been put on hold due to staffing levels. Discussions and work arounds are the next steps.	R	Conference call booked to discuss next steps for project team 3rd October.
Emergency Department Pharmacist (To identify morbidity and timely review of AKI Patients)	R	Triangulation of serious incident reviews and learning from deaths via the SJR methodology has highlighted the need for an Emergency Department Pharmacist.This positon may contribute to the identification of patient co-morbidity by correlation of medication history with diagnosis, thus contributing to the cost of the post. The post would also improve the timeliness of pharmacy review of patients with AKI.	A	A business case which includes a Pharmacist for A&E is being submitted through the Trust's Governance route for consideration commencing on 1st October.
Structured Judgement Reviews	R	There is an increasing backlog of SJR reviews in surgery and orthopaedics which is attributable in the main to clinical capacity (reviews take 1-2 hours) and the impasse caused by the lack of clarity over job planning. Reviewers do not have this work recognised in the current job planning structure. A meeting of mortality leads is being arranged to address the issues.	A	Discussions with staff to embed are ongoing.
ISSUES (Issues have already occurred / are currently impacting upon the project)	RAG	Action Taken	RAG After Mitigation	Comments
Consultant Engagement for 'Pneumonia as Complication of Heart Failure' Workshop.	R	Face to face discussions required with Lead Respiratory and Cardiac Consultants to confirm representation for second attempt at 'Pneumonia as complication of Heart Failure' Workshop.	G	This is to be incorporated into the Correct Care Pathways meeting in October.
Resus require dedicated training rooms to run training from and store equipment. (Deteriorating Patient Operational Group 23/07/19)	A	Discussed at the Deteriorating Patient Operational Group 23/07/19 and is being taken to the Mortality Operational Group 13/18/19	G	More information to follow.

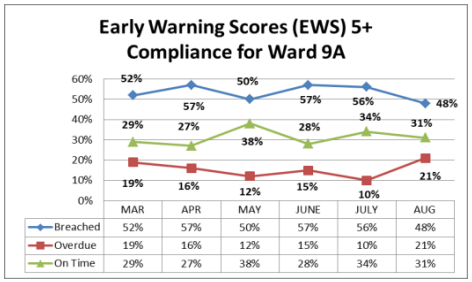
ADDITIONAL INFORMATION

Anything else by exception that requires highlighting

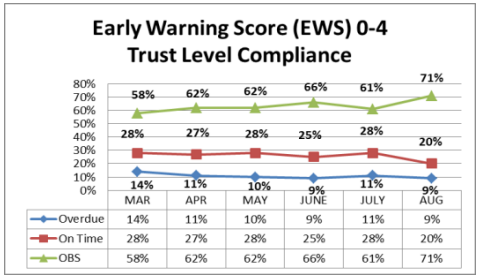
The on time figures appear to have slipped slightly into the overdue section for Aug but the 48% breach is the lowest it's been over the 6 months:



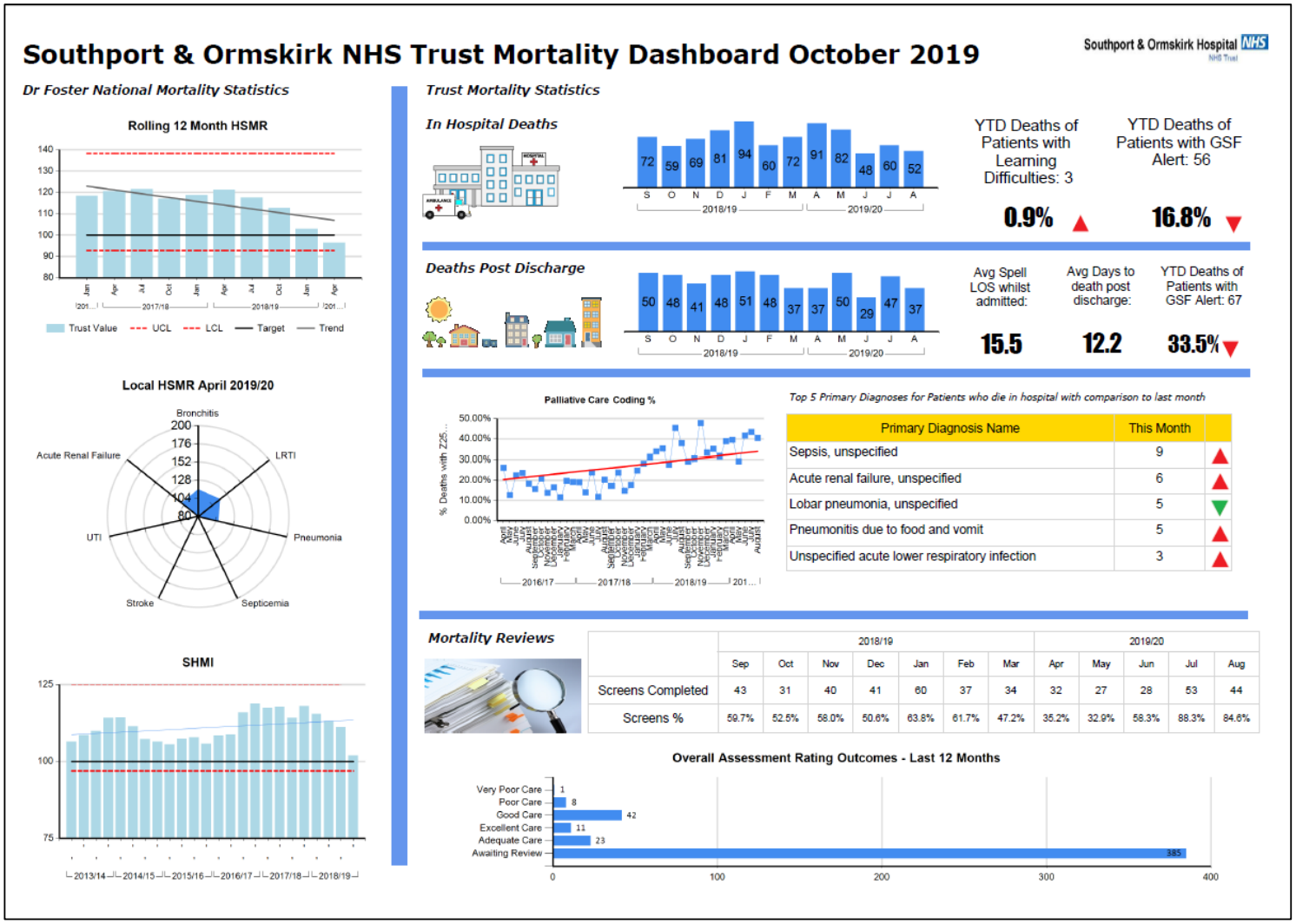
This is the breakdown of the OBS for SSU, 68% on time is the highest SSU have had over the 6 month period, although it's not the 90% we were aiming towards we did only get the daily reports developed & out to key staff in August to start monitoring changes & breaches! Another thing to point out is the amount of patients & Obs since march has increased with the highest amount being in August!



The on time figures slipped slightly in August into the overdue section is at the lowest level for over 6 months

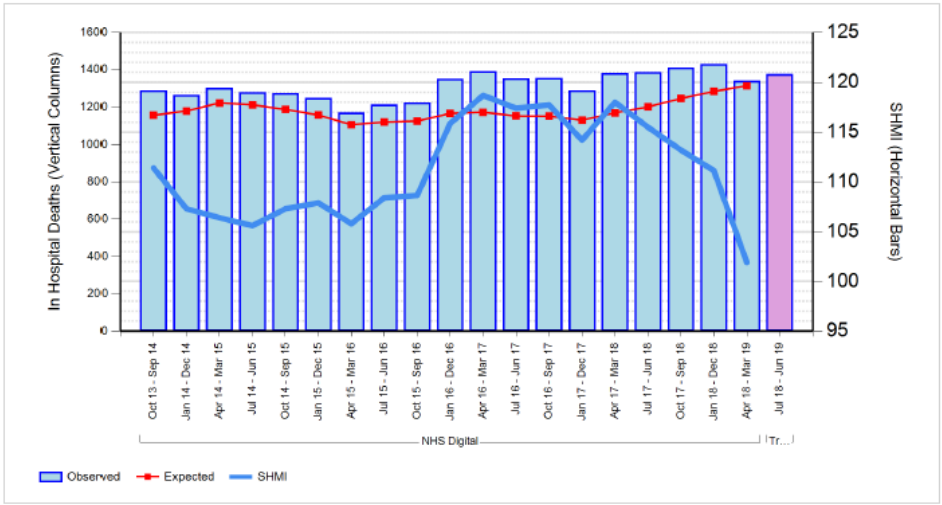


Appendix 3: Mortality Monthly Data Report



SHMI Breakdown

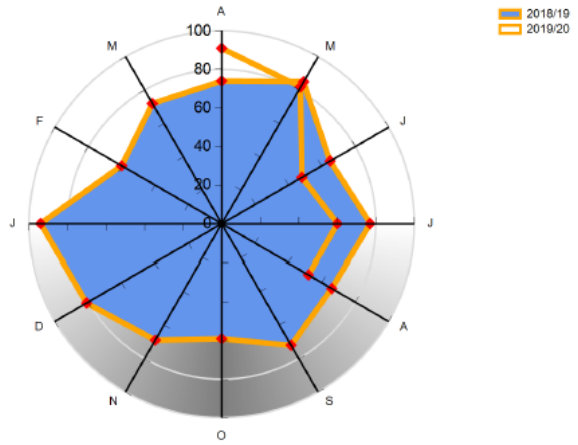
Southport & Ormskirk Hospital NHS
NHS Trust



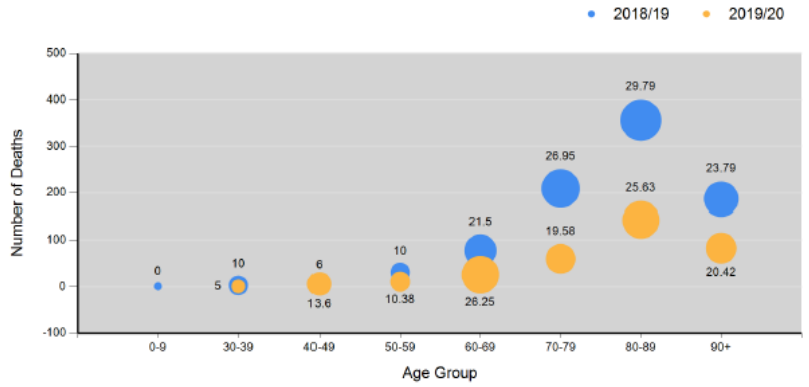
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

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

In Hospital Deaths Seasonality Distribution

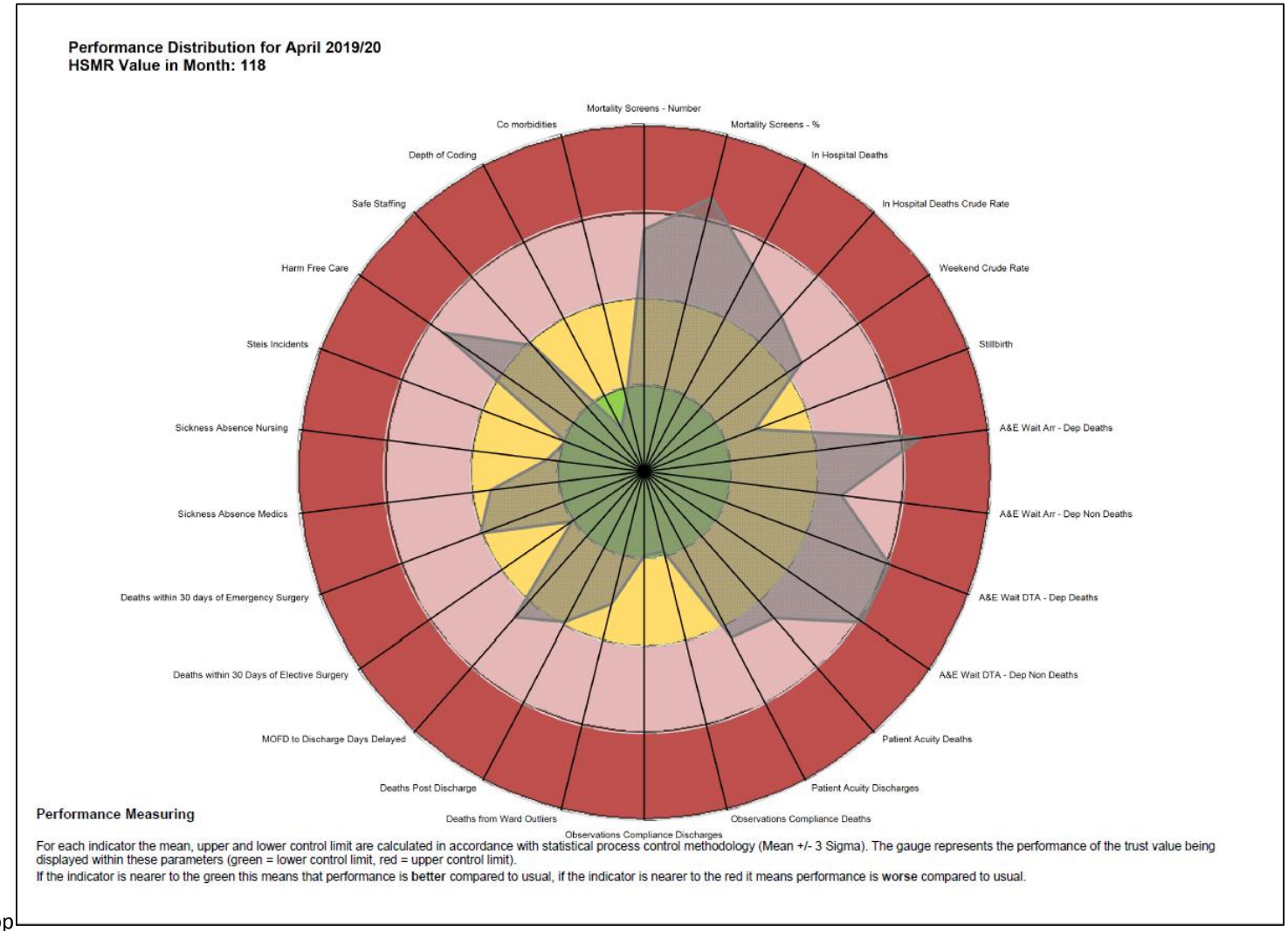


In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



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

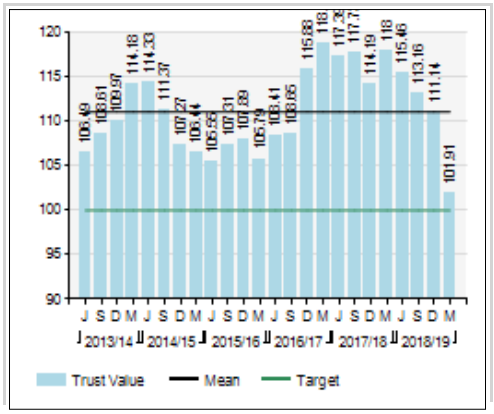
Appendix 4: Peformance Distribution for April 2019



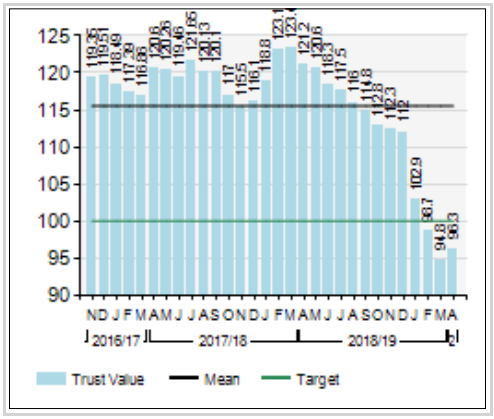
App

Appendix 5: Mortality Ratios – October Report

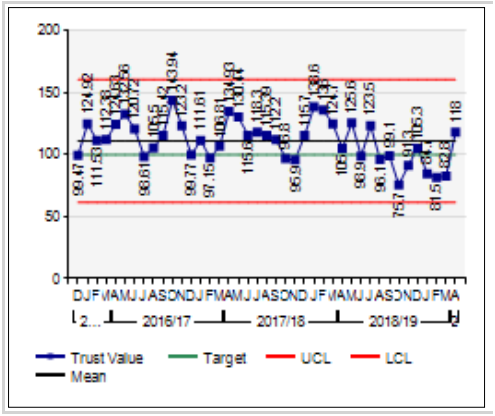
SHMI - Summary Hospital Level Mortality Indicator



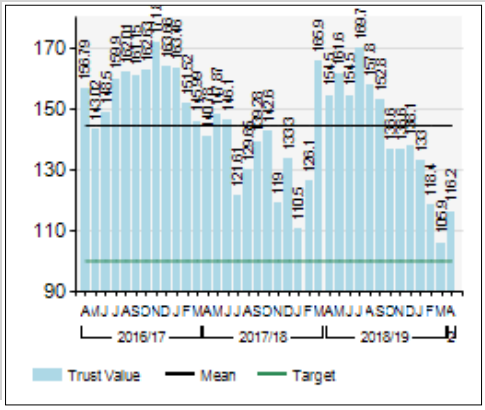
HSMR - Hospital Standardised Mortality Ratio (*Rolling 12 month*)



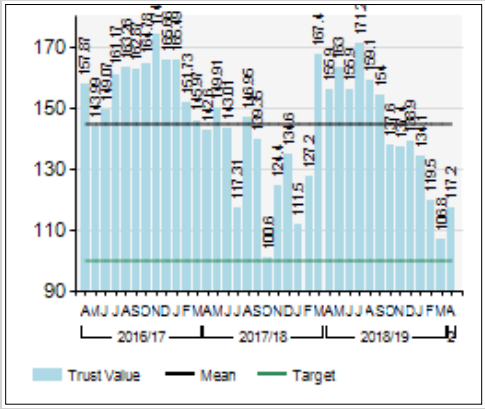
HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



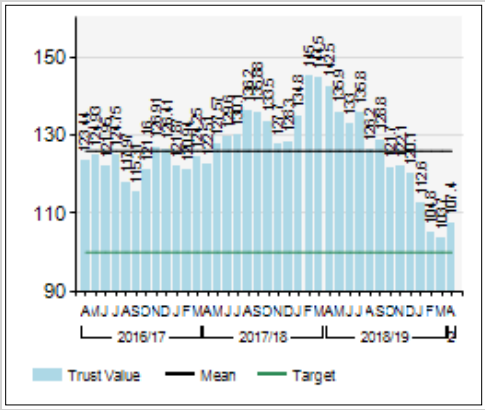
Local HSMR Bronchitis



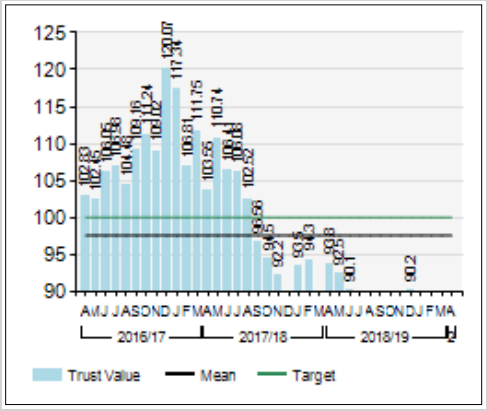
Local HSMR Lower Respiratory Tract Infection



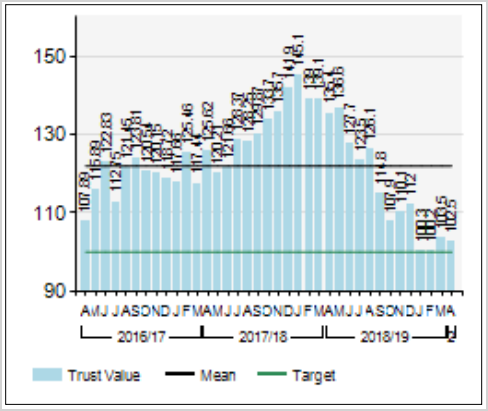
Local HSMR Pneumonia



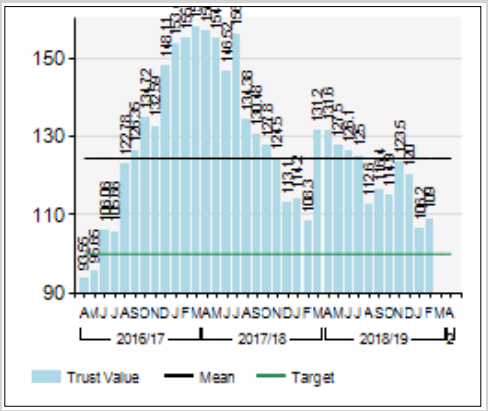
Local HSMR Septicemia



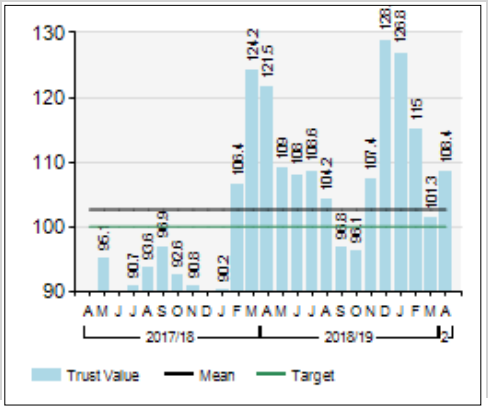
Local HSMR Stroke



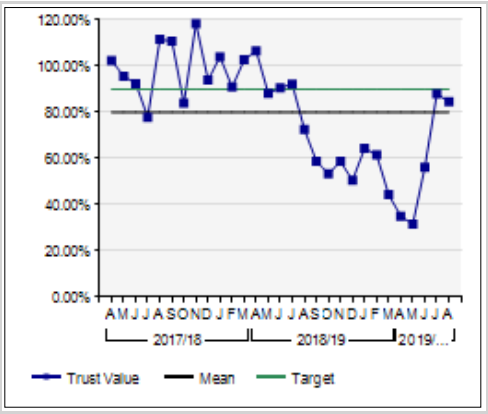
Local HSMR Urinary Tract Infection



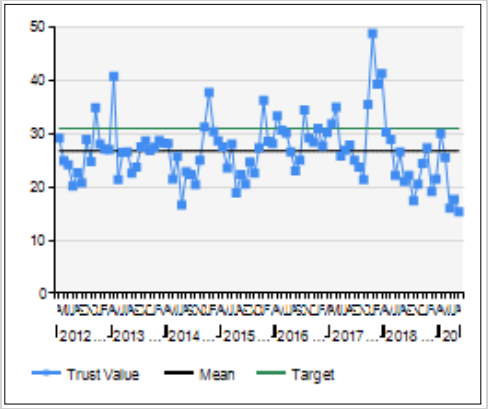
Local HSMR Acute Renal Failure



Mortality Screens - % Deaths Screened



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



Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**TB186/19d**	**Report Title**	**Monthly** Safe Nurse & Midwifery Staffing Report – September 2019
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery Therapies and Governance		
Lead Officer	Claire Blackman-Deputy Director of nursing Carol Fowler Assistant Director of Nursing – Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The Trust board safe staffing highlight report for September 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 September 2019.

