Southport and Ormskirk Hospital NHS Trust

AGENDA OF THE BOARD OF DIRECTORS PUBLIC BOARD

To be held 10:30 - 13:00 on Wednesday 4 December 2019
Ruffwood Suite, Education Centre, Ormskirk Hospital L39 2AZ

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration
PRELIMINARY BUSINESS			10:30
TB197/19 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**10**
TB198/19 (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**	
TB199/19 (D)	**Minutes of the Meeting held on 6 November 2019** To **approve** the minutes of the Public Board of Directors	**Chair**	
TB200/19 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**	
TB201/19 (D/V) **(V/P)**	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Patient Story:** Chaplaincy and Spiritual Care - the work and achievements from over the last year and its positive impact on the patient experience To **receive** the Patient Story and **note** lessons learnt	**NEDs EDs** **Michelle Kitson/Martin Abrams**	**30**
STRATEGIC CONTEXT			**11:10**
TB202/19 (D)	**Chief Executive's Report** To **receive** key issues and update from the CEO	**CEO**	**10**

Ref Nº.	Agenda Item	Lead	Duration
QUALITY & SAFETY			**11:20**
TB203/19 (P/D/V)	**Quality and Safety Reports:** a) Quality Improvement Plan Update b) Summary of Complaints & Compliments c) Learning from Deaths Report (formerly Monthly Mortality Report) d) Safe Staffing: Monthly e) Medical Vacancy Rate: Monthly f) CQC Inspection Update To **receive** the presentation and reports	**DoN/MD**	**30**
PERFORMANCE & GOVERNANCE			**11:50**
TB204/19 (P/D)	**Integrated Performance Report (IPR)** To **receive** the report	**COO**	**15**
TB205/19 (D)	**Financial Position at Month 7, 2019/20** To **receive** the report	**DoF**	**15**
TB206/19 (D)	**Risk Management** **Corporate Risk Register (CRR)** To **receive** the monthly reports.	**DoN**	**5**
TB207/19 (P/D)	**Single Improvement Plan Update (SIP)** To **receive** the report	**DCEO/ DoS**	**10**
TB208/19 (P)	**Workforce Directorate Presentation** To **receive** the presentation	**DHR**	**10**
TB209/19 (D)	**Charity Update** • Name change for the Charity • Investment Policy for the Charity To **receive** the reports	**DoF**	
ITEMS FOR APPROVAL/RATIFICATION			**12:45**
TB210/19 (V)	**a) Learning Lessons to Improve our People Practices Report** **b) Workforce Disability Equality Standard Information Report April 2019 – March 2020** **c) Workforce Race Equality Standard Information Report April 2018 – March 2019**	**Chair**	**10**

	To **approve** the reports		
CONCLUDING BUSINESS			**12:55**
TB211/19 (V)	**Questions from Members of the Public**	**Public**	**10**
TB212/19 (V)	**Any Other Business** To **receive/discuss** any other business not on the agenda, including items for forward agenda – 8 January 2020	**Chair**	**10**
TB213/19 (V)	**Message from the Board** • To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	**5**
TB214/19 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**	**5**
TB215/19 (V)	**Date and time of next meeting:** **10:30, Wednesday 8 January 2020** Seminar Room, Clinical Education Centre, Southport District General Hospital, PR8 6PN	**Chair**	**13:30 CLOSE**

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Neil Masom

Southport and Ormskirk Hospital NHS Trust

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

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GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GORRY, Mrs Julie	Non-Executive Director	**Catalyst Choices C.I.C.**	**Nil**	**Nil**	**Nil**	**Project Adviser: Hospice of the Good Shepherd** 2017 to date **Specialist Adviser CQC** 2015 to date **Macmillan Cancer Information & Support Specialist** 2017 to date	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**9 July 2019**
HANKIN Dr Terence	Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 January 2019**

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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**
PATTEN, Ms Therese	Acting Chief Executive/Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Director of Human Resources	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**25 September 2017**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother, Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport &**	**Nil**	**Nil**	**Trustee – Age Concern**	**4 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
						Ormskirk Hospital Trust.				
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health** **Member of the Medical Education Charity at Southport & Ormskirk Hospital NHS Trust**	**Nil**	**Nil**	**Nil**	**9 April 2018** **6 November 2019**