Alert

- For the month of September 2019 the Trust reports safe staffing against the national average (90%) at 91.83%.

Advise

- The draft Clinical Indicators Dashboard data is under review within the Trusts overall review of workforce dashboards and will feature in future reports.
- CHpPD reporting remains under review to support accuracy of data reporting. Trust CHpPD reports at 8.13

Assure

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

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

	Strategic Objective	Principal Risk
✓	**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

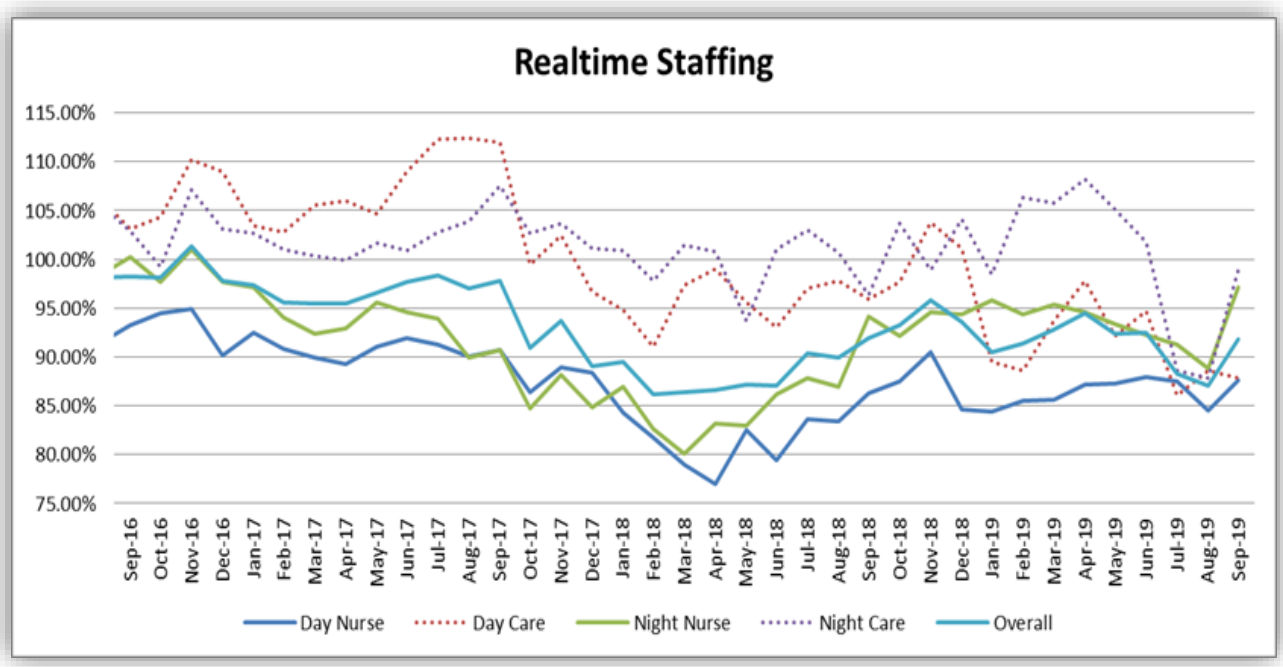
For Information: Literally, to inform the Board

1. Introduction

This report provides an overview of the staffing levels in September 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 September 2019 was 91.83% (appendix 1).

- 87.63% Registered Nurses on days
- 87.82% Registered Nurses on nights
- 97.15% Care staff on days
- 98.93% Care staff on nights



The overall CHpPD for the Trust has decreased in month to 8.13 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 11 Urgent Care CBU 6.6 and Women's and Children's 10.1 overall.

2. September Safe Staffing

Trust whole time equivalent (wte) funded establishment versus contracted for September 2019 below finance figures:

	Funded WTE	Contracted WTE	Vacancy
Registered	948.41	775.28	173.13

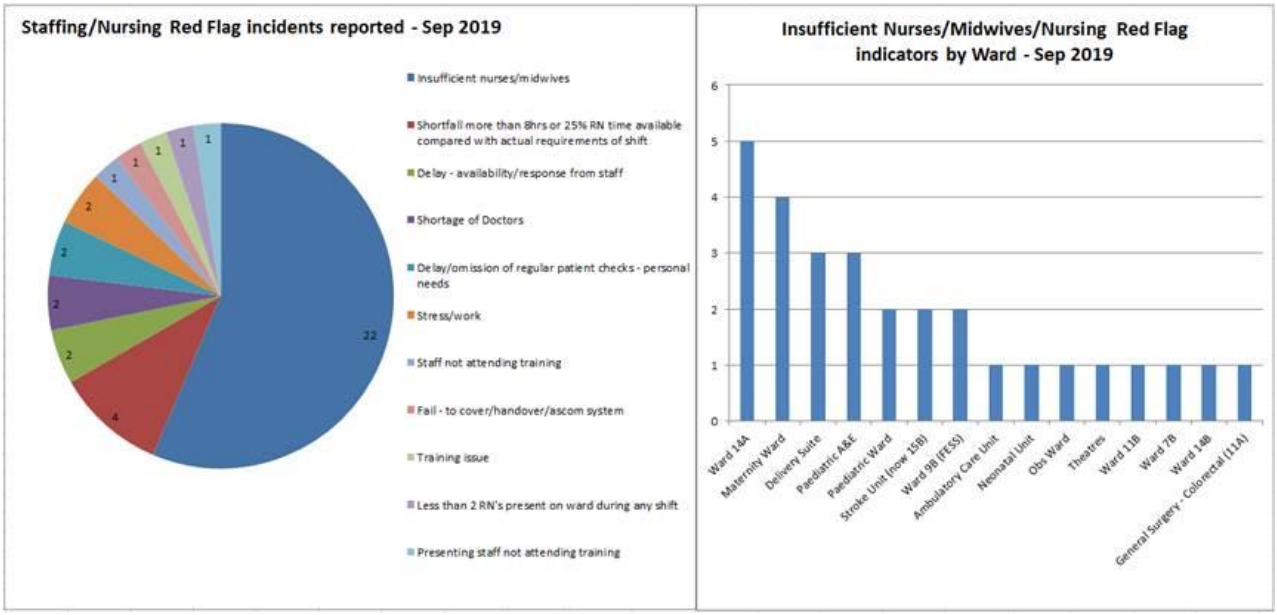
Non-registered	444.00	369.16	74.84
Total	1,392.41	1,144.44	247.97

Recruitment team new starter figures for September advise 26.42 fte, (RN20.8, HCA 5.6).

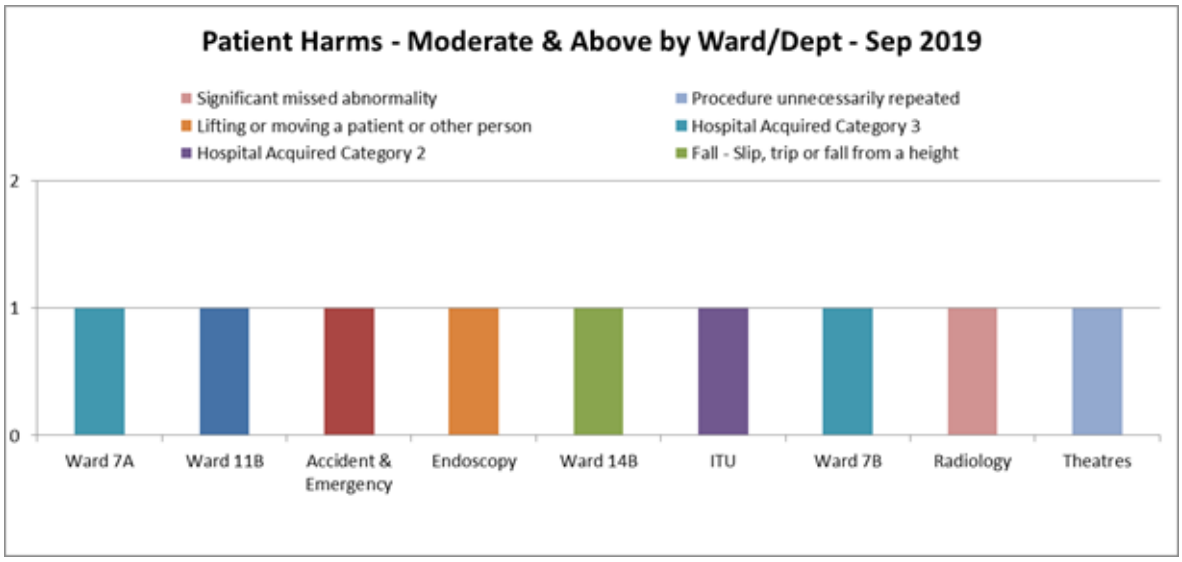
Scoping of overseas registered nursing opportunities has commenced initially with Health Education England (HEE) and NHSP.

3. Staffing Related Reported Incidents September 2019

39 staffing incidents/nursing red flags were reported in September, 4 less than the previous month. 29 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, 9 more than August. No harm was identified as a result of these incidents. Seven of these incidents related to Maternity and a further 6 to Paediatrics and Neonatal. None of these incidents resulted in harm to patients.

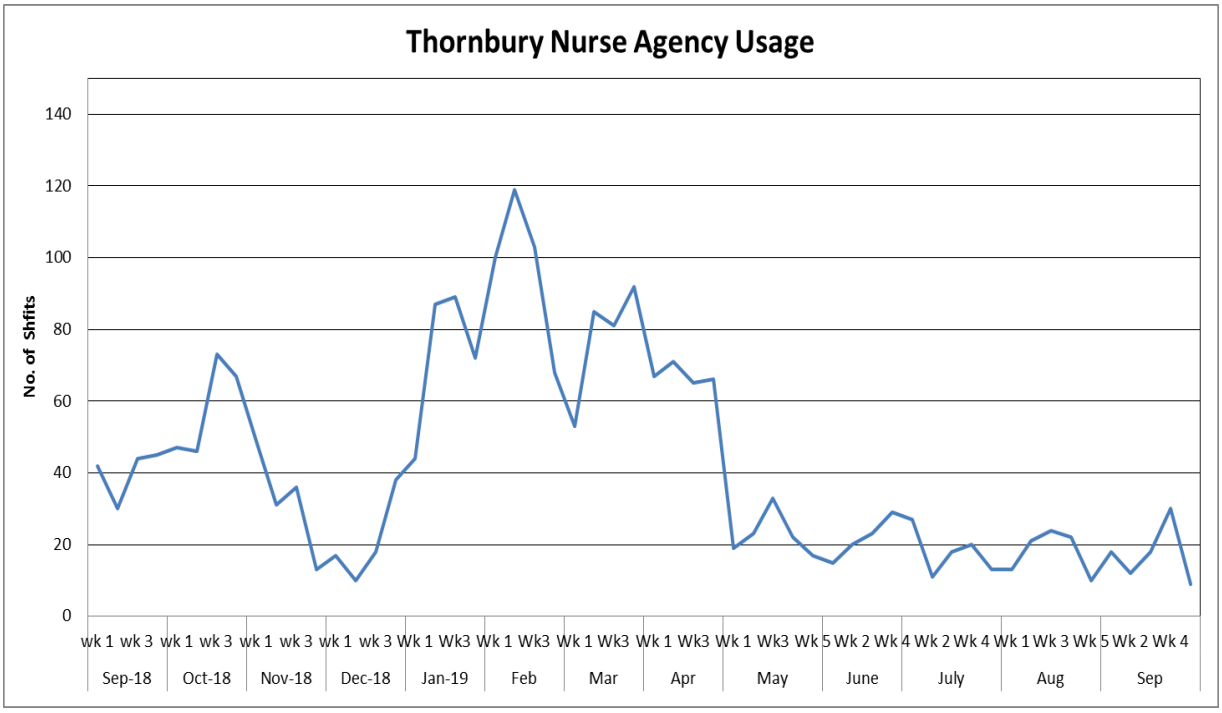


In September 9 moderate or above incidents were reported, the same as reported on August.



4. Non Framework Nurse Agency Usage

The Trust continues to proactively source nurse agencies that are within the framework to supplement NHSp and Tier 3 agencies to support withdrawing of high cost off framework agencies. This includes block booking opportunities to support continuity of care to our patient groups and further reflective of the winter contingencies for the trust.



September reports a 3% decrease on August volume utilised. This equates to a 3.5% Thornbury Nursing agency request for September.

5. 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) – September 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	1,366.75	1,296.45	1,577.25	1,186.25	1,059.50	1,129.75	1,124.50	1,062.00	805	94.86%	75.21%	106.63%	94.44%	3.0	2.8	5.8		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	700.25	643.25	358.50	358.00	709.00	709.00	342.00	342.00	242	91.86%	99.86%	100.00%	100.00%	5.6	2.9	8.5		
E A U	300 - GENERAL MEDICINE	1,448.00	1,391.00	1,114.75	1,059.75	1,046.00	1,216.34	709.17	802.75	520	96.06%	95.07%	116.28%	113.20%	5.0	3.6	8.6		
FESS Ward	300 - GENERAL MEDICINE	1,637.67	1,294.92	1,565.00	1,490.48	1,054.50	1,225.50	767.50	930.25	823	79.07%	95.24%	116.22%	121.21%	3.1	2.9	6.0	Y	Shortfall more than 8hrs or 25% RN time available due to short term staffing issues - Investigated and closed
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,369.00	1,193.00	1,330.25	1,280.00	1,013.00	1,081.50	1,066.50	1,054.50	775	87.14%	96.22%	106.76%	98.87%	2.9	3.0	5.9		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,752.00	1,506.73	1,580.25	1,298.75	1,411.50	1,191.50	1,078.00	766.00	878	86.00%	82.19%	84.41%	71.06%	3.1	2.4	5.4	Y	Delay/omission of regular patient checks - personal needs - under investigation
Short Stay Unit	300 - GENERAL MEDICINE	1,460.25	1,264.75	1,689.00	1,660.75	1,081.00	1,184.50	1,064.00	1,165.50	827	86.61%	98.33%	109.57%	109.54%	3.0	3.4	6.4		
Ward 15a General Med	300 - GENERAL MEDICINE	1,353.25	1,270.08	1,647.25	1,569.00	1,100.25	1,019.25	1,086.83	1,264.33	703	93.85%	95.25%	92.64%	116.33%	3.3	4.0	7.3		
Stroke Ward	300 - GENERAL MEDICINE	1,357.92	1,225.58	1,236.50	1,172.50	1,059.75	1,162.75	794.50	826.50	558	90.25%	94.82%	109.72%	104.03%	4.3	3.6	7.9	Y	Shortfall more than 8hrs or 25% RN time available - managed locally - no harm- incident closed
Rehab & Discharge Lounge	314 - REHABILITATION	1,614.17	1,132.75	2,183.00	1,631.50	941.50	977.00	1,095.50	1,047.50	732	70.18%	74.74%	103.77%	95.62%	2.9	3.7	6.5	Y	Less than 2 RN's present on ward during any shift - mitigated and support offered - no harm caused - incident closed
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,835.92	1,521.75	2,256.50	1,815.00	1,089.08	1,149.58	1,518.00	1,553.00	879	82.89%	80.43%	105.55%	102.31%	3.0	3.8	6.9	Y	x2 incidents -Shortfall more than 8hrs or 25% RN time available - supported by agency - no harm caused
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,181.00	1,170.75	1,310.00	1,189.00	713.50	713.50	344.00	436.50	428	99.13%	90.76%	100.00%	126.89%	4.4	3.8	8.2		
Ward H	110 - TRAUMA & ORTHOPAEDICS	720.00	544.75	712.50	376.50	719.00	527.00	0.00	129.50	53	75.66%	52.84%	73.30%	#DIV/0!	20.2	9.5	29.8		
Surgical Ward	100 - GENERAL SURGERY	1,119.33	944.33	1,119.50	1,113.50	712.00	723.00	357.50	565.00	483	84.37%	99.46%	101.54%	158.04%	3.5	3.5	6.9	Y	Delay/omission of regular patient checks - personal needs Reviewed at patient safety meeting - incident closed
Spinal Injuries Unit	400 - NEUROLOGY	2,559.08	2,457.15	2,942.17	2,840.67	2,221.25	2,174.25	1,300.00	1,171.25	584	96.02%	96.55%	97.88%	90.10%	7.9	6.9	14.8		
Ward G	101 - UROLOGY	980.00	781.00	1,039.50	687.50	716.00	644.00	353.50	329.50	238	79.69%	66.14%	89.94%	93.21%	6.0	4.3	10.3		
TOTAL		**22,454.58**	**19,638.24**	**23,661.92**	**20,729.15**	**16,646.83**	**16,828.42**	**13,001.50**	**13,446.08**	**9528**	87.46%	87.61%	101.09%	103.42%	**3.83**	**3.59**	**7.41**		

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		4,024.20	3,985.72	2,534.75	1,714.71	3,509.00	3,568.00	1,071.50	664.00	0	99.04%	67.65%	101.68%	61.97%					
Ambulatory Care Unit		346.50	310.00	334.50	348.50	0.00	0.00	0.00	0.00	52	89.47%	104.19%	#DIV/0!	#DIV/0!					
TOTAL		**4,370.70**	**4,295.72**	**2,869.25**	**2,063.21**	**3,509.00**	**3,568.00**	**1,071.50**	**664.00**	**52**	98.28%	71.91%	101.68%	61.97%	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	3,912.50	3,087.57	1,153.25	868.58	3,588.00	3,003.42	1,076.50	512.50	331	78.92%	75.32%	83.71%	47.61%	18.4	4.2	22.6		

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	1,218.25	1,133.25	1,088.75	1,058.25	606.50	580.00	1,070.00	987.00	469	93.02%	97.20%	95.63%	92.24%	3.7	4.4	8.0		
MAU	501 - OBSTETRICS														#DIV/0!	#DIV/0!	#DIV/0!		
TOTAL		**1,218.25**	**1,133.25**	**1,088.75**	**1,058.25**	**606.50**	**580.00**	**1,070.00**	**987.00**	**469**	93.02%	97.20%	95.63%	92.24%	**3.65**	**4.36**	**8.01**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,062.07	1,072.43	144.00	144.00	1,081.00	1,049.50	0.00	0.00	168	100.98%	100.00%	97.09%	#DIV/0!	12.6	0.9	13.5		
Paediatric Unit	420 - PAEDIATRICS	1,786.50	1,738.50	833.50	807.50	1,536.75	1,329.00	383.50	419.50	388	97.31%	96.88%	86.48%	109.39%	7.9	3.2	11.1		
TOTAL		**2,848.57**	**2,810.93**	**977.50**	**951.50**	**2,617.75**	**2,378.50**	**383.50**	**419.50**	**556.00**	98.68%	97.34%	90.86%	109.39%	**9.33**	**2.47**	**11.80**		
PLANNED		12,307.83	10,507.30	10,533.42	8,890.75	9,758.83	8,934.75	4,949.50	4,697.25	2,996	85.37%	84.41%	91.56%	94.90%	6.5	4.5	11.0		
URGENT		14,059.25	12,218.51	14,281.75	12,706.98	10,476.00	10,897.09	9,128.50	9,261.33	6863	86.91%	88.97%	104.02%	101.46%	3.4	3.2	6.6		
W&C		4,066.82	3,944.18	2,066.25	2,009.75	3,224.25	2,958.50	1,453.50	1,406.50	1,025	96.98%	97.27%	91.76%	96.77%	6.7	3.3	10.1		
TRUST TOTALS		**30,433.90**	**26,670.00**	**26,881.42**	**23,607.48**	**23,459.08**	**22,790.34**	**15,531.50**	**15,365.08**	**10,884**	87.63%	87.82%	97.15%	98.93%	4.5	3.6	**8.13**		

Green- 80% and above

Red- Under 80%

Southport and Ormskirk Hospital NHS Trust

TRUST BOARD

6 November 2019

Agenda Item	**TB186/19e**	**Report Title**	**CQC UPDATE**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	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 Board with an update on progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November/December 2017 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018.
The Report also provides an overview of the two recent unannounced core services and Well Led inspections undertaken between July 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	✓ Statutory Requirement
✓ Effective	☐ Annual Business Plan Priority
✓ Responsive	☐ Best Practice
✓ Safe	☐ Service Change
✓ Well Led	

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

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

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

Board of Directors to note the report and next steps

Previously Presented at:

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

CQC UPDATE

1. PURPOSE OF REPORT

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

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

The format of this report will be reviewed following the publication of the CQC Inspection Report and the revision of the Must & Should do quality improvement plan.

2. TRUST PROGRESS AGAINST 2017 /18 MUST AND SHOULD Dos

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 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

We continue to internally monitor progress and have begun the task of mapping across any key themes from the 2019 inspection feedback / draft report against current amber and green actions, a number of the amber actions are still highlighted as must or should do actions in the draft report.

3. CQC INSPECTIONS – JULY & AUGUST 2019

As previously reported to Quality & Safety Committee, the CQC carried out two unannounced inspections in July and August 2019. Areas for improvement were identified during these inspections, key themes have been identified and will be incorporated into the revised improvement plan. Key themes include:

Key Themes from 2019 Inspection feedback

Medicine
• The documentation relating to MCA/DoLS/DNACPR was not consistent • Issues relating to privacy and dignity of patients • IPC and use of side rooms • Medicines management across the service • Medical records storage was also highlighted as a concern • Storage of hazardous substances
Surgery
• Medicines management across the service • Mandatory Training
Urgent & Emergency Care
• Medical records storage • Equipment Checks • Completion of risk assessments
Children & Young people services
• Resuscitation Trolleys • Mandatory Training
Sexual Health
• Medicines Checks and Fridge Temperatures
End of Life
• Recording of incidents and risk
Critical Care
• Mixed Sex Breaches • Delayed Discharges
Ormskirk Outpatients
• Medicines management – storage of medicines
• Improve complaint response times
Well Led
• Pace of improvement • Medicines Management • Management of policies • Systems for recording mandatory training, skills and competencies

4. DRAFT REPORT & FACTUAL ACCURACY

The Trust received the draft report for factual accuracy checking on 8 October 2019, the deadline for return is 29 October 2019. The Quality Team are working with the Core Service leads to identify any inaccuracies relating to typo or numerical errors, other challenges to the accuracy of the evidence in the draft report or any additional relevant information that the CQC should be taken into account.

5. MEDICINES MANAGEMENT

Following the development of the medicines management development plan (MMDP), work has continued to improve the governance relating to medicines management. The initial and 30 day plans are completed and the 3 month is on course for 25 October 2019. An additional 6 month element of the pan has been developed along with an assurance tracker to ensure all completed actions and improvements have been embedded and sustained. Weekly progress meetings continue to take place led by Medical Director and Chief Pharmacist. A Quality Assurance Panel is being arranged for November 2019 to test the progress made on the immediate and 3 month development plans assess improvement

6. RECCOMENDATIONS

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

Highlight Report
Vision 20/20 Single Improvement Plan - Strategic Objective 1
Improve clinical outcomes and patient safety to ensure that we deliver high quality services

Project Original Start Date	01/04/2018
Refresh date	01/05/2019
Project End Date	31/03/2020
Programme	Vision 20/20 Single Improvement Plan
Work stream	SO 1 - Improve clinical outcomes and patient safety to ensure that we deliver high quality services

Executive Sponsor	Juliette Cosgrove - Director of Nursing Terry Hankin - Medical Director
Programme Lead	Jo Simpson
Clinical Lead	Juliette Cosgrove & Terry Hankin
Programme Office Lead	Rebecca Walsh
Reporting To / Via	HIB / Quality & Safety Group
Meeting Date	21st October 2019

BRAG for KPI actual versus in month target	
BRAG for progress of activity against projected timeframes	

Green also denotes activity that has not yet commenced and remains within date for delivery

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

1. EXECUTIVE SUMMARY

Governance established via monthly Quality & Safety Group and weekly QID meetings.
CQC Inspections completed, feedback from the inspection and KLOE have been incorporated into the CBU Quality Improvement Plans, Quality Assurance Panels will be re-established to review evidence to ensure improvements are embedded and sustained, draft report for factual accuracy checking is expected October 2019
SONAAS - The formal assessment programme commenced 21st August 2019, 3 areas to date have been assessed, their overall ratings are 2 bronze and 1 silver . Initial feedback is provided to the ward manager on the day of assessment, with a written report and formal meeting the following day.
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
PIDs or Project Briefs are being reviewed and developed for all Quality & Safety Workstreams
At October Quality & Safety Group, Safe and Effective Discharge was identified as a cross cutting workstream, this will also be monitored via Patient Flow & Improvement Programme (PFIP)
The Documentation workstream (Executive Leads Steve Christian) is also cross cutting and will be monitored across different priority areas, a programme lead will need to be identified

2. KPIs impacted

KPIs will need to be incorporated into new 19/20 template by end November 2019

3.Priority Areas

- Recognition and care of the deteriorating patient (see Mortality Improvement)
- Care of the older person
- Infection prevention and control
- Medicines management

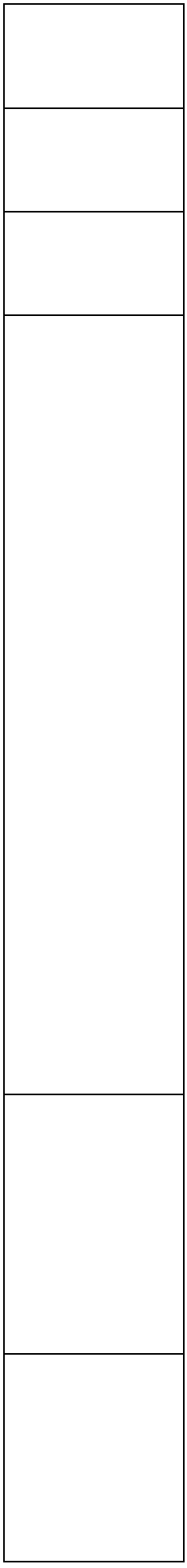
High Impact Activity	Project Objectives	Project Deliverables	Start date	End date	Completion % (PROGRESS MEASURED AGAINST END DATE)	BRAG (PROGRESS MEASURED AGAINST END DATE)
Mortality Improvement (Care of the Deteriorating Patient) - external mortality review and Reducing Avoidable Mortality Group actions to be delivered across clinical workforce	Continue to deliver the Mortality Improvement Action Plan, including improvements in learning from deaths	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. 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. Fractured NOF update - The Trust remains an outlier for mortality on the National Hip fracture database and action plan in place and a review of NOF deaths is planned. Fractured NOF time to surgery remains variable and constantly monitored by Medical Director. Urinary tract infection is a 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. 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. Mortality Screening - Screening rate for July has increased to 88.14%, the screening tool is intranet based and triggers SJR process automatically, screening rates have improved, process reviewed with addition of i-pads made available.	01/04/2019	31/03/2020	70%	
Medicines Management - One of the Trust's 4 quality priorities, following CQC Inspections Medicines Development Plan	Deliver against the actions in the Medicines Management Programme Plan	Medicine management development plan- 30 day completed 25 August 2019, 3 month on course for 25 October 2019 Business case for staffing completed 13 staff@ £495758 to address 'extreme risk' Datix ID 1345 Serious Incident RCA in relation to the CQC concern has been completed and recommendations have been incorporated into Medicine management development plan, after been through SIRG Focus remains on improving 7 day working, staffing and Electronic prescribing	01/04/2019	31/03/2020	20%	
Care of the Older Person - Standardisation of Best Practice Ward Processes to Improve Care of Older People	Deliver against the actions in the Care of Older People Programme Plan	Mouth care roll out will begin on 14B on 30/9/19 with products selected by the mouth care group. Naso Gastric Tube suppliers have been invited to the next NG tube meeting to inform the group of possible products / packs they could supply to support strategy going forward. Falls bundle on all wards at Southport Hospital excluding Spinal Centre and, will be rolled out in Ormskirk Hospital week commencing 30 October 2019 A blueprint for resource boxes has been created specifically for patients with cognitive impairment, this is currently being costed before generating charitable funds bid, work is ongoing with procurement and infection control departments. Revised nutritional screening policy has been rolled out on Ward 10B with demonstrable improvement, further roll out has been paused until the lead dietitian has taken up their post in October 2019 The training programme for Care of Older People has continued to be delivered to excellent feedback, with 170 people booked to undertake by the end of 2019. Spinal Fracture Pathway ready to present to major trauma network in October 2019 for approval. Recruited Admiral Nurse x 2 Band 6's	01/04/2019	31/03/2020	60%	
Infection Prevention and Control - One of the Trust's 4 quality priorities.	Deliver against the actions in the Infection Prevention and Control Programme Plan	Programme PID requires further development - date in diary for November Priorities in relation to policy updates is ongoing MRSA bacteraemia reported in August on ward 9B 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 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 Spinal Centre refurbishments and deep cleaning - work has been completed in acute respiratory care area to provide 2 isolation cubicles and a bathroom, these areas are now in use, as part of the improvement programme, 6 beds have reopened w/c 30 September	01/04/2019	31/03/2020	10%	
Clinical Workforce Development ● **Clinical education -** develop programmes across all roles including implementing new NMC Educational standards ● **Medical Staffing Numbers -** ensure rotas are covered ● **Professional Standards** - NMC process, NMP governance, roles & responsibilities for matrons & ward managers	Delivery of the related actions in the Workforce Improvement Plan	Workshops supporting delivery against the updated Nursing and Midwifery Council (NMC) standards of proficiency for registered nurses and Standards for education and training remain in place in collaborationwith HEI's. Expectations for the learning, support and supervision of students are key deliverables from these workshops. A revised Preceptee programme has commenced with mapping of core clinical competencies. A revised Clinical induction programme is drafted, awaiting ratification and alignment to trust induction programme. All nursing job descriptions are being reviewed to align to national standards and competencies. Medical Staffing - The Workforce plan includes a work stream focusing on reducing agency spend and improving time to hire, going forward this will be reported within this work stream in addition to establishment and vacancies 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	01/04/2019	30/09/2019	10%	

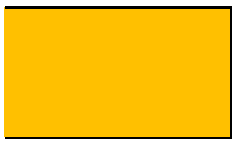
Quality Standards Compliance ● **Quality Improvement** - Focus on fundamentals including observations of care ●**CQC** – receive improved feedback following inspection and continue to move towards Good	●Continuation of the delivery of the actions within the Quality and Safety Improvement Plan (previously the Quality Improvement Plan To improve fundamental standards of nursing care) ●Delivery against CQC Preparation Plan ●Delivery of 'must-do' actions	SONAAS - The assessment programme continues to be rolled out across the Trust as of w/c 14.10.19 we currently have 2 bronze wards and 3 silver, reassessment of the bronze wards are due to take place w/c 28.10.19 Ward Co-ordinator (daily) and Ward manager (weekly) checklists in progress. Compliance improving however, not consistently across the trust. Matron Quality Care Indicators are monthly and has recently been rolled out electronically across the Trust. Governance systems and processes need to be reviewed in relation to the checklists to ensure compliance is reported to the most appropriate meeting for assurance 2019 CQC Inspection now complete, draft report for factual accuracy checking is expected October 2019. Key themes from the inspections have been circulated to core services and corporate leads to incorporate into their Quality Improvement Plans The Trust received a letter from CQC asking for additional assurance in relations to Medicine Core Service, the response was submitted back to CQC within timescale. 92 of the Must and Should Do Actions have been completed (Green & Blue), 22 are on track to deliver (Amber), zero are Red 'not progressing to plan'. Quality Assurance Panels are being re-established to test evidence and ensure improvements are embedded and sustained.	01/04/2019	31/01/2020	70%	
Patient Safety ●**Complaints –** improved complaints management and learning from feedback ● **Risk Management** - Improved Risk Management	Full review of processes and development of action plan	Complaints process mapping review and incident process mapping exercise completed with subsequent actions developed, a further complaints review will take place in quarter 3 incorporating patient experience led by the Deputy Director of Nursing any additional actions will be built into the Integrated Governance Improvement Plan Numbers of complaints and concerns are decreasing, the responses within 40 days is improving – this was 30.7% April 2019 - September 2019 compared to 17.91 in April 2018 - September 2018 The Trust is currently on track to meet the CCG's agree timescales to close the current contract performance notice On-going review of the risk registers and Risk and Compliance Group monthly to monitor progress.	01/04/2019	31/12/2019	60%	
Patient Experience and Engagement - enhance feedback, develop volunteers, improve care within frail older peoples care	Improve level of patient engagement and experience across the Trust and develop an improvement plan.	Performance Sept-19 has deteriorated compared to the previous months results from 94.4% to 88.85%% but remains within tolerance. Response rates although slightly increased, continued to be low. Trust Overall response rate has increased slightly from 6.48% to 6.74%. Digital enhancement of FFT went live with on the 1st October, overall Trust response rate for mid – October is currently at 25%. A+E response rates have risen from 3.93% (Sept-19) to currently 25%. Response rates and % that would recommend continue to be monitored monthly. Following a patient story presented to board regarding a patient with hearing difficulties this has led to the development of a Sensory Group for patients with visual and hearing impairments facilitated by Patient Engagement Matron and Equalities and Diversity Lead. The group have held their first meeting in October and have agreed to move forward with regards to accessibility of letters and identification of additional support needs in the pre-operative stage of the patient journey.	01/04/2019	31/03/2020	40%	
Safeguarding - Improve training compliance and documentation regarding MCA and DoLs **Safe and effective Discharge** - High Impact Activity definition to be developed	Review of training and development of action plan Project objectives to be agreed	Safeguarding Team have reviewed the MCA/DoLS documentation and have provided wards with information in 'purple folders' level 3 safeguarding training continues to be monitored, 84.7% - 13 outstanding, al have been booked onto training. New worrkstream identified at Quality & Safety Group on 7 October 2019, this will link to PFIP. Working Group has been established to look into discharges including Head of Older People, Head f Patient Flow, MAtron for Patient Experience and Safeguarding Team	01/04/2019	31/03/2020	30%	
Documentation - High Impact Activity definition to be developed	Project objectives to be agreed	Poor documentation is an issue trust wide, Steve Christian is the Executive Lead, a programme leads needs to be identified and a PID or Programme Brief developing	01/04/2019	31/03/2020	0%	

Top risks and issues to achieving programme / project objectives				
Risks	**RAG**	**Mitigation Activity**	**RAG After Mitigation**	**Comments**
No current Dietitian Lead for Trust has led to slippage in the roll out of Nutrition, Hydration & Mouth Care projects	A	New Lead Dietitian due to start end October 2019, Meg to chair the group in the interim.	G	
Inability to release clinical staff to participate in Mouth Care Matters projects	R	Secured 3 additional places for Mouth Care Matters programme in London 15th November 2019	A	
Approval and implementation of Medicines Management Business Case	R	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	R	Participate in the development of the system winter plan	R	
Work force	R	Managed by Workforce Improvement Board	R	

Issues	**Owner(s)**	**Action Taken**	**RAG**	**Comments**
Clinical demands of the Mouth Care Team has led to the launch of the mouth care project being delayed	Meg Langley	Roll out of mouth care project delayed timescales have been reset	A	
IPC priorities need to be agreed , awaiting date for CSR date to be confirmed	Andrew Chalmers	TORs agreed, draft dates in proposed in November for Spinal, Trust wide to be confirmed	A	

Other	
Anything else by exception that requires highlighting to: Southport & Ormskirk I Improvement Board / HMB / TB	Draft CQC report received, currently going through factual accuracy checking process Discussion needed about the ownership of Documentation workstream





Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**TB186/19f**	**Report Title**	**Freedom to Speak Up Report Quarter 2 1st July - 30th September 2019**
Executive Lead	Name, Title Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Name, Title Juliette Cosgrove, Claire Blackman, Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required *(Definitions below)*	☐ To Approve ☐ To Note ☒ To Assure ☒ To Receive ☐ For Information		

Executive Summary

This report identifies the number of concerns raised to the FTSU Guardian during quarter 2 2019 (1st July – 30th September), once again this shows a further increase on previous quarters (41).

The committee 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.

The ongoing FTSU vision and strategy document was presented to the October board and has been used as part of freedom to Speak up Month, and will be highlighted as part of the ongoing communications strategy.

In the FTSU index report 2019 our organisation has been highlighted as an outlier in relation to the staff survey questions relation to speaking up.

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.*
☐	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
☐	**SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*

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

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

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

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

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

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

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

Add actions with milestones and Leads here

Previously Presented at:

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

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

Purpose of the Report

To give an update on concerns raised to the Freedom to Speak Up Guardian during the last quarter and to give assurance that the Freedom to Speak Up Process is known about and being accessed across the organisation.

1 Report on Submission to National Guardians Office

Quarter 2 1st July – 30th September 2019

Date to be submitted to NGO: **Monday 7th October 2019**

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

Number of concerns raised: **41**

1.1 During quarter 2, 41 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG). This is in addition to the 7 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
July	13	1	2 concerns raised about Trust uniforms one concern was around people being unfairly treated. It was requested that all senior managers remind their managers and staff of the Trust uniform policy. Both concerns closed. Patient Safety. Concern closed. 2 concerns raised by staff member around treatment by manager. Employee has left the Trust. It is part of a bigger picture and being monitored. Concern closed. Staff wellbeing. Length of time disciplinary process is taking. Employee back at work and concern closed. Staff and patient safety. Process of whistleblowing to department. Feels no support given, raised concern about process with FTSUG . Ongoing. 2 concerns raised in the same department regarding	Staff Nurse 2 Anonymous 1 Specialist Nurse 1 AED 1 HR 2 HCA 1 Medical Equipment 1 Radiology 1 Manager 2 Patient 1

			being bullied by the manager. Ongoing. Information pertinent to a Trust internal investigation. Advice given and concern closed. Bullying and Harassment and disclosure of personal information. Concern ongoing. Allegation of financial irregularity. Ongoing.	
Aug	12	0	2 concerns have been raised regarding the Supporting Attendance policy. Both Concerns are ongoing. 6 concerns have been raised by the same department regarding relationship with manager, lack of communication, bullying behaviour and HR. Concerns are ongoing. Relationship with colleague. Ongoing. Length of time for HR investigation. Ongoing. 2 concerns were raised about patient care. One person did not wish to pursue theirs and is closed. The other concern is ongoing. Process relating to maternity pay ongoing.	Team Leader 1 Education 1 ODP 1 TA 2 Manager 1 Student Nurse 1 Public 1 Nurse 1 Theatre Practitioner 1 Not to be disclosed 1 Specialty Doctor 1
Sept	16	0	Relationship with colleague/bullying. Concern is ongoing. 3 concerns raised regarding the length of time it is taking for HR to deal with grievance process. Ongoing. 10 concerns have been raised by the same department regarding relationship with manager, lack of communication, bullying behaviour concerns are ongoing and being investigated at executive level. 3 concerns have been raised regarding the Supporting Attendance policy. (Concerns ongoing) Pension issues, support given advice offered. Issue resolved. Concern closed. Treatment of family member in A+E. Ongoing.	HCA 1 Admin 2 Sister 1 TA 1 Nurse 2 Manager 2 ODP 2 Theatres 3 Domestic 1 Pharmacy 1

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

1.2 Situations where detriment was expressed because of speaking up:

On the return made to the NGO one case of detriment suffered was noted. The person had raised a concern (whistleblew) within her own department. The concern was not raised with the FTSUG until sometime later by which time she had felt alienated by some of her

colleagues and has since left the organisation, citing her experience of whistleblowing as a major factor. Relevant executive has offered to meet the person and investigate.