Minutes of the Public Section of the Board of Directors' Meeting
Wednesday, 6 November 2019
Seminar Room, Clinical Education Centre, Southport Hospital
(Subject to the approval of the Board on 4 Dec 2019)

Members Present

Mr J Birrell, Non-Executive Director
Mr D Bricknell, Non-Executive Director
Mrs J Cosgrove, Executive Director of Nursing, Midwifery & Therapies
Mrs J Gorry, Non-Executive Director
Mrs T Patten, Acting Chief Executive / 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 for Corporate Governance
Mr T Ellis, PR & Communications Manager
Mrs P Gibson, Non-Executive Director Designate
Mrs C Griffiths, NHSE/I Improvement Director
Mrs A Marshall, PA to the Chief Executive & Chair
Mrs J Royds, Director of Human Resources & Organisational Development

Apologies:

Dr T Hankin, Executive Medical Director
Neil Masom, Chair

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB180/19	**Chair's Welcome and Note of Apologies**	
	Mr Birrell opened the meeting by welcoming members of the public who were in attendance. He reminded them that although this is 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. Apologies noted from Mr Masom, Dr Hankin and Mrs Roberts.	
TB181/19	**Declaration of Directors' Interests Concerning Agenda Items**	
	The Chair asked that members declare any interests in relation to the agenda items and asked that any changes or additions to the Register of Interests declared by the Board of Directors should be submitted to the Company Secretary. Mr Singh confirmed that he had been asked to become a member of	

	the Medical Education Charity at Southport & Ormskirk Hospital NHS Trust.	
TB182/19	**Minutes of the Meeting Held On 6 March 2019**	
	The minutes of the meeting held on 2 October were agreed as a correct record and were approved. . **RESOLVED:** The Board **approved** the minutes as an accurate record.	
TB183/19	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **January 2019, Min No. TB028/19 Monthly Mortality Report/External Mortality Review** Dr Hankin to provide a progress update to provide Board assurance. **September 2019, Min No. TB149/19 Quality Improvement Plan** Awaiting final CQC report	**MD** **DON**
TB184/19	**Patient and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts** • **Patient/Staff Story: Surgical Assessment Unit – How they improved the patient journey**	
	NEDs & Executive Visits/Walkabouts Mrs Gorry & The Director of Finance had visited Spinal Injuries Unit (SIU)on 23 October. The SIU had recently been refurbished following the Klebsiella outbreak. The visit went well with engaging feedback from the staff, who were proud of the patient centred team, the standard of work and care and the comprehensive induction programme in place. It was noted however the staff on SIU felt frustrated with overall communications which came from the management team of the hospital and were unsure how they fitted into the strategic plans for the future. There are elements of the IT systems which do not align. Some of the staff felt the profile of SIU should be raised and run as a separate Clinical Business Unit (CBU). There was a suggestion to link the NEDs with designated wards. The Acting Chief Executive & Director of Strategy will provide a summary of actions from the NED and Executive visits which would provide valuable feedback and ensure the visits are viewed as a meaningful exercise. It was noted that both the Chief Operating Officer and the Director of Nursing, Midwifery & Therapies were providing support and visibility around the wards during this period of overwhelming demand. The Director of Human Resources & Operational Development confirmed there were dates in the diary for her and Gurpreet Singh to arrange ward visits during the next couple of months. Back to the floor visits for all of the Executive Team were also being arranged. **Patient/Staff Story: Surgical Assessment Unit – How they improved the patient journey** The Board were apprised of the background of the opening of the	