1.3 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 2 feedback was received from 4 people. All of the feedback was positive with positive outcomes. The relatively low number in relation to feedback is due to the significant number of concerns still open.

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?

All feedback for this quarter has been positive and those raising the concerns have been very grateful to FTSU.

There have not been any suggestions improving the service.

Two of the people commented that they are really glad that they spoke up. There are all pleased with the outcome and with the service and support offered by FTSU.

Some examples:

I was undecided at first and felt worried about it but I am glad I did in the end. My experience really knocked my confidence and I wouldn't want someone else to go through that.

I think it is an excellent service and the champions I spoke to were very understanding and responded quickly with any communications.

I am really glad I spoke up and I am delighted with the result. I was very pleased with the FTSU service.

My complaint was resolved and I am happy with the support given by FTSU.

Table 2: Straight to Silas inquiries July – September 2019

7 Concerns received

Month	Number	Themes
July	1	Bullying (1)

Aug	4	Car parking (2) HR issue (2)
Sept	2	

1.4 Freedom to Speak Up Index Report

I have included below (appendix 1) a letter from Dr Henrietta Hughes in relation to the Freedom to Speak up Index Report.

This is based on the staff survey about staff perceptions of feeling encouraged, knowledgeable and secure to speak up.

There is also some reflection on CQC ratings and trust in the speaking up process.

As a trust we are listed in the bottom 10.

In November Martin Abrams is meeting with the Regional Liaison Lead (North West) to look at this in more detail and potentially "buddy up" with an organisation which has shown improvement.

However it is worth noting that the information is based on information over a year on and as an organisation we have done significant work to raise the profile of speaking up. As an organisation we are hopeful that this year the figures will be much improved.

The report has been published on the NGO new, independent website:

https://www.nationalguardian.org.uk/publications/

1.5 Freedom to Speak Up Month

For Freedom to Speak Up month the FTSUG and FTSU Champions are engaging in different activities.

The FTSU strategy was presented at board. The FTSUG from Salford Care Organisation came to visit and we are visiting St Helens and Knowsley Trust.

As it is Halloween, the Champions will be taking part in 'Freedom to Spook Up' by going out to wards and departments introducing themselves and promoting the service.

It is also planned to do drop-in sessions in November to recruit more Champions.

Appendix 1

National Guardian
151 Buckingham Palace Road
London SW1W 9SZ
0207 4489469
enquiries@nationalguardianoffice.org.uk

9 October 2019

Dear Colleagues

I am delighted to announce the publication of the Freedom to Speak Up Index. The Freedom to Speak Up index is the first time that the speaking up culture has been measured in trusts and foundation trusts. It is derived from 4 questions in the NHS annual staff survey about staff perception of feeling encouraged, knowledgeable and secure to speak up.

The survey questions that have been used to make up the FTSU index are:

• question 17a the % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly
• question 17b the % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents
• question 18a the % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it
• question 18b the % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice

We have seen a national improvement since 2015 and in some trusts a remarkable improvement in the responses to the four questions. 180 trusts have had an improvement in the results of these four questions since 2015.

I want to pay tribute to the hard work of Freedom to Speak Up Guardians and those who support them to have seen this improvement in such a short time.

As the National Guardian I have seen examples of excellent practice supporting speaking up but also poor practice. When Sir Robert Francis set out his recommendations and principles following the events at Mid Staffs, every organisation in health accepted all recommendations. But accepting recommendations is not sufficient. What matters is how organisations have embedded these principles and how it feels for their workforce.

We have previously shown that the perceptions of Guardians of the speaking up culture is linked to the CQC overall rating. More important is the views of your staff. We recognise there are limitations in that not all workers are included in the staff survey.

The organisations featured in the report are the best in class for each type of trust and the most improved in England. Their examples, illustrated in the case studies in the report, show that they have opened an important conversation with their staff. We know that they and other organisations have taken on board the advice and guidance from my office, appointed freedom to speak up guardians, considered the role of board members and communicated the message to their

staff. It's clearly important to have the right systems, structures and processes in place, the next step is to think about how it feels and what matters to your workers. This is fundamentally a mindset change and is the essence of leadership.

This index will give you more information about the speaking up culture in your organisation and can act as an opportunity to learn and to share your experience with other trusts.

The report has been published on our new, independent website https://www.nationalguardian.org.uk/publications/

This website includes information for workers, for guardians and for organisations. I would encourage you and your executive and non-executive leads for Freedom to Speak Up to use the information and guidance available.

Please also let us know at enquiries@nationalguardianoffice.org.uk how we can improve the website.

This is the first step in measuring the speaking up culture in trusts. I look forward to working with you in your journey to making speaking up business as usual in your organisation.
Finally, also bear in mind it is Speak Up Month and we have already seen organisations find all manner of innovative ways to raise awareness of speaking up. From films shared, events taking place, development sessions rolled out, word searches produced, poems written, trees planted, flags hoisted, and cupcakes baked!

Do please continue to raise awareness of speaking up and use the hashtag #speakuptome so we can really make an impact this October.

Dr Henrietta Hughes FRCGP

National Guardian for the NHS

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**TB187/19**	**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 **receive** the report and highlight any further assurance necessary in relation to areas of poor performance.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

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

NHS
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Board Report - September 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	0	1	0			
C-Diff	3	1	14	1			
Never Events	0	0	1	0			
VTE Prophylaxis Assessments	95%	96.7%	97.9%	151			
Harm Free (Safety Thermometer)	95%	97.7%	97.7%	8			
Falls - Moderate/Severe/Death	1	2	10	2			
Patient Safety Incidents - Low, Near Miss or No Harm		713	4579	713			
Safe Staffing	90%	91.8%	91.1%	N/A			
Fractured Neck of Femur	90%	73.5%	69.9%	25			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Percentage of Deaths Screened	100%	84.6%	54.5%	8			
SHMI (Summary Hospital-level Mortality Indicator)	100	101.1		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%	75%	69.1%	7			
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	11	125	11			
Written Complaints	35	19	121	19			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	88.9%	93.3%	70			

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

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Accident & Emergency - 4 Hour compliance	94.99%	88.6%	88.6%	1193			
Accident & Emergency - 12+ Hour trolley waits	1	5	35	5			
Ambulance Handovers <=15 Mins	99%	58.7%	53.9%	583			
Diagnostic waits	1.01%	2.6%	3.8%	75			
14 day GP referral to Outpatients	93%	92.3%	94%	73			
31 day treatment	96%	94%	98%	3			
31 day treatment (Surgery)	94%	100%	100%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	75.3%	77.3%	11			
62 day GP referral to treatment	85%	75.3%	76.4%	11			
Referral to treatment: on-going	92%	93.4%	93.4%	731			
Bed Occupancy - SDGH	93%	88.9%	92.5%	N/A			
Bed Occupancy - ODGH	60%	52.1%	47.7%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	100%	98%	0			
Duty of Candour - Evidence of Letter	100%	100%	97.9%	0			
I&E surplus or deficit/total revenue	-1%	-7.9%	-19%	N/A			
Liquidity	-106	-122	-122	N/A			
Distance from Control Total	0%	0%	-7.9%	N/A			
Capital Service Capacity	0.21	-0.46	-3.559	N/A			
% Agency Staff (cost)	5.45%	9.4%	8.3%	N/A			
Use of Resources (Finance) Score	3	3	3	N/A			
Distance from Agency Spend Cap	0%	135%	135%	N/A			
Staff Turnover	0.76%	1.3%	6.8%	N/A			
Staff Turnover (Rolling)	10%	12.3%		N/A			
Vacancy Rate - Medical	5%	16.4%		N/A			
Vacancy Rate - Nursing	8%	17.8%		N/A			
Sickness Rate	4%	4.3%	4.9%	N/A			
Personal Development Review	85%	69.6%	71.7%	N/A			
Mandatory Training	85%	88.6%	87.1%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.1	8.5	N/A			
Time to Recruit	30	64	67	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	64	63	64			
DTOC - Number of Beds lost per month		183		183			
Length Of Stay	6.5	6.5	7.1	N/A			
New:Follow Up	2.64	2.6	2.5	N/A			
DNA (Did Not Attend) rate	8%	7.1%	7.1%	1706			
Cancelled Ops	0.61%	0.2%	0.3%	4			
Theatre Utilisation - SDGH	80%	66%	60.7%	N/A			
Theatre Utilisation - ODGH	90%	72%	69.3%	N/A			
Stranded Patients (>6 Days LOS)	170	169	1069	169			
Super Stranded Patients (>20 Days LOS)	58	66	418	66			
Southport A&E Conversion Rate	20%	20.2%		971			

Reporting Frequency is monthly except for SHMI which is quarterly.

Board Report - September 2019

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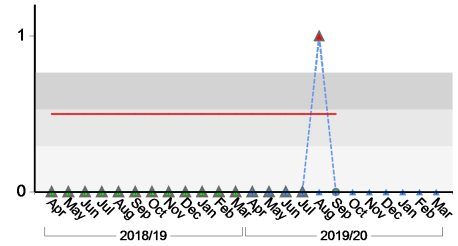
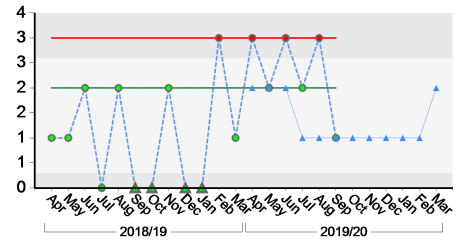
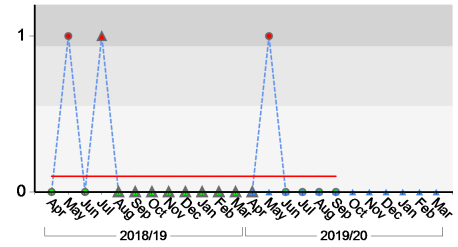
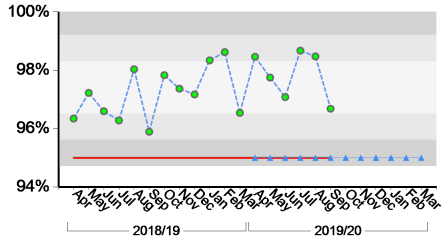
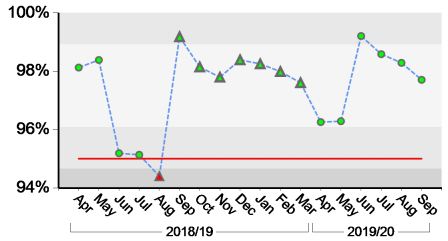
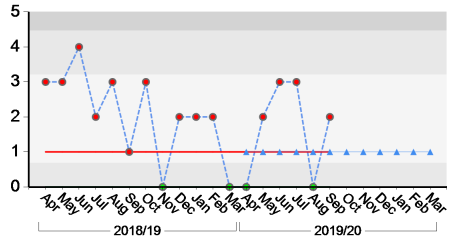
Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	In September, zero MRSA bacteraemia was reported - In August there was one MRSA bacteraemia - the 1st in 23 months; the Trust continues to be a low incidence Trust.	
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.	Single C diff case attributed to the Trust in September - Single C diff case on ward 7A; patient isolated and treated and room had a disinfection clean. The Trust has a target for not exceeding 16 cases for fiscal year 2019-20 and with this case the current total is 15. 1 case has been successfully appealed and there are 6 further cases to be appealed in October when the panel convenes. 2 isolation pods have been completed in the NWRSIC, RCAs are being organised and held and even though there are delays in isolation of patients with diarrhoea they are eventually getting isolated.	
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 September Ongoing training and monitoring of processes continue	

Board Report - September 2019

Southport and Ormskirk Hospital NHS Trust

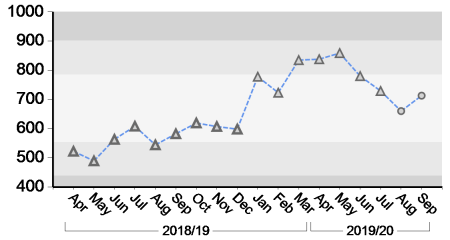
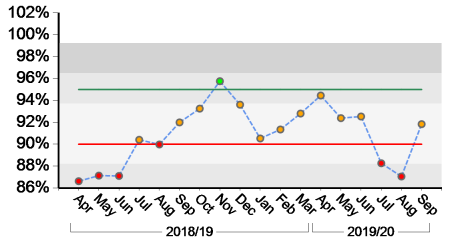
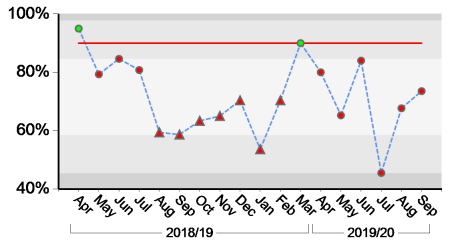
Safe

Indicator Name	Description	Narrative	Month Trend
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	The percentage of assessments slightly deteriorated compared to the previous month but remains within the normal range for the trust - The trust maintains compliance	
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Patient harms reported as part of monthly Harm free care audit continues to be compliant with target. - During census day in September 2019 the Trust reported 5 patient harms which were: 1 x low harm fall on ward 7a 4 x CAUTI reported on wards 10b, ward 9b, G ward and NWRSIC, Local investigation for each of the reported harms is the responsibility of the relevant CBU	
Falls - Moderate/Severe/Death	The total number of falls within the Trust were the severity of the harm was either moderate, severe or resulted in death. Threshold:0	Good progress with plan implementation, some indicators of good improvement - The risk assessment roll-out is almost complete with the specialist areas/pathways only now requiring review. The post-falls assessment is to be tested on 2 wards and launched across the Trust by the end of October- all previous documentation will be removed form the intranet by the end of November. The release of staff to complete training is a challenge and discussions are underway on how to plan release ahead of rota. Finally the falls strategy is in draft form and hope to launch by the end of November.	

Board Report - September 2019

NHS Southport and Ormskirk Hospital NHS Trust

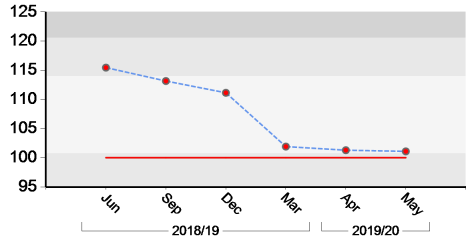
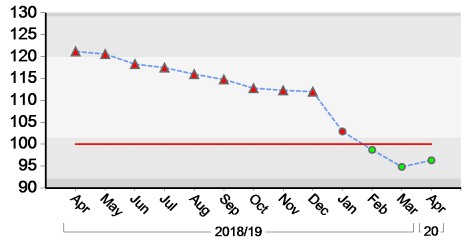
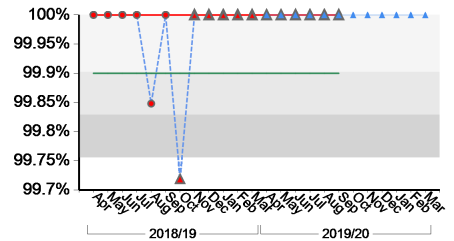
Safe

Indicator Name	Description	Narrative	Month Trend
Patient Safety Incidents - Low, Near Miss or No Harm	The number of incidents relating to patients where the severity was Low, Near Miss or No Harm caused. A higher number is good.	There were 714 No Harm/Near Miss/Low Harm in September an increase from the previous month of 660 - In September there were 714 lower level incidents reported - 27 Near miss incidents, 609 No harm and 78 Low harm incidents. 100 of these were DoL's applications , 49 safeguarding . The other categories with the highest reported incidents relate to themes within Bed management issues including delay in transfer to the ward -49 reported , 12 hour breaches 33 reported ,same sex breaches 11 reported and patients nursed in the corridor in A&E -17 , transfer to inappropriate ward 15 reported , the other category relates to patient falls where 63 incidents . 63 incidents were no harm from the Trust as they relate to externally acquired pressure ulcers reported via AED which are now reportable to the NRLS (new pressure ulcer guidelines) the category 3/4 or multiple category 2's trigger a safeguarding review so this has a positive result.	
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 within tolerance 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 the financial year. Review of flexible working opportunities to support fill to vacancies is on-going with additional agencies joining the trust cascade.	
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance is showing comtinued improvement due to better ulitlization of the 'golden patient' - Golden patient has now been implemented, and patients are getting to theatre quicker. This means that theatre utilization is now improving as more cases are getting done per session.	

Board Report - September 2019

NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly (rolling 12 months) and is 6 months behind due to when Dr Foster publish the data.	Performance within tolerance, figure is within statistical norms. - 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 Septermber 2019 - Reports from the checklist audits will supplement this performance update in future reports to validate this	

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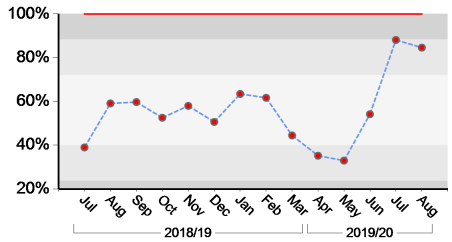
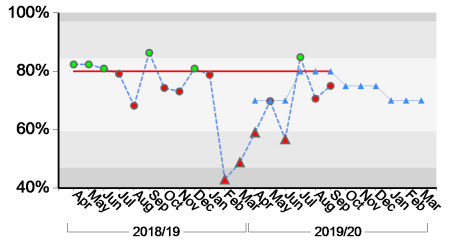
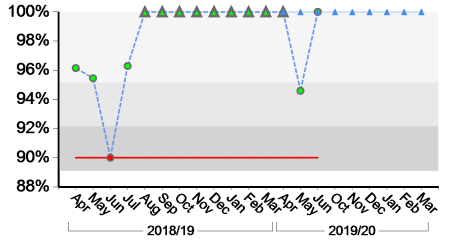
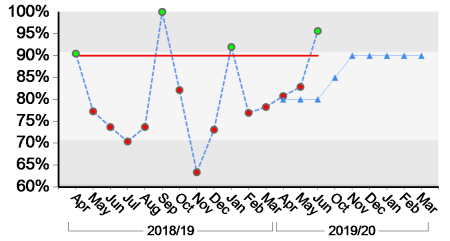
Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
Percentage of Deaths Screened	Percentage of Deaths Screened - DATIX	Significant improvement maintained although slight deterioration in month but not materially - this improvement is since the implementation of the iPAD system and the reminder posters.	
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.	Improvement in Target - Latest Ssnap Report (Aprl - June 19) published and 59.4% patients spent 90% stay on ASU but improvement in July, August + September 19 due to actions implemented. Ssnap report for July - Sept 19 due December 19.	
Sepsis - Timely Identification	Sepsis Timely identification of sepsis in emergency departments and acute inpatient settings - National early warning score (NEWs) recorded within 1 hour of hospital arrival.	Performance remains consistently high - at 100%.	
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.	Perfomance steadlity improving - Although performance still has variability, we are continuing to improve.	

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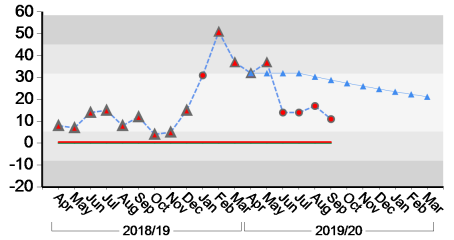
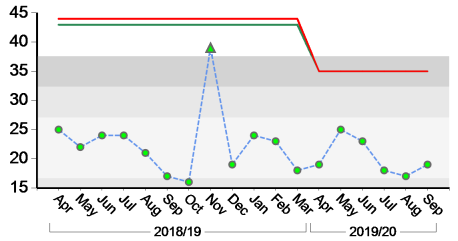
NHS
Southport and Ormskirk Hospital
NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	Continued improvement in breaches - 11 in September - 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; new single sex breach for critical care to be reviewed	
Written Complaints	The total number of complaints received. A lower number is good.	There were 19 complaints in August - 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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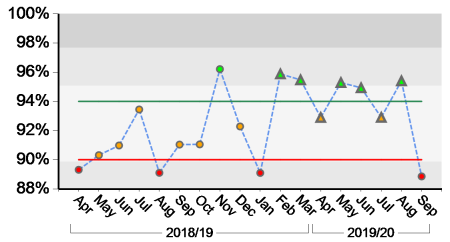
NHS Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance significantly deterioration in comparison to the previous month. - Trust Overall response rate- has increased slightly from 6.48% to 6.74% Those that would recommend has decreased again to 88.85% from 95.41% Planned Overall response rate- has decreased to 10.78% from 16.88% Those that would recommend has decreased to 94.34% from 98.48% Urgent Overall response rate- has increased to 6.28% from 4.86% Those that would recommend has decreased to 79.67% from 91.02% Maternity Overall response rate- has increased to 12.08% from 9.29% Those that would recommend has stayed practically the same at 97.09% from 97.33% Paediatrics Overall response rate- has increased to 5.03% from 2.14% (Children's Ward 16.73% and A&E 3.62%) Those that would recommend has decreased to 93.33% from 97.14% A&E Southport response rate has increased significantly to 4.25% from 0.96% The 'would recommend' has decreased to 70.09% from 90.48% A&E Ormskirk response rate has increased to 3.62% from 0.48% The 'would recommend' has increased to 90.91% from 85.71% Those achieving 100% that would recommend are Obs, 11A, 7B, 15B, CCU, F, MFU & CDU. A total of 655 comments were received from the Friends and Family Cards in Sept-19, 80% of these were from patients who were extremely likely to recommend the Trust and 7.9% were recorded alongside ratings of don't know/neither likely nor unlikely /unlikely/extremely unlikely to recommend. SMS Text and Interactive Voice messaging went live on the 1st October to A+E Departments, Out-patients and Day case areas. This has demonstrated an increase in response rates and qualitative comments across these settings. This will provide more representative feedback to identify areas to focus improvements.	

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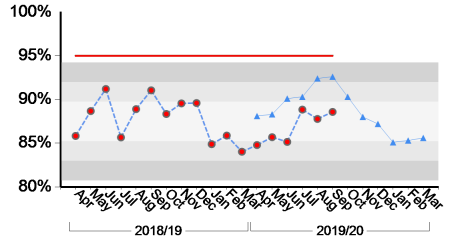
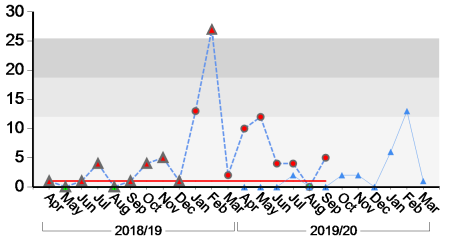
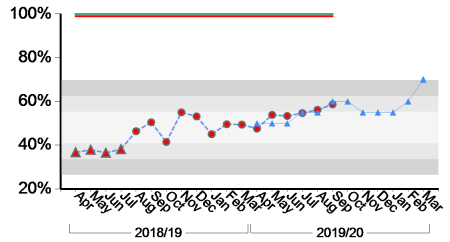
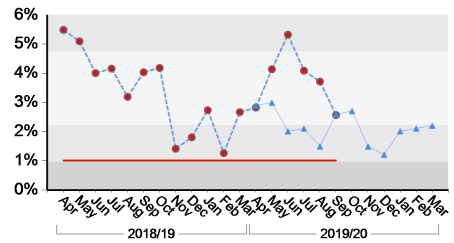
NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	- 4 hour performance dropped to 88.57% compared to last September, however this is against a backdrop of a further 5% increase in attendances (additional 238 patients and an additional 296 patients who were categorised as majors). Attendance patterns and volumes continue to cause concern with late shifts routinely seeing pressures as attendances spike with high numbers of patients are referred to specialties, bottlenecks in bed availability collectively leading to increased waiting times. Night shifts are routinely staffed with 4 doctors but there is an urgent need to bolster late shifts with senior decision makers, but this a challenge given the market. Discussions have been held in PAG regarding this. The new medical proforma between ED and Medicine launched in September has had positive feedback and reduced some of the previous delays in specialty reviews. Discussions are due to take place with a few selected GP practices to test if the form could be adapted for primary care referring into the Trust to ambulatory pathways. This work is progressing with support from Strata. It is critical that ambulatory units have capacity to stream appropriate patients from ED to reduced avoidable delays. ED welcomed its newest substantive consultant on 1 October taking the substantive headcount to 7wte, supported by 1 Associate Specialist, 1 locum consultant and 1 pure Paediatric ED substantive consultant. This is the strongest workforce the department has seen, particularly as we head into winter.	
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 5 12-hour breaches declared across the month of September. - 4 were attributable for patient flow (all 4 occurred on a Monday morning following a challenging weekend) and 1 was a delay in securing a mental health bed. Full clinical timelines have been completed for all 5 patients and shared with the CCG. Patient flow remains a challenge, particularly across the weekend. September saw a 5% increase in attendances (an additional 238 patients). There were 296 more patients this September categorised as majors than last year. As a result of continued bed pressures, specialty reviews continue to take place in ED, with specialties enhancing senior decision making support to ensure patients have timely reviews and management plans. Workstream 2 continues to pursue reducing length of stay with daily tracking of discharges, discharge huddles, red to green board rounds, and stakeholder meetings. Workstream 1 continues to progress streaming from the front door. Plans had been in place to run a perfect week on ACU w/c 30 September which sadly was restricted as the Unit was bedded each day as an escalation area. Timely availability of mental health beds remains a challenge.	
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 58% of ambulance handovers were completed within 15 minutes from arrival - the best reported position to date. This was despite a 5% increase in attendances and the ongoing bed pressures experienced. 268 ambulances were handed over over 30 minutes last September compared to 125 this year. There is still further work that can be done to improve handover times. The timestamp for patients brought straight into resus remains inaccurate as there is no HAS screen in resus. The Trust has signed up to a collaborative starting at the end of October to work as a system to improve ambulance handover times.	

NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower.	Diagnostic waits compliance improved in September down to 2.57% of patients. This demonstrates improvements for the third month in a row - Breaches were as follows: Audiology 4pts 1.7% 3 month secondment of key personnel impacted on delivery of targets. Extra sessions booked Colonoscopy 4pts 2.7% - patients not attending to have the procedure of the offered date within the 6 week period Cystoscopy 14pts 13.9% Consultant activity - specialist service - spinal service , staff sickness, lack of theatre capacity, patient not attending within the 6 week period Dexa Scan 2pts, 0.8% - Unable to contact patients, and patient choice Flexi Sigmoidoscopy, 1pt 1.9%, patient choice MRI, 2pts 0.6% - equipment failure and a patient requiring next available slot for special examination Non Obs Ultrasound 41pts 4.4% - muscular-skeletal scans requiring next available appointment. Musculo-skeletal scans continue to be outsourced to Renacres hospital. PDS locum sonographers still in place for October. Ongoing two evening Radiologist sessions per week and ongoing Sonographer evening sessions in place. Urodynamics (treatment centre, Urology) – 6pts – reduced activity due to leave Video Urodynamics (Urol) 1pt Consultant activity - specialist service, no capacity issues going forward 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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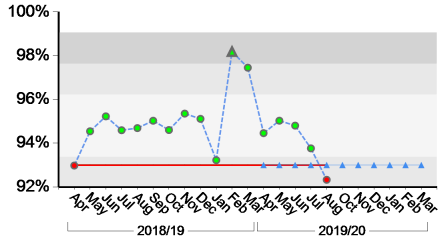
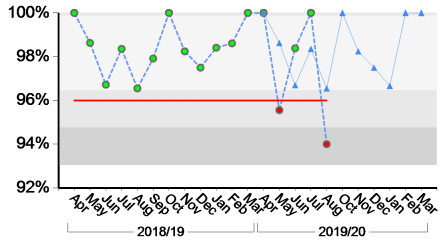
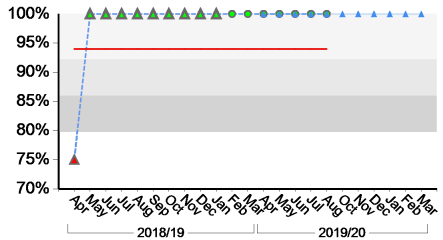
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher.	Trust closed just below standard - Continuing high numbers of referrals combined with high levels of patient holidays resulted in the Trust just missing the compliance level for this target in August. it is anticipated that this will be resolved in September.	
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 missed at 94% - Non-compliance caused by 3 breaches in colorectal. These were all due to lack of theatre capacity.	
31 day treatment (Surgery)	Percentage of patients receiving first definitive surgical treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Compliance of 100% maintained - The Trust continues to maintain it's compliance against this standard at 100%	

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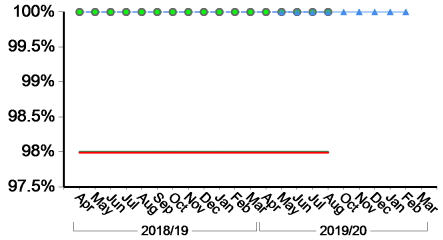
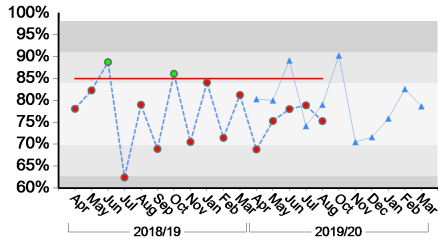
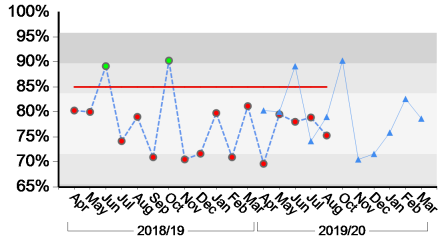
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
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	
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 11 breaches in the month of August. These were; 3 full Haematology,3 full lung, 1 full skin, 1 full and 1 half urology, 2 full upper GI and 1 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.	The Trust still endeavouring to meet the 62 day target - the Cancer Action programme is well underway to ensure changes are put in place to establish timed pathway of 7 day steps	

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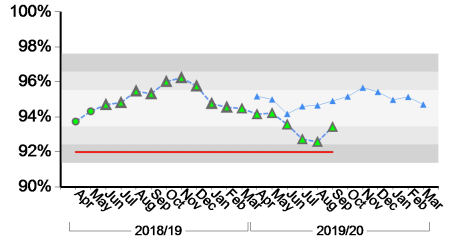
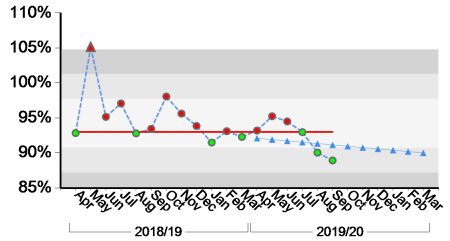
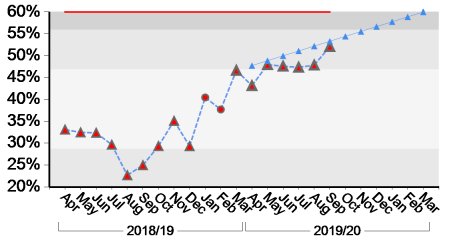
NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher.	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%.	September saw a reduction in occupancy for Southport site for the third month in a row - target level was achieved at 88.92% - 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	
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site, based on open beds. A higher percentage is good. Threshold is 60%.	Occupancy has increased in month to 52.09% and is alalmost in line with trajectory - 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	

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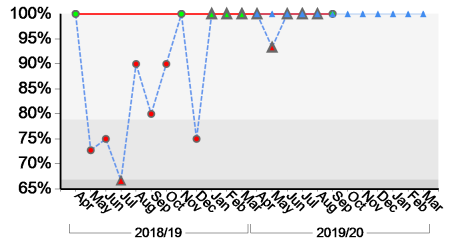
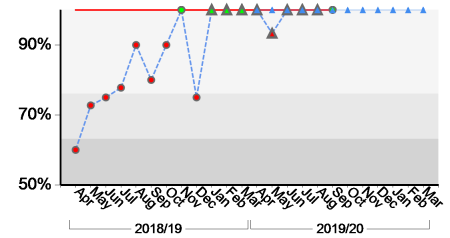
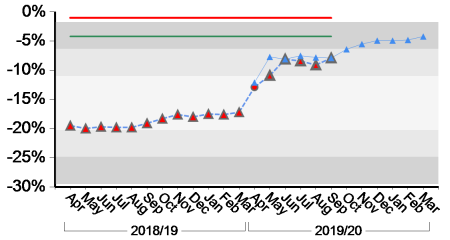
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	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.	Performance improving and target achieved - The target is an I&E margin of -7.9% and the Trust has achieved this. In order to maintain this the Trust needs to get a tight grip on expenditure and deliver on its Cost Improvement Programme.	

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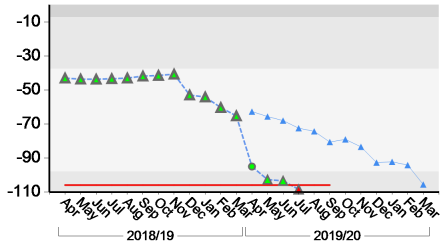
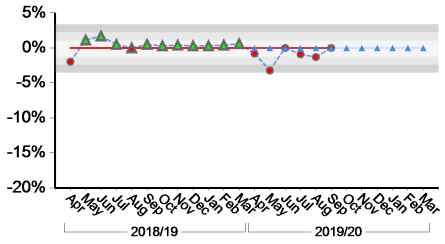
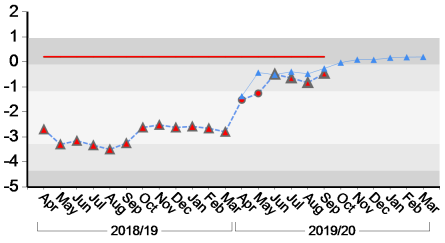
NHS
Southport and Ormskirk Hospital
NHS Trust

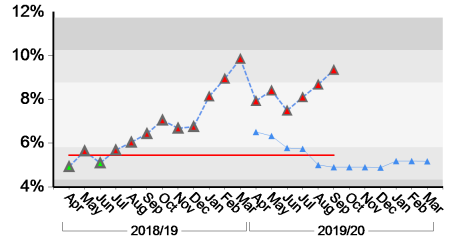
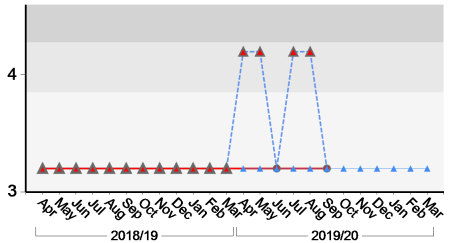
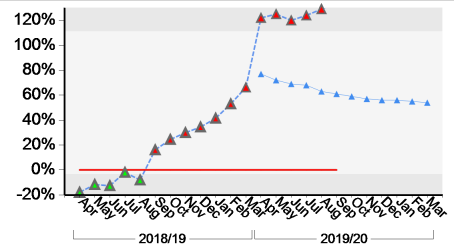
Well-Led

Indicator Name	Description	Narrative	Month Trend
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Downward trend continues - The downward trend will only increase as loans due within 12 months are being reclassified as current. This significantly affects the calculation of the metric and this can be seen in the monthly step changes.	
Distance from Control Total	Distance from Control Total.	Performance improving and target achieved - The Trust has achieved its plan for Quarter 2 and will qualify for non-recurrent monies - PSF (Provider Sustainability Fund) and FRF (Financial Recovery Fund) of £3.653 million. Working with the system the Trust was able to build in further income over-performance. On the expenditure side the Trust reviewed spend relating to previous financial years and has re-profiled accruals into Quarters 3 & 4. However, it should be noted that the underlying problems are still there with agency spend consistently at circa £1 million per month.	
Capital Service Capacity	The level of debt the Trust is required to service. This indicator is 1 of 5 used to derive the 'Use of Resources (Finance)' score.	Performance improving - In month improvement which is directly related to achieving financial targets for Quarter 2. 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.	

Board Report - September 2019

NHS Southport and Ormskirk Hospital NHS Trust

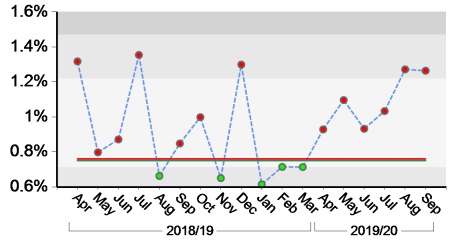
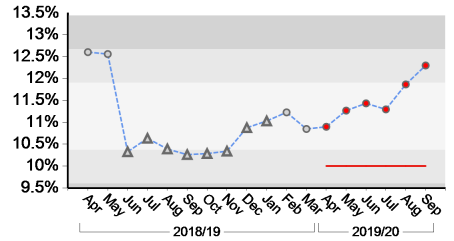
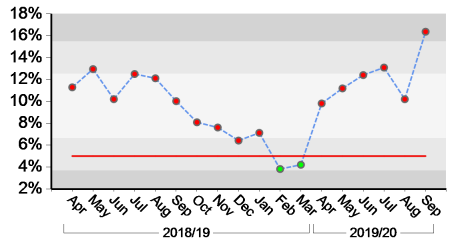
Well-Led

Indicator Name	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	Agency costs remain high as a percentage of staff costs - In absolute terms agency spend is slightly up on last month (£1.05m against £1.024m last month). However total pay spend is lower this month due to a review of accruals and therefore with a lower denominator the percentage has risen. 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 - Overall score has reduced from a 4 last month to 3 this month. The main change has been on the distance from plan metric which is now a 1 (last month 3) as the Trust has achieved its plan at the end of September. All the other metrics remain at 4- Capital service cover, Liquidity, I&E margin and agency rating.	
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.	

Board Report - September 2019

NHS Southport and Ormskirk Hospital NHS Trust

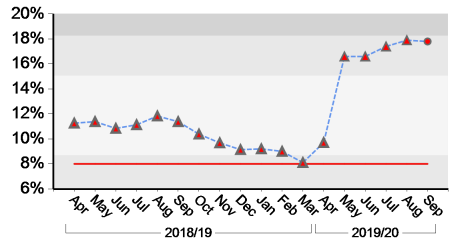
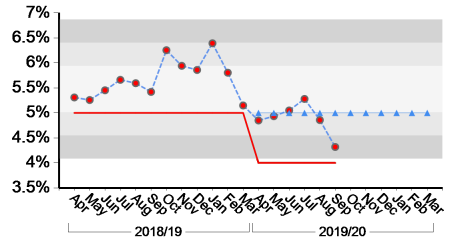
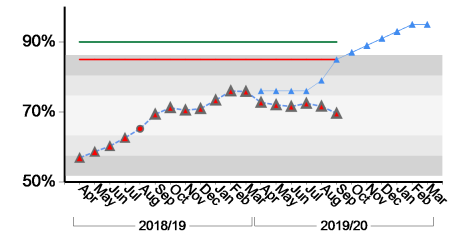
Well-Led

Indicator Name	Description	Narrative	Month Trend
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month.	Staff turnover over target - September saw a turnover of 1.26% - The number of leavers remained the same as August 38 leavers. 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 September at 12.3% compared to 11.87% in August. - There was an increase in month with 38 leavers in August and September 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 Group. Medical establishment control implementation - Process to be implemented to identify recruitment areas	

Board Report - September 2019

NHS Southport and Ormskirk Hospital NHS Trust

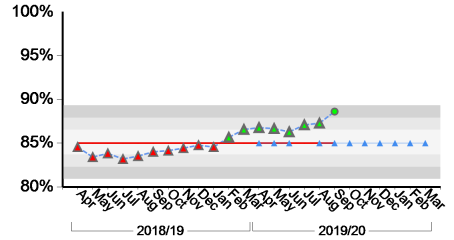
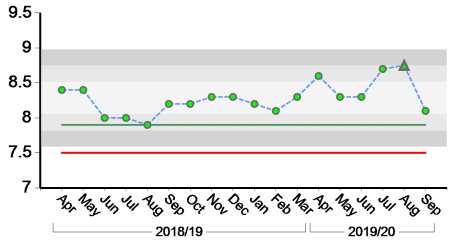
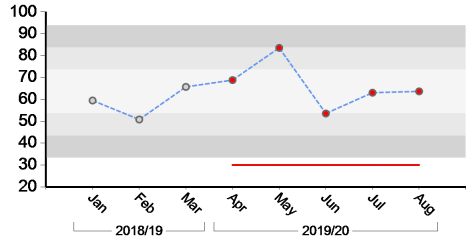
Well-Led

Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Reflective of trust investment to nursing establishments and attrition in month - 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. Overseas recruitment to RN posts is currently being scoped	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 4%. Lower is better.	Septembers 2019's sickness absence rate has improved again 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 which has been sustained for 9 months: 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% Aug-19 – 5.54% Sept-19 – 5.35% 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 is underway 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 again to 69.58% in September. - Data audit identified that PDR's are taking place but that the dates are not being successfully recorded on ESR.Support is ongoing in continuing the data cleanse and educating on process.	