	Surgical Assessment Unit (SAU). The SAU was 18 months in the planning and opened in October 2018. It is a purpose built area for ambulatory patients who require surgical review. The process of embedding the new service into practice has taken 12 months. There were some initial teething issues but these have now been resolved. The aim of the unit is to reduce avoidable admissions. Some of the achievements to date include: ➢ March 2019 - Cohort 4 NHS Elect Programme: Trust commitment to best practice and developing ambulatory models of care. The team have been asked to coach Cohort 5 and asked to share their data template ➢ May - Acute Abdomen Pathway formalised ➢ June - Pilot of Hot clinic ➢ July - Formalisation of Standard Operating Policy for Hot Clinic and Ward Attender Referral Process The work continues to provide excellent safe and appropriate care. Improvements to service provision adapt in relation to feedback received. There is further work underway with NHS Elect to ringfence the unit and increase revenue from Best Practice Tariff. There had been some HRG coding issues which had indicated under-costing however this issue has been resolved and should be reflected in the August data. The staff on SAU are very proud of this service and are looking forward to the future development of the unit. The next 12 months will be looking at developing a 7 day service. **Patient Story – Sally's Story** The outcome from Sally's story was very positive. Sally had given permission to use both her story and her name. Following a 3 year history of a cyst to her back Sally's GP referred her to SAU for assessment. As a result of the review Sally was listed by the Surgeon for same day 'see and treat'. This process allowed Sally to attend the hospital on the morning of her procedure. Her husband who required a carer was able to attend with her and was looked after by the staff on duty. The procedure was completed and Sally was discharged home. There was no capacity within the Community to provide a wound check the following day so Sally returned to the unit for wound care and no follow up appointment was required. Mr Birrell thanked Gemma for attending the meeting offered his praise for the development of the service and encouraged Board members to visit the area. The Chief Operating Officer praised Gemma and her team for their hard work and dedication noting that Gemma was an exemplar colleague. **RESOLVED:** The Board **received** the presentation and **noted** the excellent progress being made	
STRATEGIC CONTEXT		
TB1850/19	**Chief Executive's Report**	

	The Chief Executive's Report was presented to the Board, with key issues being highlighted as follows: ➢ **Ormskirk hospital is the key to winter planning**. The Trust plans to make better use of the excellent facilities at Ormskirk hospital following extensive clinical consultations. ➢ **Visit by the Secretary of State for Health and Social Care** Matt Hancock, the Secretary of State for Health and Social Care, visited Southport hospital visited the Trust on 9 October. He was visiting at the invitation of Southport MP Damien Moore. ➢ **Time to Shine Awards** Nearly 250 staff and guests gathered at Formby Hall Golf Resort and Spa last month to celebrate our annual staff awards, the Time to Shine Awards. Congratulations to be offered to the Time to Shine winners and moninees. ➢ **Bed 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 following an increase in the incidence of patients colonised with the Klebsiella bacteria. ➢ **Flu Campaign at week 5 – 73%** ➢ **Winter Plan approved at Private Board subject to a clinical conversation**. ➢ **Electronic Medical Prescribing**. £700k funding approved to support implementation of Electronic Medical Prescribing, this is a major investment into IT systems it is hoped this will be mobilised by the beginning of January 2020. RESOLVED: The Board **noted** the report.	
QUALITY & SAFETY		
TB186/19	**QUALITY & SAFETY REPORTS**	
	The key issues from the 5 comprehensive reports provided in relation to this agenda item (Summary of Complaints & Compliments, Learning from Deaths Report (formerly 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** This month's report shows a breakdown of the number of compliments, complaints and concerns received for the month of September and the improvements now in place following the closure of complaints in August. It was noted the number of complaints and concerns had appeared to stabilise, however plans to address the backlogs will be managed by the newly appointed Deputy Directors of Nursing. ***Action:*** **Director of Nursing, Midwifery & Therapies** ***By: January Board*** **Learning from Deaths Report (formerly Monthly Mortality**	