Board Report - September 2019

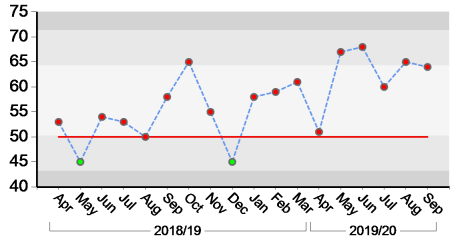
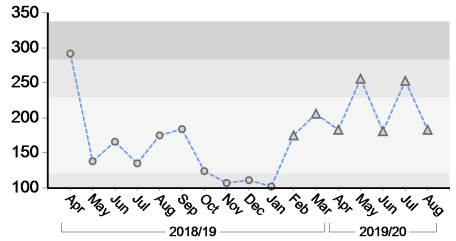
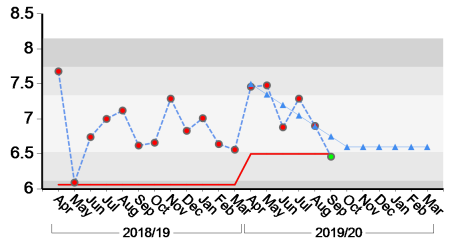
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Core mandatory training remains above the Trust's 85% at 88.61% - The Trust reports on all core mandatory training subjects as per the National Core Skills Framework. Trust local requirements - local fire safety and hand hygiene training - were transferred to a new role specific training report for Sept 2019 which has impacted on the % rise in overall compliance. This new report will continue to increase as TNA's are completed for role specific training courses for reporting & monitoring purposes	
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 - The overall CHpPD for the Trust has decreased in month to 8.13 hours and remains slightly above the national average of 7 hours CHpPD, Planned care clinical business unit (CBU) report overall 11 Urgent Care CBU 6.6 and Women's and Children's 10.1 overall.	
Time to Recruit	The number of working days from Advert Close to Start Date. Please note that candidates requiring a Visa are included.	Perfomance deteriorated in month. This was predicted thorugh the recruitment of pipeline candidates inflating the time to hire measure. - There is a detailed action plan in place to improve on time to hire which is managed through the Workforce Improvement Group.	

NHS
Southport and Ormskirk Hospital
NHS Trust

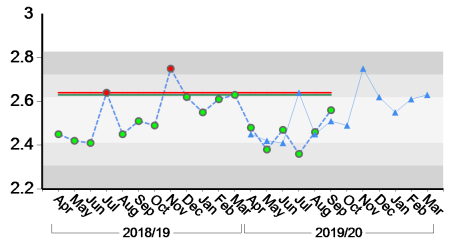
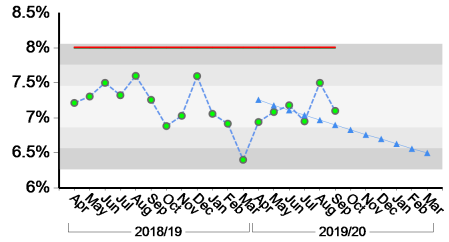
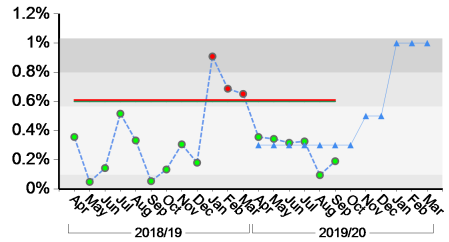
Efficiency

Indicator Name	Description	Narrative	Month Trend
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	Average Number of Daily Beds Lost In Month.Taken from A Daily Snapshot Of Patients Medically Fit For Discharge. Lower is better.	no significant change in MOFD - Although there was an decrease 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 and is now showing an improvement from last years monthly data. 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. new weekly DTOC meeting commenced to formalise reports	
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). These patients will have been Medically Optimised for Discharge (MOFD) and the delay confirmed by the local authority.	The number of beds lost in August returned to below 200 in alignment to June's figues - Continued work with partners from Community and LA supporting discharges through daily huddle and weekly long stay review. introduction in October of formal DTOC meetings with both LA to agree delays	
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.	continued reduction in LoS - 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	

Board Report - September 2019

Southport and Ormskirk Hospital NHS Trust

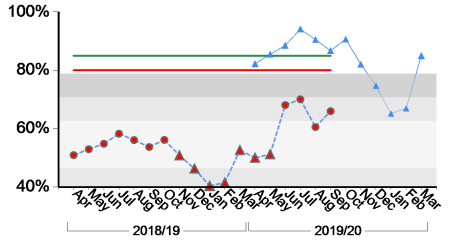
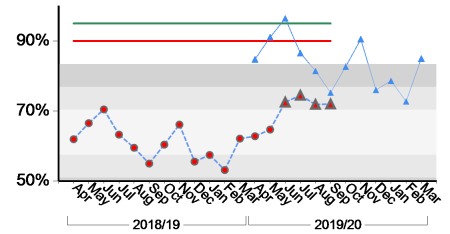
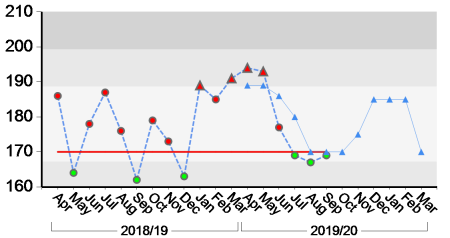
Efficiency

Indicator Name	Description	Narrative	Month Trend
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	The Trust continues to 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 sixth month in a row - returning back to performance within the normal range for the trust at 0.19% - 4 elective operations out of 2107 were cancelled at short notice in August	

Board Report - September 2019

NHS Southport and Ormskirk Hospital NHS Trust

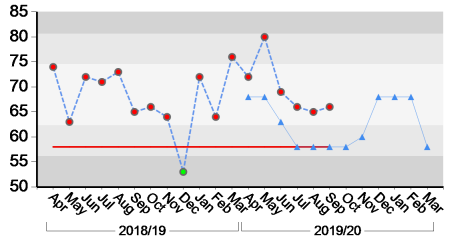
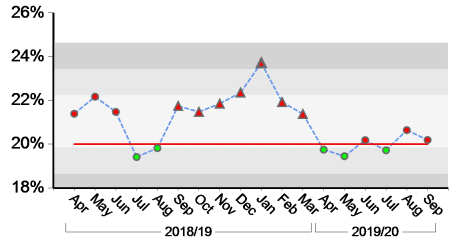
Efficiency

Indicator Name	Description	Narrative	Month Trend
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	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	
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.	Performance maintained - 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 was completed 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	

Board Report - September 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Super Stranded Patients (>20 Days LOS)	Patients who spend 21 days or more as an inpatient.	There was a slight increase in month for superstranded to 66 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 20.19% - 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

6 November 2019

Agenda Item	**TB188/19**	**Report Title**	**Director of Finance Report – Month 6 2019/20**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Note ☐ To Assure ☑ To Receive ☐ For Information		

Executive Summary

This report contains the month 6 performance against the plan submitted to NHSI on 4th April 2019.

The month 6 YTD position before Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) is a deficit of £13.957 million which is £14,000 better than plan. By delivering the Quarter 2 plan the Trust has secured £3.654 million of PSF/FRF in Quarter 2. This takes the total PSF/FRF secured to date to £6.395 million.

The in-month position before PSF/FRF is a deficit of £1.506 million, £1.013 million better than plan.

The Trust's total income plan is on schedule to be achieved. Contracts have been signed except for NHS West Lancashire CCG; impact of the arbitration decision is being finalised in order to be able to sign a contract for 2019/20. The impact on the Trust is a reduction in income of £0.4 million to £0.6 million.

The 2019/20 CIP programme is £996,000 behind plan at month 6; the forecast outturn is down £200,000 to £4.6 million leaving an unidentified gap of £1.7 million.

Expenditure levels in month 6 are again consistent with previous months and remain too high to achieve the year end control total. There are no further mitigations available and, therefore, the Trust is at risk of not achieving its 2019/20 control total if expenditure levels cannot be reduced.

The Trust currently has an unmitigated risk of £5.0 million to the delivering its control total.

A number of business cases have been implemented recently in 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 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 note the Director of Finance Report – Month 6 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 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

Director of Finance Report – Month 6 2019/20

1. Purpose

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

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

1.3. This report provides the Board with the financial position for Month 6 (September 2019) and the progress on delivery of the Trusts control total against the plan submitted to NHSI on 4th April 2019.

2. Executive Summary

2.1. The month 6 YTD position before Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) is a deficit of £13.957 million which is £14,000 better than plan.

2.2. By delivering the Quarter 2 plan the Trust has secured £3.654 million of PSF/FRF in Quarter 2

2.3. This takes the total PSF/FRF secured to date to £6.395 million.

2.4. The in-month position before PSF/FRF is a deficit of £1.506 million, £1.013 million better than plan

2.5. The Quarter 2 plan was achieved following the application of a number of adjustments as follows:

- Prior year income and expenditure issues re-profiled into Quarter 4
- Balance sheet items
- A reassessment of commissioning income performance

2.6. Despite the achievement of Quarter 2 the Trust is forecasting to miss the financial plan by £5.0 million if expenditure cannot be reduced below current levels.

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

2.8. The Trust's total income plan is on schedule to be achieved.

2.9. The income budget is performing well apart from elective activity which continues to under perform.

2.10. Expenditure levels in month 6 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.

2.11. The 2019/20 CIP programme is £996,000 behind plan at month 6; the forecast outturn is £4.6 million (a reduction of £0.2 million from month 5) leaving an unidentified gap of £1.7 million.

2.12. 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.

2.13. The table below is the Income & Expenditure statement for month 6:

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	165,449	82,876	82,929	52	13,559	13,890	331
PP, Overseas & RTA	1,093	549	401	(148)	91	67	(24)
Other Income	12,113	6,241	6,635	394	1,052	1,201	149
PSF & FRF	18,271	6,395	6,395	0	1,218	1,218	0
Total Operating Income	**196,926**	**96,061**	**96,360**	298	**15,920**	**16,376**	456
PAY	(139,981)	(70,663)	(70,584)	79	(11,723)	(11,235)	488
NON PAY	(53,126)	(26,902)	(27,258)	(356)	(4,480)	(4,443)	37
Total Operating Expenditure	**(193,107)**	**(97,565)**	**(97,842)**	**(277)**	**(16,203)**	**(15,678)**	**525**
EBITDA	**3,820**	**(1,503)**	**(1,482)**	**21**	**(283)**	**698**	**981**
Net Financing Costs	(12,149)	(6,090)	(6,114)	(24)	(1,004)	(999)	5
Retained Surplus/Deficit	**(8,329)**	**(7,593)**	**(7,595)**	**(3)**	**(1,287)**	**(301)**	**986**
Technical Adjustments	33	17	34	17	(14)	13	27
Break Even Surplus/(Deficit)	**(8,296)**	**(7,575)**	**(7,562)**	**14**	**(1,301)**	**(288)**	**1,013**
Less PSF/FRF Funding	(18,271)	(6,395)	(6,395)	0	(1,218)	(1,218)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(13,970)**	**(13,957)**	**14**	**(2,519)**	**(1,506)**	**1,013**

2.14. The YTD deficit in the above table (£13.957 million) equates to a monthly average of £2.3 million.

2.15. As there are a number of non recurrent items that have been actioned in Quarters 1 and 2 it is estimated that the current underlying deficit is in the region of £2.7 million per month excluding PSF/FRF.

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

3. 2019/20 Contract Position

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

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

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

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

- £51.0 million for West Lancashire CCG; based on month 6 activity performance this may be underachieved by up to £0.5 million.

- £74.9 million for Southport & Formby CCG; the Trust is currently underperforming against the conditional elements of the contract but the contract is expected to overachieve (see section 4.6 below).

4. **Income**

4.1. Trust activity and income performance at month 6 YTD is as follows:

- Elective – activity is 3.1% below plan; £494,000 loss of income.
- A&E – activity 9% above plan; £485,000 of additional income.
- Non Elective – activity is 5% below plan; £2,037,000 additional income due to case mix (see 4.2).
- Outpatients – activity is 5.4% above plan; £678,000 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. Elective activity performance is forecast to improve once the contract with HBS is agreed and work commences.

4.5. Progress is now being made against the Best Practice Tariffs target within the plan.

4.6. The Trust's commissioning income in the month 6 YTD position assumes the following:

- Southport & Formby CCG will achieve the contract at the year end (full year contract value is £74.9 million).
- All other commissioning income is in line with the agreed contract.

5. Expenditure

5.1. Expenditure levels in month 6 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.

5.3. No reductions were applied in months 4 and 5 but in month 6 a number of further adjustments (mostly non-recurrent) have been made which have contributed to the achievement of the Quarter 2 control total.

6. Bank/agency spend

6.1. Monthly agency spend has increased again in September to £1,050,000 (9.3% of the pay bill); Medical staff £575,000; Nursing £370,000.

6.2. Month 6 YTD agency spend is £5.869 million (8.3% of the pay bill); Medical staff £3.206 million; Nursing £2.161 million.

6.3. The Trust has breached the NHSI agency target cap of £4.891 million; the Trust's Operational Plan highlighted that the cap could not be achieved.

6.4. Total Bank spend is consistent with previous months; September is £936,000 (8.3% of the total pay bill) bringing YTD spend to £5.590 million (7.9% of the total pay bill).

6.5. The Trust spent almost £2.0 million in September on bank and agency staff which is consistent with August.

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 6 Budget £000	Month 6 Actual £000	Month 6 Var £000	YTD Budget £000	YTD Actual £000	YTD Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	356	119	(237)	1,739	841	(898)	1,309	954
19/20 Plan - Expenditure (non pay)	1,724	1,724	164	75	(89)	750	654	(96)	1,136	973
19/20 Plan - Income (other op income)	325	325	39	32	(7)	88	217	129	337	65
19/20 Plan - Income (BPT)	1,800	300	26		(26)	131		(131)	0	0
19/20 Plan - Total	**6,314**	**6,314**	**585**	**226**	**(359)**	**2,708**	**1,712**	**(996)**	**2,782**	**1,992**

7.4. The forecast outturn against the £6.3 million target has reduced to £4.6 million leaving an unidentified gap of £1.7 million (see separate agenda item).

8. Forecast Outturn

8.1. The Trust's current expenditure levels, together with assumptions on CIP delivery and future impact of agreed business cases, derive a predicted £5.0 million overspend against the plan. This was included in the System Recovery plan submitted to NHSI/E on 18th October 2019.

8.2. Despite the achievement of the Quarter 2, there is a possibility that the Trust will not achieve the Quarter 3 deficit plan without further financial improvement.

8.3. If the Quarter 3 plan was not achieved the Trust would not receive PSF/FRF for that quarter (£5.481 million).

9. Cash

9.1. Cash balances remain high at £7.2 million (£7.0 million previous month) as the Trust received support from the CCGs in August. In addition, due to the achievement of the Quarter 1 plan, the Trust received PSF and FRF of £2.741 million in September.

9.2. The Trust has performed below the cash plan in September 2019 although this could be absorbed.

9.3. The PSF/FRF funding has been repaid in October 2019 as the Trust had already borrowed monies from the Department of Health & Social Care on the strength of achieving its Quarter 1 target.

9.4. Loans will be required from November 2019 onwards.

9.5. The Trust is not achieving the Better Payment Practice Code (BPPC). However, the main constraint is the availability of cash plus the current corporate governance arrangements which adds delay into the system. The achievement of the e-invoicing target (70% of all invoices submitted electronically) is expected to improve performance against this metric.

10. Debtors

10.1. Debt levels have increased from £3.0 million at the end of August 2019 to £3.8 million at the end of September 2019. The rise is due to recent sales invoicing.

10.2. Progress has been made in reducing debt that is more than 90 days overdue (reduced from £1.853 million last month to £1.467 million).

10.3. The over 90 day debt is split NHS £1.103 million and non NHS £0.364 million.

10.4. Progress has been made in reducing the non NHS debt above 90 days. NHS debt is more difficult to address as the support of external debt collection agencies is not utilised in these instances.

10.5. There is a robust SBS debt management policy in place and the Trust has a partnership approach by providing local knowledge to assist SBS in the pursuit of debt.

11. Capital

11.1. Actual capital expenditure remains low, however, when commitments are included then the Trust is at 46.1% of the plan at the end of September.

11.2. The low spend is more a reflection of an optimistic plan that schemes such as the ward upgrades and library extension would have progressed further by this point in the year.

11.3. Southport ward upgrade project has started with completion of first 6 wards before Christmas.

11.4. Potential cost pressures are emerging on a number of schemes. These will be reviewed at Capital Investment Group and FP&I Committee will be alerted to any issues via the AAA report. The Board will be informed of any changes in line with the appropriate governance.

11.5. There's an opportunity for the Trust to receive national funding towards the cost of implementing an electronic prescribing and medicines administration **(**EPMA**)** system (circa. £0.700m).

12. **Recommendations**

12.1. The Board is asked to receive the Director of Finance Report – Month 6 2019/20.

List of Appendices

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

1. Activity run rate by month

	2018/19							2019/20					
	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
AandE	6,918	7,309	7,328	6,896	7,269	6,756	7,595	7,176	7,446	7,162	7,783	7,224	7,162
Day Case	1,616	1,906	1,984	1,444	1,878	1,731	1,854	1,707	1,706	1,605	1,815	1,802	1,837
Elective	179	212	189	138	180	175	179	144	187	183	177	175	153
Non Elective (Including Short Stay)	2,482	2,654	2,679	2,644	2,741	2,480	2,646	2,368	2,505	2,340	2,662	2,704	2,560
Non Elective Non Emergency	273	239	233	285	241	254	262	75	78	60	76	62	69
Outpatients (Including Procedures)	14,307	16,515	15,871	12,855	14,926	14,462	15,302	15,075	15,615	14,366	16,778	14,032	15,010

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

I&E (Including R&D)	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
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Less PSF/FRF Funding	(18,271)	(6,395)	(6,395)	0	(1,218)	(1,218)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(13,970)**	**(13,957)**	**14**	**(2,519)**	**(1,506)**	**1,013**

3. Expenditure run rate by month

RUN RATE Month on Month - £(000)
As at 30th September 2019

NHS Southport and Ormskirk Hospital NHS Trust

Class	STAFF GROUP	STAFF TYPE	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
PAY	Consultants	Substantive	(1,346)	(1,319)	(1,299)	(1,319)	(1,395)	(1,324)	(1,118)	(1,238)	(1,239)	(1,234)	(1,321)	(1,235)	(1,396)
		Bank	(70)	(50)	(40)	(70)	(101)	(78)	(104)	(98)	(70)	(65)	(112)	(65)	(75)
		Agency	(109)	(110)	(154)	(187)	(179)	(206)	(272)	(279)	(279)	(201)	(275)	(266)	(341)
	Consultants Total		(1,525)	(1,479)	(1,494)	(1,577)	(1,675)	(1,608)	(1,494)	(1,615)	(1,587)	(1,500)	(1,708)	(1,566)	(1,812)
	Other Medical	Substantive	(1,165)	(1,243)	(1,202)	(1,263)	(1,319)	(1,307)	(1,256)	(1,337)	(1,305)	(1,327)	(1,297)	(1,313)	(1,431)
		Bank	(129)	(129)	(163)	(142)	(137)	(115)	(167)	(165)	(167)	(195)	(155)	(174)	(171)
		Agency	(240)	(226)	(217)	(208)	(244)	(273)	(316)	(256)	(257)	(277)	(288)	(255)	(235)
	Other Medical Total		(1,534)	(1,597)	(1,581)	(1,612)	(1,699)	(1,695)	(1,739)	(1,758)	(1,730)	(1,799)	(1,740)	(1,742)	(1,837)
	Nurses & Midwives	Substantive	(3,600)	(3,628)	(3,604)	(3,571)	(3,704)	(3,672)	(3,388)	(3,954)	(3,818)	(3,797)	(3,745)	(3,722)	(3,771)
		Bank	(544)	(529)	(565)	(543)	(595)	(588)	(684)	(609)	(637)	(645)	(632)	(671)	(656)
		Agency	(291)	(367)	(294)	(262)	(427)	(415)	(436)	(372)	(397)	(319)	(303)	(400)	(370)
	Nurses & Midwives Total		(4,435)	(4,524)	(4,463)	(4,375)	(4,726)	(4,675)	(4,508)	(4,935)	(4,852)	(4,761)	(4,680)	(4,793)	(4,796)
	Scientific, Technical & Theraputic	Substantive	(1,320)	(1,331)	(1,330)	(1,307)	(1,320)	(1,319)	(1,260)	(1,437)	(1,349)	(1,329)	(1,323)	(1,348)	(1,372)
		Bank	(12)	(11)	(13)	(12)	(9)	(12)	(12)	(7)	(7)	(7)	(8)	(6)	(5)
		Agency	(17)	(16)	(20)	(15)	(12)	(8)	(14)	(4)	(8)	(20)	(35)	(26)	(72)
	Scientific, Technical & Theraputic Total		(1,349)	(1,358)	(1,363)	(1,334)	(1,341)	(1,339)	(1,286)	(1,448)	(1,364)	(1,355)	(1,366)	(1,380)	(1,449)
	Other Staff	Substantive	(1,989)	(2,010)	(2,040)	(1,981)	(1,965)	(2,008)	(1,731)	(2,284)	(2,156)	(2,147)	(2,090)	(2,115)	(2,150)
		Bank	(24)	(31)	(7)	(28)	(27)	(19)	(34)	(38)	(17)	(27)	(34)	(40)	(28)
		Agency	(48)	(63)	(51)	(58)	(59)	(50)	(54)	(59)	(54)	(48)	(64)	(78)	(34)
	Other Staff Total		(2,060)	(2,105)	(2,098)	(2,067)	(2,051)	(2,077)	(1,818)	(2,381)	(2,227)	(2,223)	(2,188)	(2,232)	(2,213)
	Pay Reserves	Substantive	0	0	35	184	232	798	(176)	(57)	(56)	149	(191)	(54)	914
	Pay Reserves Total		0	0	35	184	232	798	(176)	(57)	(56)	149	(191)	(54)	914
	Pay CIP	Substantive	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pay CIP Total		0	0	0	0	0	0	0	0	0	0	0	0	0
	Apprenticeship Levy	Substantive	(38)	(39)	(44)	(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)
	Apprenticeship Levy Total		(38)	(39)	(44)	(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)
PAY Total			(10,941)	(11,102)	(11,008)	(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)
NON-PAY	Supplies & Services Clinical		(2,260)	(2,317)	(2,290)	(2,228)	(2,249)	(2,227)	(2,413)	(2,263)	(2,325)	(2,259)	(2,420)	(2,264)	(2,227)
	Supplies & Services General		(222)	(204)	(214)	(200)	(203)	(199)	(212)	(186)	(172)	(173)	(164)	(189)	(219)
	Non-Executive Directors									(6)	(6)	(6)	(8)	(4)	(6)
	Establishment Expenses		(291)	(288)	(352)	(295)	(298)	(292)	(268)	(191)	(226)	(232)	(221)	(245)	(242)
	Premises & Fixed Plant		(936)	(990)	(943)	(993)	(953)	(917)	(775)	(1,018)	(1,035)	(991)	(985)	(1,055)	(948)
	Miscellaneous		(625)	(616)	(632)	(659)	(638)	(654)	(595)	(717)	(720)	(716)	(735)	(717)	(666)
	Services From Other NHS Bodies		(269)	(279)	(293)	(209)	(287)	(253)	(328)	(103)	(61)	(69)	(145)	(188)	(136)
	Non Pay Reserve		0	0	0	0	0	0	0	(7)	7	0	0	0	0
	Non Pay CIP		0	0	0	0	0	0	0	0	0	0	0	0	0
NON-PAY Total			(4,603)	(4,695)	(4,725)	(4,583)	(4,628)	(4,543)	(4,590)	(4,491)	(4,538)	(4,446)	(4,678)	(4,662)	(4,443)
NON-OPERATING EXPENDITURE			(959)	(920)	(939)	(942)	(939)	(940)	(479)	(1,031)	(1,023)	(1,037)	(1,006)	(1,042)	(1,016)
Grand Total			**(16,503)**	**(16,717)**	**(16,672)**	**(16,346)**	**(16,868)**	**(16,119)**	**(16,137)**	**(17,761)**	**(17,418)**	**(17,009)**	**(17,608)**	**(17,506)**	**(16,694)**

PAY SUMMARY BY STAFF TYPE

PAY	Substantive	(9,457)	(9,570)	(9,485)	(9,296)	(9,511)	(8,871)	(8,975)	(10,351)	(9,964)	(9,723)	(10,016)	(9,822)	(9,248)
	Bank	(779)	(749)	(788)	(795)	(869)	(813)	(1,001)	(918)	(898)	(940)	(942)	(956)	(936)
	Agency	(704)	(782)	(735)	(730)	(920)	(952)	(1,092)	(970)	(995)	(864)	(966)	(1,024)	(1,050)
PAY Total		(10,941)	(11,102)	(11,008)	(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)

4. Statement of Financial Position (Balance Sheet)

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	30/09/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	121,125	(1,942)	(93)
Other assets	966	1,568	602	321
TOTAL NON CURRENT ASSETS	**124,033**	**122,693**	**(1,340)**	**228**
CURRENT ASSETS				
Inventories	2,382	2,210	(172)	(128)
Trade and other receivables	11,678	11,135	(543)	(1,332)
Cash and cash equivalents	1,042	7,219	6,177	210
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**20,564**	**5,462**	**(1,250)**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(20,427)	2,344	711
Provisions	(199)	(212)	(13)	14
PFI/Finance lease liabilities	(1,153)	(1,153)	0	(930)
DH revenue loans	(20,487)	(53,545)	(33,058)	(2,532)
DH Capital loan	(411)	(400)	11	0
Other liabilities	(1,025)	(7,683)	(6,658)	966
TOTAL CURRENT LIABILITIES	**(46,046)**	**(83,420)**	**(37,374)**	**(1,771)**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(62,856)	(31,912)	**(3,021)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**59,837**	**(33,252)**	**(2,793)**
NON CURRENT LIABILITIES				
Provisions	(207)	(180)	27	0
DH revenue loans	(82,953)	(57,769)	25,184	2,532
PFI/Finance lease liabilities	(13,831)	(13,583)	248	(40)
DH Capital loan	(1,000)	(800)	200	0
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(72,332)**	**25,659**	**2,492**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(12,495)**	**(7,593)**	**(301)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,214	0	0
Retained earnings	(112,432)	(120,025)	(7,593)	(301)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(12,495)**	**(7,593)**	**(301)**

In month material movements are as follows:

Trade and other receivables have reduced by £1.332 million. Last month there were high balances for Queenscourt and St Helens & Knowsley. Sales invoices were raised in September for these recharges totalling just over £700k. In addition the split of RTA debt has been reviewed with a £300k reduction in current debt.

Finance leases were incorrectly included in other liabilities in last month's balance sheet. This has now been corrected and explains these movements.

DH revenue loans - there is a transfer of £2.532 million as an existing loan has been re-classified as current.

5. Capital

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M6 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0090	1,000	75	184	(109)	179	288	1,000	651	349
	Pharmacy Robots	G0060									
	Sub total MEDICAL DEVICES		**1,000**	**75**	**184**	**(109)**	**179**	**288**	**1,000**	**651**	**349**
IM&T	Electronic Patient Record Bluespier	G0100	111	111		111			111		111
	Electronic Patient Record PDS	G0101	69	35		35			69		69
	Electronic Patient Record Careflow	G0102	149	75		75		277	149	277	(128)
	Vitalpac	G0007	10		19	(19)		6	10	25	(15)
	Patient Service Signposting	G0103	184	92	106	(14)			184	106	78
	eDMS Evolve	F6447	80	40	43	(3)			80	43	37
	Windows 10 Project	G0104	318	159	438	(279)		35	318	473	(155)
	Telephony System Replacement	G0059	50						50		50
	Baby Tagging	G0105	50	50		50		48	50	48	2
	Cyber Security	G0071	80	40	22	18			80	22	58
	Fixed Network Infrastructure	F6498	120	60	9	51	0	34	120	43	77
	PAS Replacement	F6409			6	(6)		1		7	(7)
	Data Storage Infrastructure	G0106	25						25		25
	Wireless Network Upgrade	G0073			2	(2)				2	(2)
	IM&T Contingency	G0107	450	115	30	85		61	450	91	359
	Sub total IM&T		**1,696**	**777**	**675**	**102**	**0**	**462**	**1,696**	**1,137**	**559**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	350	200		200			350		350
	6 Facet Survey	G0150	90	90	48	42	10		90	58	32
	Nurse Call System	G0151	100		3	(3)		12	100	15	85
	Upgrade Ventilation Plants	G0152	100						100		100
	Fire compartmentation	G0052	100						100		100
	Fire Precautions - Fire Doors	G0019	100						100		100
	Legionella Prevention	G0153	50	25		25			50		50
	Spinal Lift & Ramp	G0154	85						85		85
	Spinal isolation works	G0099	150	150	213	(63)	0	16	150	229	(79)
	SDGH Ward Upgrades	G0155	600	600	131	469		9	600	140	460
	Library Extension	G0156	145	145		145			145		145

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M5 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
ESTATES	Capital Team	F6305	160	66	67	(1)			160	67	93
	CCTV	G0157	50	50		50			50		50
	UPS Theatre	G0053			15	(15)				15	(15)
	Southport A&E	G0068			13	(13)				13	(13)
	Sexual Health Accomodation	G0079			(1)	1				(1)	1
	Car Parking Scheme										
	Waste Management	G0080									
	EBME Lift										
	Endoscopy both sites										
	Spinal Ward Bathrooms	G0158						69		69	(69)
	HR Move - Further Alterations to LRC	F6301			11	(11)				11	(11)
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,080**	**1,126**	**280**	**846**	**8**	**95**	**2,080**	**383**	**1,697**
FACILITIES	Catering equipment	G0026	75	50	18	32			75	18	57
	Vehicle Replacement	G0145	50						50		50
	Sub total FACILITIES		**125**	**50**	**18**	**32**			**125**	**18**	**107**
	CONTINGENCY	**F6301**	**202**	**62**	**(4)**	**66**	**1**	**4**	**202**	**0**	**202**
	Capital plan excluding donations and IFRIC 12		**5,103**	**1,864**	**1,041**	**823**	**43**	**663**	**5,103**	**1,747**	**3,356**
OTHER	Donated assets	000000	100	25	41	(16)			100	41	59
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,214	544		544			1,214		1,214
	Sub total Donations and IFRIC 12		**1,314**	**569**	**41**	**528**			**1,314**	**41**	**1,273**
	TOTAL CAPITAL SPEND		**6,417**	**2,433**	**1,082**	**1,351**	**43**	**663**	**6,417**	**1,788**	**4,629**

SUMMARY % SPEND (excl. donations and IFRIC 12)	%
ACTUAL SPEND AGAINST YTD PLAN	55.8%
SPEND AGAINST 19/20 PLAN	20.4%
SPEND AGAINST REVISED 19/20 PLAN	20.4%
SPEND AGAINST 19/20 PLAN INCL. COMMITMENTS	34.2%
SPEND v. REVISED 19/20 PLAN INCL. COMMITMENTS	34.2%

6. Cashflow Forecast – 2019/20

	Actual Apr-19 £'000s	Actual May-19 £'000s	Actual Jun-19 £'000s	Actual Jul-19 £'000s	Actual Aug-19 £'000s	Actual Sep-19 £'000s	Plan Oct-19 £'000s	Plan Nov-19 £'000s	Plan Dec-19 £'000s	Plan Jan-20 £'000s	Plan Feb-20 £'000s	Plan Mar-20 £'000s	Total £'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(1,593)	(1,005)	(26)	(1,093)	(1,391)	126	749	308	(263)	438	(189)	737	(3,202)
Income recognised in respect of capital donations	(9)	1	0	(34)	0	0	0	0	(33)	0	0	(25)	(100)
Depreciation and Amortisation	594	593	601	571	572	572	580	581	581	596	596	596	7,033
Impairments and Reversals	0	0	0	0									0
(Increase) in Inventories	59	(86)	200	(143)	(74)	216	(10)	(50)	8	10	(10)	0	120
(Increase) in Trade and Other Receivables	(949)	(2,096)	(1,115)	1,143	1,947	1,011	(2,454)	(2,454)	1,200	(2,758)	(2,758)	2,888	(6,395)
Increase in Trade and Other Payables	3,517	(1,123)	(1,871)	(1,887)	5,822	(512)	(488)	(3,758)	373	(1,325)	(428)	(696)	(2,376)
Increase in Provisions	1	(8)	(3)	10	0	(14)			(25)			(28)	(67)
Net Cash Inflow/(Outflow) from Operating Activities	1,620	(3,724)	(2,214)	(1,433)	6,876	1,399	(1,623)	(5,373)	1,841	(3,039)	(2,789)	3,472	(4,987)
Cash Flows from Investing Activities													
Interest Received	3	4	5	5	8	17	5	5	5	5	5	5	72
(Payments) for Intangible Assets	(57)	0	(2)	(152)	127	0	(74)	(92)	(112)	(83)	(80)	(165)	(690)
(Payments) for PPE and investment property	(190)	(117)	(186)	40	(1,144)	(325)	(475)	(391)	(570)	(381)	(291)	(1,070)	(5,100)
Receipts from disposal of fixed assets	0	0	0	0									0
Receipt of cash donations to purchase capital assets	9	(1)	0	34					33			25	100
Net Cash Inflow/(Outflow) from Investing Activities	(235)	(114)	(183)	(73)	(1,009)	(308)	(544)	(478)	(644)	(459)	(366)	(1,205)	(5,618)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0									0
Public dividend capital repaid	0	0	0	0									0
Loans received from DH	2,456	1,458	2,386	2,179	0	0		6,186	3,042	3,800	3,900	4,160	29,567
Loans repaid to DH	(200)	0	0	0	0	0	(2,941)		(3,654)			(5,481)	(12,276)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(580)		(24)		(256)	(24)	(932)
Capital element of PFI, LIFT	(16)	(15)	(118)	(16)	(15)	(119)	(15)	(16)	(118)	(16)	(15)	(119)	(598)
Interest Paid	(190)	(234)	(225)	(195)	(228)	(545)	(195)	(238)	(234)	(205)	(236)	(552)	(3,277)
Interest element of finance lease	0	0	0	0			(240)				(158)		(398)
Interest element of PFI, LIFT	(80)	(81)	(209)	(80)	(81)	(209)	(81)	(81)	(209)	(81)	(80)	(209)	(1,481)
PDC dividend (paid)/refunded	0	0	0	0									0
Net Cash Inflow/(Outflow) from Financing Activities	1,962	1,120	1,826	1,880	(332)	(881)	(4,052)	5,851	(1,197)	3,498	3,155	(2,225)	10,605
NET INCREASE/(DECREASE) IN CASH	**3,347**	**(2,718)**	**(571)**	**374**	**5,535**	**210**	**(6,219)**	**0**	**0**	**0**	**0**	**42**	**0**
Cash - Beginning of the Period	1,042	4,389	1,671	1,100	1,474	7,009	7,219	1,000	1,000	1,000	1,000	1,000	1,042
Cash - End of the Period	**4,389**	**1,671**	**1,100**	**1,474**	**7,009**	**7,219**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,042**	**1,042**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**PB189/19**	**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, no risks have been added onto the risk register.

Since the last meeting, two risks have been removed from the risk register.

- **2021** - In Hospital Mortality - This has been reduced to high (10) due to the ongoing reduction in the HSMR and SHMI figures for the Trust.
- **1977** - Paediatric Dietetics Band 6 - This risk is to be amalgamated into an overarching risk covering all fragile services in the Trust.

There are currently 7 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

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

OCTOBER 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 28/10/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-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	20↑	=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↓	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	16↓	=16	=16	=16	12↓	=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	=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↑	=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	10↓
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↑	Risk to be amalgamated into overarching Fragile Services risk
2072	SO3 - Efficiently and productively provide care within agreed financial limits	Failure to achieve 2019/20 financial control total	Director of Finance					!16	=16

TRUST RISK PROFILE AS AT 28/10/2019

	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**	**1688 - Inadequate Staffing Levels in Anaesthetic Department** **2056 – Missing Patient appointments/admissions**
Possible (3)					
Unlikely (2)					
Rare (1)					

Committee: Trust Board
Risk Register

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards						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 Clinic outcome sheets now retained and outcomed on the day Clinic outcome sheets now retained and outcomed on the day						**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 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	22/10/2019	22/11/2019
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	Delivery against the Trust overarching lost to follow up action plan						**Action Plan Due Date**	31/01/2020	**Action Plan Rating** Moderate Progress Made
Latest Month Progress	• Review of the Action Plan continues in the weekly assurance meetings. • CCG have attended all of their specified meetings. • Execs have attended one meeting. • CCG are currently satisfied with the content of the action plan and the progress to date. • Tracking tool has been produced by BI and is being used to validate. • Five patients identified as lost to follow up to date – escalated for clinical review. • Two interim trackers have commenced. Should see increasing numbers being validated. • Business Case being written specifically for tracking team only. • CBUs have highlighted priorities within their patient cohorts for prioritisation. • SOC being put together for Data Quality. • Substantive Directorate Manager has commenced in Access.								

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 Clinical 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	21/10/2019	25/11/2019

Assurance	Monthly staffing report CQC inspection Quality and safety reports Complaints Incident reporting Bi annual staffing reports mandatory training Workforce data (sickness & AL) Dedicated H roster Lead for N&M Establishment review process SOP ratified by HMB - May 2019 Monthly E roster meetings & dashboard in place E-Roster policy QI methodology in place to support E-Roster performance	**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 Ward 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 Review workforce dashboards to assure against position Table top establishment review Oct/Nov 2019 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 • Recruitment Events planned across the year to support delivery against the NER • QI programme for e-roster delivery ongoing • Workforce dashboard being reviewed to support assurance and monitoring through WIG				

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	Bridget Lees	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 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 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

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	21/10/2019	29/10/2019

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 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 Factual accuracy to be completed within agreed time scales of 10 days. work with communications team to engage widely with staff develop training for staff across the organisation Key leaders to access training with lead CQC executive/manager	Action Plan Due Date	17/07/2019 28/02/2020 29/10/2019 30/09/2019 28/06/2019 22/10/2019	Action Plan Rating	Completed Little or No Progress Made Moderate Progress Made Completed

	Establish confirm and challenge sessions for each action and core service to expedite progress against action Plan, and look at re-establishing the Quality Improvement Development (QID) Group To deliver against the 96 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.		29/11/2019		Completed Actions Almost Completed Moderate Progress Made
Latest Month Progress	Draft inspection report has been received into the Trust. This is currently being reviewed for factual accuracy.				