	Report) It was noted the Monthly Mortality Report to the Board is now a Learning from Deaths Report. In April the HSMR increased to 118 from 82.8 the previous month. There had been no significant spikes in any disease specific areas and the main primary diagnoses of these patients were similar to previous months. Fortnightly Mortality Meetings are now in place to support the delivery of a responsive and learning approach to the screening of deaths. **Mortality Screening** Following a review of the process the screening rate has shown an improvement. Structured Judgement Reviews and potential avoidance of death reviews are in place. There are still a percentage of patients receiving poor care. Director of Nursing, Midwifery & Therapies noted these cases would be managed through the Mortality Operational Group and the themes would be consolidated. **Quality Improvement Plan** Training is being delivered on the Older Peoples Care Training Programme to include Nutrition, Hydration & Mouth Care, Dementia & Delirium, Continence, End of Life Care, Falls, Care of the Deteriorating Patient, Infection Prevention and Control (IPC) and Medicines Management. There are some issues around nutrition due to the lack of ability to release Dietitians from clinical duties in the absence of a Dietetic lead. The Falls Strategy is being developed with a view to launch in November. A new Neck of Femur (NOF) Pathway has been approved and will be reviewed and audited. **IPC Update** The Team is working across the Community in conjunction with AQUA. There is a focus on reducing antimicrobial use. The C.Diff target is more challenging this year due to a change in how cases are attributed to the Trust. There had been an MRSA bacteraemia in August which was the first one in almost 2 years and was a result of cannulation, relevant learning identified. To date there have been 3 cases of flu but no transmission noted and a table top exercise has been completed. Klebsiella outbreak on Spinal Injuries Unit had been handled effectively. **Medicines Management** Following the issues raised by the CQC and the information provided by the Model Hospital Team which identified the department was under resourced a Business Case for additional staffing had been completed and was approved at Private Board on 6 November 2019. **Safe Staffing** There has been an overall improvement to the fill rate which is as a result of an increase in the number of allocate on arrival shifts which attract an enhanced rate. There have been a number of recruitment events but the Trust is only just managing to maintain	**Comms**

	safe staffing levels. The Trust has one of the highest vacancy rates across Cheshire & Merseyside. International recruitment is a consideration. There is no central point for the management of medical vacancies and these are managed within the individual CBUs. The Executive Medical Director will be asked to provide a paper update to the Board which will provide details of the medical vacancy rate across the Trust, it was noted this would be a complex piece of work and would require discussion at Workforce Committee. ***Action: Executive Medical Director*** ***By: December Board*** **Improving Criteria Led Discharge** Important for the Trust to ensure there are nurses available to support Criteria Led Discharge, work is progressing in this area but not something that will be fully established this year. The Red to Green multi-disciplinary approach will also support patient flow. **CQC Update** The Trust received the draft report for factual accuracy checking on 8 October 2019 the Quality Team worked with the Core Service leads to identify any inaccuracies and the report was returned by the deadline 29 October 2019. The CQC have been asked to consider amendment to some key ratings. The date for official publication of the report is yet unclear due to the process of Purdah. **Freedom to Speak Up Quarterly Update** During October the Freedom To Speak Up Champions engaged in different activities, plans for November include drop-in sessions to recruit more Champions. It had been noted within the Freedom To Speak Up Index Report that the Trust had been listed in the bottom 10 but there was no indication as to why this is the case. Martin Abrams is meeting with the Regional Liaison Lead for the North West to discuss the potential to 'buddy up' with an organisation which has shown improvement. **RESOLVED:** The Board **received** the Complaints & Compliments Report, the Learning from Deaths Report (formerly Monthly Mortality Report) and the Monthly Safe Staffing Report and was **assured** by the Quality Improvement Report and the CQC Preparation Update	
PERFORMANCE & GOVERNANCE		
TB187/19	**Assurance & Performance**	
	INTEGRATED PERFORMANCE REPORT The Chief Operating Officer provided an overview of this report which identified an improvement of 31 indicators and a deterioration of 24. **Key areas:** **12 hour DTA breaches** 5 declared for the month of September 4 of which were attributed to patient flow and 1 a delay in securing a mental health bed. Assurance given that all patients did receive senior review during this time. Currently showing as an outlier for the region which is also bringing scrutiny from the Regulators.	