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire		Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**	
13/06/2019	2052	Director of Nursing & Quality	Megan Langley	Older Peoples Care	
Description	If there is continued poor quality care delivered in particular to older people in Southport & Ormskirk NHS Trust, continue then harm may be caused to our older patients impacting negatively on their quality of life, function and experience. The areas of concern relate to specific practices: •Deconditioning of patients •The inappropriate use of bed rails •Poor mouth care •Poor nutrition assessment and management •Poor hydration management •Poor continence assessment and management •Lack of interaction and social/cognitive stimulation increasing confusion and delirium • A lack of education and training specifically in caring for older people • A lack of end of life care education strategy within the Trust •Limited availability of Geriatricians to provide holistic comprehensive assessment and advanced care management plans for patients in addition to limited clinical support for the Frailty Practitioners •Inability to discharge patients home due to lack of resource to support at home particularly care and rehabilitation provisions in the community •Poorly established pathway for patients with spinal fractures •An environment not conducive to stimulating people and enabling them to maintain and maximise their function •The lack of a formally agreed frailty pathway and model			
Controls	Red2Green rolled out - Therapy developing a competency and training for staff to be equipped to chair and challenge in a consistent way sustaining te Red2Green principles at board rounds across the Trust. Nutrition - New policy approved, New E-learning module provided to RNs on ward 10B with new care plans being tested - in addition to this, additional Dietetic support is being offered to this ward while they implement the new practices. Business Intelligence are working on a new collection of KPIs to measure and monitor improvement. Mouth Care- 5 staff completed Mouth Care Matters Train the Trainer programme- currently developing new policy, care plans and product availability. Dementia & Delirium - New cognitive risk assessment and care plan being trialed on 6 wards with new patient information leaflets and reporting of FAIR nationally on a new proforma as the screening tool has been changed. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Falls - 6 wards using new risk assessment, care plan and daily checklist with new e-learning module accessible to staff for completion. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Bedrails- 6 wards trialing new risk assessment, care plan and daily check - being reviewed after 1 month (end of June) for any amendments and further roll out. (Education included in falls e-learning module) Frailty Team delivering service M-F in AED and in-reaching - continuing to work on competencies particularly around CGA completion. As part of the Red2Green, EndPJparalysis Get Up, Get Dressed, Keep Moving was introduced - this will be formally launched as a project in July as part of the Trust's QI work.		**Gaps in Controls**	Care plans not always used appropriately and not all care plans are appropriate - these are being reviewed by the documentation group Falls and bed rails new risk assessment and care plans in 6 wards being trialed - need to continue roll-out. Inability to consistently staff additional care bay Training for staff re: older people risks not currently provided - New Training Programme to be launched end of July. Environment not conducive to reabling patients and maintaining function, social interaction or orientation. Environment not wholly adapted for additional/enhanced care needs 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	21/10/2019	21/11/2019

Assurance	CQC Review	**Gaps in Assurance**	Need to develop internal assurance of improved quality around all domains listed in the hazard. Need to develop action plan and RAG rate, identify projects and leads for the improvements which have been identified. Need to commence audits of older people incidents, harm, impact of admission, causes of 'red days' and delays between being fit to leave and leaving hospital.		
Action Plan	Establish and develop staff knowledge, focus and education on patient function. Ensure appropriate equipment available, develop resource boxes specifically for patients with cognitive impairment, develop action planners for engaging and stimulating activities on the wards. Falls policy expired. Falls Education not established/provided. Falls documentation review. Falls reporting and KPIs to be reviewed. Falls strategy to be developed. Previous policy for nutrition screening did not comply with best practice or national guidance. Practices therefore did not align either. Establish Training Programme for Older Peoples Care Mouth Care provision of care - review of policy, care plan, education and care provision required. Establish a clinical pathway and practice for the assessment and management of continence for patients. This will involve writing a pathway/policy, care plans, education package and champions on the wards with a roll out plan for the new practices.	**Action Plan Due Date**	03/02/2020 29/11/2019 03/02/2020 31/12/2019 29/02/2020 31/01/2020	**Action Plan Rating**	Moderate Progress Made Actions Almost Completed Actions Almost Completed Actions Almost Completed Moderate Progress Made Moderate Progress Made
Latest Month Progress	The falls strategy draft 1 has been shared with the Falls Group for feedback and is to be approved and sent to the Nursing and midwifery Group for approval on 06/11/19 with a view to launching by the end of November. The company who provide continence products are attending a meeting in November to present the range of products with specialists attending from the community to support reviewing and if necessary changing the products we use to support the management of continence including the education, assessment, product provision, care planning and follow-up plan. A charitable fund request has been submitted for red walking frames and dementia crockery. The resource boxes will have funds bi for as soon as they are approved by IPC and the costings are confirmed. The Mouth Care Assessment and Care Plan will be rolled out on 04/11/19 with education and new products on ward 14B. After a month this will be reviewed and rolled-out further across the Trust. The post-falls assessment will be tested on 2 wards (9B and 7A) throughout November and any amendments made before rolling out Trust wide by the end of November.				

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	17/10/2019	15/11/2019
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	1 x Locum General consultant appointed for 12 months and 1 x substantive General consultant post recruited to, both due to start on 4th and 11 Nov respectively. This risk should be downgraded once all posts are recruited to.								

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	Update of the System Financial Recovery Plan submitted 18th October; System Partners and Regulator met 23rd October; NHSE/NHSI Regional Director of Finance (Northwest) has asked for the system to rapidly develop additional recurrent and non-recurrent actions to reduce the £29.5m system gap; Trust to deliver its control total for 2019/20 and for Commissioners to push on further and more substantial savings opportunities using the national efficiency opportunity models available to you. Commissioners should also continue to ensure operational budgets remain in line with plan and seek further savings where possible during the remaining months of the financial year. System to deliver by Friday 1st November a jointly agreed FRP improvement plan which describes the areas the system will be targeting and the associated key delivery milestones. This plan must present a material improvement from the £29.5m adverse gap to control total currently forecast with								

	month on month financial profile of the plan demonstrating a much-improved exit financial run rate moving into 2020/21. System to provide by 8 November a strategic financial plan that bridges the gap to 2020/21 and sets out how the system will deliver the notified financial trajectories

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 Latest System Recovery Plan (18.10.19) shows a £5.0 million unmitigated risk for the Trust against its deficit control total of £26.567m (before PSF and FRF)	

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	21/10/2019	18/11/2019

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	Update of the System Financial Recovery Plan submitted 18th October; System Partners and Regulator met 23rd October; NHSE/NHSI Regional Director of Finance (Northwest) has asked for the system to rapidly develop additional recurrent and non-recurrent actions to reduce the £29.5m system gap; Trust to deliver its control total for 2019/20 and for Commissioners to push on further and more substantial savings opportunities using the national efficiency opportunity models available to you. Commissioners should also continue to ensure operational budgets remain in line with plan and seek further savings where possible during the remaining months of the financial year. System to deliver by Friday 1st November a jointly agreed FRP improvement plan which describes the areas the system will be targeting and the associated key delivery milestones. This plan must present a material improvement from the £29.5m adverse gap to control total currently forecast with month on month financial profile of the plan demonstrating a much-improved exit financial run rate moving into 2020/21. System to provide by 8 November a strategic financial plan that bridges the gap to 2020/21 and sets out how the system will deliver the notified financial trajectories			

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 November 2019

Agenda Item	**TB190/19**	**Report Title**	**Vision 2020 and the Single Improvement Plan**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Donna Lynch, Head of PMO		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note X To Receive	

Executive Summary

Vision 2020 describes a number of strategic objectives which have been refined and agreed by the Trust Board during winter 2019.

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

Quality: 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 – Amber

- 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

There are seven risks rated as red with a further eight rated as amber, after mitigation is in place.

The executive assurance reports are included in the paper for information purposes.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

This report will come to Trust Board on a monthly basis.

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

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

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

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

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

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

For Information: Literally, to inform the Board

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY STANDARDS

Draft CQC inspection report shared with Trist for Factual Accuracy Checking

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 October 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.

Spinal Centre refurbishments and deep cleaning - work has been completed in acute respiratory care area to provide 2 isolation cubicles and a bathroom, these areas are now in use, as part of the improvement programme, 6 beds have reopened w/c 30 September

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 was held on 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.
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

A&E 4 Hour Performance

- The Trusts reported 4 hour A&E performance in September was 88.6% a slight increase from the August position of 87.9%
- This is due to a slight increase in Southport performance which has improved from 76.6% in August to 77.6.% in September 2019.
- Ormskirk & WIC Performance was slightly worse in September 2019 but this was offset by the improvement at Southport hence the improvement in overall Trust Performance.
- September 2019 failed to meet the trajectory target of 92.6% agreed with NHSI by 4.0%.

18 Week RTT Performance

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- Predictions for October show performance will remain around 93% and continue to be above the 92% threshold.
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- Performance was 73.57% which is a 1% improvement from August.

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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) • Ensuring the winter plan delivers against the capacity gap as identified through the Venn modelling.	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. The Trust is planning to open escalation beds from 1st January on the Ormskirk site. In addition, the Trust is workign with the system to optimise current and new schemes / pathways (identified within the system winter plan) to deliver the best possibly efficiency.	R

2019/20 FINANCIAL PLAN (1)

RAG Rating

Key Achievements/Progress

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

Current performance

The month 6 YTD position before Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) is a deficit of £13.957 million which is £14,000 better than plan. By delivering the Quarter 2 plan the Trust has secured £3.654 million of PSF/FRF in Quarter 2. This takes the total PSF/FRF secured to date to £6.395 million.

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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 6, the Trust had transacted £2.782 million of CIPs. The Trust is forecasting delivery of £4.6 million, down £200,000, a gap of £1.7 million.

Key actions

To ensure that the CIP gap continues to close, the Trust is working on the development of further CIPs as part of its Financial Recovery Plan.

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 £1.564 million (planned spend year to date of £2.918 million) with a further £928,000 committed expenditure. Comparing this against the annual plan, £5,103,000 excluding donated and GE radiology assets, then the Trust has spent/committed 61.3% of the plan at the end of September 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 refurbishment in the Spinal Injury Unit to address the Klebsiella infection risk is being funded out of capital contingency.

The Trust is revising its capital plan to accommodate capital works required at Ormskirk hospital which forms part of the winter plan to create 16 bedded ward; total cost £350,000

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

- Procurement
- 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

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, which is 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.*	A
New CIP target for expenditure reduction of £6.3 million	*Development of Trust Financial Recovery plan (part of overall System Recovery Plan).* *6 key areas of focus are:* ➢ *Establishment controls* ➢ *Medical bank (Patchwork)* ➢ *Digitalisation of outpatients* ➢ *Repatriation* ➢ *Unfunded services* ➢ *Fragile services* *Each area has an executive lead and the Trust CEO reviews progress on these projects on a weekly basis.*	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 and continue to do so in August 2019. The YTS rolling sickness absence rate has reduced by 0.4% in December to 5.54% in August 2019. Monthly sickness absence rate for August 2019 was a reduction to 4.86% therefore putting the sickness absence rate below the trust target of 5%.

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 continue to work with HR to set trajectories to increase mandatory training rates to stretch target of 95%
CBU's continue to work 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
Leadership Strategy approved at Board Sept 2019

- *Shadow Board Programme commenced Sept 2019*
- *Triumvirate Development Programme due to commence 13th/14th Nov – focussed conversations for 9 x triumvirate leads (ADO/AMD/HoN) & 3 x Exec Leads*
- *'Foundations of Leadership Programme' - mini-competition closes 11th Oct Programme – to establish the 'Southport & Ormskirk Way' of leadership for all staff (2020)*
- *New Consultants/SAS Doctors programme (2020) - scoping exercise completed, specification document under development*

Apprenticeship Levy – scoping exercise to gain feedback on the Trust's proposal to spend 25% of apprenticeship levy with partner organisations (Paper to HMB Nov 2019)
Leading Healthy Workplaces – bespoke training day under development with a focus on supporting attendance to be piloted in Q3
Customer Service training under consideration for roll out starting Q4

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 continue across the organisation – data gathering for behaviours that underpin our SCOPE values, focus group to be held Nov/Dec 2019
Coaching Strategy approved at Workforce Committee Sept 2019
In-house coaching service launched with write up from CEO (Oct 2019) Purchase of online coaching modules for all staff to access for a 12 month period
FFT – increase in completions from 79 (Q1) to 342 (Q2) – downward trend in recommending the Trust as a place to work and/r receive treatment
Staff Survey launched Oct 2019 – increase in communications via e-comms and social media
Talent Management Self-Diagnostic Tool – currently out for consultation – online report expected Oct 2019 to WFC Nov 2019
Bespoke OD Interventions to support the roll out of SONAAS & team developments for specific hot spot areas
Corporate Induction - under review for Jan 2020 to deliver an improved on boarding experience and a reduction in repetition of mandatory training
Ensure the Trust meets its statutory Equality and Diversity obligations

HR IMPROVEMENT PRIORITIES

Workforce efficiencies programme model delivery

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. Review discussion took place with all key stakeholders 06/09/19 and a further follow up meeting is scheduled for 01/11/19.	A
Development of admin and clerical staff bank	Engagement with NHSP to provide support to development of admin and clerical bank.	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. There is also now unplanned absence in the team and some new appointments of team members who are not as experienced as some colleagues.	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'	NHSI discussed with Head of PMO – no further update at present	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

The draft outline PCBC is near completion with all expected final outputs due week commencing 14th October (with the exception of Estates which will be ready week commencing 21st October)

CLINICAL SCENARIOS

All 5 clinically led models of care have undergone the final stage of the check and challenge process which cumulated in a wider engagement event on the 25th September which also indicated the start of the pre engagement process (subject to approval to proceed to a full business case post Oct).

ESTATES SOLUTIONS

GB Partnerships are developing schedules of accommodation and site plans (including indicative costs) aligned to the 5 emerging scenarios

FINANCE SOLUTIONS

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

Key Achievements/Progress in Month

Activity and financial modelling outputs have started to be produced and tested within the Clinical Leadership Group and the Sefton Finance Group. The draft outline PCBC has been drafted and is being developed and refined. Wider engagement with the system has commenced with a meeting booked on 8th November with CMHCP, NHSEI and the two CCGs. The Joint Committee of West Lancs and Southport and Formby has had it's inaugural meeting booked in for the 7th November 2019.

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 Workforce programme to be established and align issues across the STP footprint External Expertise secured from Attain to quantify the challenge for S&O and support the development of solutions	R

NHS
Southport and Ormskirk Hospital
NHS Trust

Single Improvement Plan

Board Update

November 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

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	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 – October 2019

Southport and Ormskirk Hospital
NHS Trust

Priorities	RAG
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	**Amber**
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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 October 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

Priorities	Risks (after mitigation)			
	Amber	Red	Narrative	Mitigation
Quality Priorities	1	2	Approval and implementation meds mgt business case Winter pressures	Corporate input into the business case Participation in the development of the system winter plan
Operational Priorities	0	2	Workforce gaps impacting on current performance against 4 hour standard and cancer and disgnostic services Ensuring that the winter plan delivers against the capacity as identified through the Venn modelling	Workforce improvement board established to support timely recruitment of critical posts CCG commissioner discussions; plans to open beds on the Ormskirk site
Finance Priorities	2	1	Underlying expenditure levels will not reduce to pre Q4 2018/19 level	Development of Trust Financial Recovery plan
Workforce Priorities	5	1	Capacity of the HR business services tea	Temporary funding through E&F team to support volume of work in this area
Strategic Priorities	0	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	Sefton Workforce programme to be established and align issues across the STP footprint External Expertise secured from Attain to quantify the challenge for S&O and support the development of solutions

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY STANDARDS

Draft CQC inspection report shared with Trist for Factual Accuracy Checking

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 October 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.

Spinal Centre refurbishments and deep cleaning - work has been completed in acute respiratory care area to provide 2 isolation cubicles and a bathroom, these areas are now in use, as part of the improvement programme, 6 beds have reopened w/c 30 September

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 was held on 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.
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

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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 6, the Trust had transacted £2.782 million of CIPs. The Trust is forecasting delivery of £4.6 million, down £200,000, a gap of £1.7 million.

Key actions

To ensure that the CIP gap continues to close, the Trust is working on the development of further CIPs as part of its Financial Recovery Plan.

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 £1.564 million (planned spend year to date of £2.918 million) with a further £928,000 committed expenditure. Comparing this against the annual plan, £5,103,000 excluding donated and GE radiology assets, then the Trust has spent/committed 61.3% of the plan at the end of September 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 refurbishment in the Spinal Injury Unit to address the Klebsiella infection risk is being funded out of capital contingency.

The Trust is revising its capital plan to accommodate capital works required at Ormskirk hospital which forms part of the winter plan to create 16 bedded ward; total cost £350,000

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

- Procurement
- 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

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, which is 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.*	A
New CIP target for expenditure reduction of £6.3 million	*Development of Trust Financial Recovery plan (part of overall System Recovery Plan).* *6 key areas of focus are:* ➢ *Establishment controls* ➢ *Medical bank (Patchwork)* ➢ *Digitalisation of outpatients* ➢ *Repatriation* ➢ *Unfunded services* ➢ *Fragile services* *Each area has an executive lead and the Trust CEO reviews progress on these projects on a weekly basis.*	A

WORKFORCE (1)

AMBER

Key Achievements/Progress in Month

- **Workforce Improvement Group - held 2 weekly – driver diagrams & action plans in place**
- **NHSP contract renewed in collaboration with C&M cluster trusts establishing shared position on pricing and delivery models. Savings realised and backdated in August.**
- **Cheshire & Merseyside collaboration on nursing and midwifery agency call off contract and rate card – Trust engaged with implementation from 1 November following Carter at Scale sign off.**
- **Tier 2 agency cascade implemented with further enhancements for nursing with a 3% off framework improvement achieved in September and month to date October tracking at a 13% improvement.**
- **Allocation ward shift modelling in progress to assess areas and patterns where higher demands will support reduction in off framework nursing utilisation.**
- **The new Supporting Attendance Policy is undergoing 6 month review with the initial review session completed and a further session scheduled; attendance figures have recorded a month on month improvement based on rolling average for the last 8 months.**
- **Sickness absence has decreased in month to August figures of 4.86% which is below the Trust's 5% target. Sickness absence improvement on a YTD has been encouraging; the Trust will continue to monitor levels closely and continue the focused work around improving and support staff's attendance to work.**
- **PDR compliance decreased in month to 71.16% for August 2019 which is disappointing from the slight increase reported in July of 72.44% compliance. All CBU's have presented their revised PDR improvement at the August/September 2019 Performance Review Boards.**
- **Core mandatory training remains above the Trust target at 88.61%**
- **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 – focussed conversations on the behaviours to underpin our SCOPE Values.**
- **Leadership Strategy approved at Board Sept 2019**
- **Coaching Strategy approved at WFC Sept 2019**
- **In-house coaching service launched Sept 2019**
- **Shadow Board Programme commenced September 2019 – 12 delegates confirmed**
- **Staff Survey - communications plan commenced Oct 2019**
- **FFT – increase in completions / decrease in recommending the Trust as a place to work or have treatment**
- **Q2 Staff Friends and Family Test and Pulse check results will be provided to the Trust at October's Workforce Committee**
- **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
- **Rostering policy development – attained final sign off at policy ratification group.**
- **Review of format and behavioural contract of the Workforce Committee**
- **Development of agency rate approval process giving more accountability to divisions and clinical directors; to be finalised and implemented in November.**
- Enhancement to nurse rostering dashboard in progress with enhanced support being provided to check and challenge processes.
- Health & Wellbeing Strategy approved at Workforce Committee September.
- Engagement with alternative medical bank provider commenced.

WORKFORCE

AMBER

Key Achievements/Progress (2)

OD, CULTURE AND STAFF ENGAGEMENT

SoProud Big Conversations continue across the organisation – data gathering for behaviours that underpin our SCOPE values, focus group to be held Nov/Dec 2019
Coaching Strategy approved at Workforce Committee Sept 2019
In-house coaching service launched with write up from CEO (Oct 2019) Purchase of online coaching modules for all staff to access for a 12 month period
FFT – increase in completions from 79 (Q1) to 342 (Q2) – downward trend in recommending the Trust as a place to work and/r receive treatment
Staff Survey launched Oct 2019 – increase in communications via e-comms and social media
Talent Management Self-Diagnostic Tool – currently out for consultation – online report expected Oct 2019 to WFC Nov 2019
Bespoke OD Interventions to support the roll out of SONAAS & team developments for specific hot spot areas
Corporate Induction - under review for Jan 2020 to deliver an improved on boarding experience and a reduction in repetition of mandatory training
Ensure the Trust meets its statutory Equality and Diversity obligations

HR IMPROVEMENT PRIORITIES

Workforce efficiencies programme model delivery

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. Review discussion took place with all key stakeholders 06/09/19 and a further follow up meeting is scheduled for 01/11/19.	A
Development of admin and clerical staff bank	Engagement with NHSP to provide support to development of admin and clerical bank.	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. There is also now unplanned absence in the team and some new appointments of team members who are not as experienced as some colleagues.	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'	NHSI discussed with Head of PMO – no further update at present	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

The draft outline PCBC is near completion with all expected final outputs due week commencing 14th October (with the exception of Estates which will be ready week commencing 21st October)

CLINICAL SCENARIOS

All 5 clinically led models of care have undergone the final stage of the check and challenge process which cumulated in a wider engagement event on the 25th September which also indicated the start of the pre engagement process (subject to approval to proceed to a full business case post Oct).

ESTATES SOLUTIONS

GB Partnerships are developing schedules of accommodation and site plans (including indicative costs) aligned to the 5 emerging scenarios

FINANCE SOLUTIONS

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

Key Achievements/Progress in Month

Activity and financial modelling outputs have started to be produced and tested within the Clinical Leadership Group and the Sefton Finance Group. The draft outline PCBC has been drafted and is being developed and refined. Wider engagement with the system has commenced with a meeting booked on 8th November with CMHCP, NHSEI and the two CCGs. The Joint Committee of West Lancs and Southport and Formby has had it's inaugural meeting booked in for the 7th November 2019.

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