	RTT Remains above the 92% target however performance is currently being impacted by anaesthetics and various workforce issues. **C.Diff** Mr Birrell asked for clarification of the Trust target as there appeared to be conflicting information within the description and narrative columns. ***Action: Executive Medical Director*** ***By: December Board*** **Friends & Family Test** Performance has shown a significant deterioration in comparison to the previous month. **LOS** Interventions in place are showing an improvement, with continued work around embedding the Home First solution. **Theatre Productivity** July – September 2019 showed an improvement of 5% **Agency Staff** Costs continue to remain high due to the reliance on agency staff to provide safe patient care in both medical and nursing areas. The Director of Human Resources & Organisational Development noted there are 4 consultant panel interviews taking place over the next 3 weeks and there have recently been 3 appointments within the Anaesthetics Department which is a positive step. **Diagnostic Waits** There was a demonstrable improvement for the third month in a row however Radiology and Endoscopy are key services which are impacting on performance. The Trust has improvement plans in place to address the issues. Mr Birrell noted that the sickness rate was currently at the lowest level for some time however the staff turnover rate was the highest. The Director of Human Resources & Organisational Development advised there was a focused piece of work underway looking at staff retention issues. For noting there are currently over 450 recruitment opportunities in various stages of progression. The Executive Assurance Reports were noted. **RESOLVED:** The Board **received** the IPR	
TB188/19	**Financial Position at Month 6, 2019/20**	
	The report for month 6 of 2019/20 was received and noted by the Board. The Director of Finance noted the Trust had delivered the Quarter 2 plan and assured the Board that accounting adjustments had been made in conjunction with the Regulators. However he noted the financial position was set to get more challenging in the forthcoming months. The Trust currently has an unmitigated risk of £5m to the delivery of the control total. Agency spend had increased to above £1m which is a significant risk heading into	

	winter. The use of Thornbury Agency has reduced but there was still a reliance on Tier 2 nursing agency and an increase in the use of allocate on arrival which is paid at an enhanced rate. **RESOLVED**: The Board **received** the report	
TB189/19	**Risk Management: Risk Register**	
	The Risk Management Risk Register was received and noted by the Board. A more detailed discussion took place relating the following risks: • Risk 1688 – Inadequate Staffing Levels in Anaesthetic Department. This is for discussion at Risk & Compliance Group to consider the potential to reduce the risk score. • Risk 2056 – Lost to Follow Up. Work continues following the identification of a number of individual incidents where patients were not on the RTT pathway. 98% of pathways closed down the remaining 2% required clinical review following which they were also closed down. Comprehensive overview will take place at the next Quality & Safety Committee. **RESOLVED:** The Board **received** the Risk Register report.	
OTHER REPORTS FOR RECEIVING		
TB190/19	**SINGLE IMPROVEMENT PLAN UPDATE (SIP)**	
	The Board received the Single Improvement Plan Board update. The Acting Chief Executive & Director of Strategy advised that following a recent Southport & Ormskirk Improvement Board the Trust had been asked to review the detail contained within the narrative of the assurance reports to ensure a clear and comprehensive progress update was provided. Business Planning Session arranged for 7 November to agree quality and operational priorities for next year. The outline Pre Consultation Business Case has been completed and unlikely to be circulated until after the General Election on 13 December. **RESOLVED:** The Board **received** the paper.	
TB191/19	**ITEMS FOR APPROVAL/RATIFICATION**	
	a) 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 RESOLVED: The Board **noted** and **approved** the request**.**	
CONCLUDING BUSINESS		
TB192/19	**Questions from Members of the Public**	
	Ms Wright - Could the Trust confirm where the company was based that covered the out-sourcing of Radiology.	

	In view of the high numbers of vacancy rates especially within Radiology the Trust had developed a solution to ensure the timely review of patient assessments was provided. The service has been outsourced via the national framework to Telemedicine who are an internationally based company with their head office in Australia. **Ms Wright - Clarity around Criteria Led Discharge** Juliette Cosgrove, Director of Nursing advised that the Multi-Disciplinary Team decides a criteria for discharge for individual patients and when this is met then the patient can go home. This is normally led by a nurse. This process is designed to prevent discharge delays when Therapies are required. It is not an alternative to using doctors.	
TB193/19	**ANY OTHER BUSINESS**	
	To **receive/discuss** any other business not on the agenda.	
TB194/19	**Message from the Board**	
	Messages which the Board wished to communicate to the wider Trust were: • *SAU – Spotlight on positive achievements* • *Thank you - Time to Shine award winners and nominees* • *More patients treated – less Theatres used* • *Achievement of Quarter 2 Finance Plan* • *EPMA Funding* • *Approval of Winter Plan Business Case* • *Sickness at lowest level since September 2014*	**Communications**
TB195/19	**Meeting Evaluation**	
	To give members the opportunity to evaluate the performance of the Board meeting • Clear presentations to support discussions • Willingness to respond to questions • Would be helpful if Board members introduced themselves • Page direction would be helpful • Time Management of meeting – some items rushed, insufficient time to cover items	
TB196/19	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 4 December 2019, 10:30am Ruffwood Suite, Education Centre, Ormskirk District General Hospital	

There being no other business, the meeting was adjourned

Board Attendance 2019/20												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓											
Jim Birrell	✓											
David Bricknell	✓											
Ged Clarke	✓											
Juliette Cosgrove	✓											
Julie Gorry	✓											
Terry Hankin	✓											
Silas Nicholls	✓											
Therese Patten	✓											
Steve Shanahan	✓											
Gurpreet Singh	**A**											
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓											
Audley Charles	✓											
Steve Christian	✓											
Jane Royds	✓											
A = Apologies ✓ = In attendance												

Public Board Matters Arising Action Log
as at 6 November 2019

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB028/19	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 **November 2019** Reviewed monthly as part of Mortality Operational Group (MOG).	**BLUE**

Public Board Matters Arising Action Log
as at 6 November 2019

Southport and Ormskirk Hospital NHS Trust

			Board awaiting confirmation that all actions have been completed.	**MD**	May 2019	Dec 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. **December 2019** Dr Hankin to give a progress update to provide Board assurance	**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	Dec 2019	**October Update:** Mapping underway, pending results of CQC inspection report, which may possibly require reconsideration **November Update:** Awaiting final CQC report **December 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		**GREEN**
		Workforce Disability Equality Standard Information Report April 2019 – March 2020 (DoHR)		**DoHR**	Oct 2019	Dec 2019		**GREEN**

Public Board Matters Arising Action Log
as at 6 November 2019

Southport and Ormskirk Hospital NHS Trust

		Workforce Race Equality Standard Information Report April 2018 – March 2019 (DoHR)		**DoHR**	Oct 2019	Dec 2019		**GREEN**
TB186/19	Nov 2019	Quality & Safety Reports Complaints & Compliments	Provide an update to the Board on response times for complaints	**DON**	Jan 2020	Jan 2020		**GREEN**
TB186/19	Nov 2019	Quality & Safety Reports Safe Staffing	Paper to the Board which will provide details of medical vacancy rate across the Trust	**MD**	Dec 2019	Dec 2019	**December Update:**	

Public Board Matters Arising Action Log
as at 6 November 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**
TB187/19	Nov 2019	Integrated Performance Report C.Diff Trust Target	Clarification of the Trust target 16 or 36	**MD**	Dec 2019	Dec 2019	**December Update:** **Annual Trust target is 16 – IPR amended**	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 DECEMBER 2019

Agenda Item	**TB202/19**	**Report Title**	**Acting Chief Executive report to Board**
Executive Lead	Acting Chief Executive		
Lead Officer			
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓ To Note ☐ To Receive	

Executive Summary

- Care Quality Commission report published
- £1.4m investment in electronic prescribing
- Further improvement is mortality performance
- CQC Children's and young people's survey
- Honorary professorship for Dr May Ng

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

ACTING CHIEF EXECUTIVE'S REPORT TO BOARD – December 2019

Care Quality Commission report published

Improvements to care and leadership were recognised in the Trust's latest Care Quality Commission report published on 29 November. It was our first full inspection since November 2017.

Across many of the Trust's services, the inspectors found staff to be kind, treated people with compassion and respected their privacy and dignity.

They said leaders were approachable, experienced and capable, and were helping staff to develop their skills. There was active engagement between patients, staff and leaders alongside external stakeholders and equality groups to further develop collaboration and improve services.

Eight areas of inspection were rated as improving: six at Southport hospital in urgent and emergency care, surgery and end of life care, and two in the children's and young people's services at Ormskirk.

End of life care and Sefton Sexual Health were both rated "good". This is the first time they have been inspected as individual services. Overall the Trust remains rated "requires improvement".

The report reflects the significant progress the Trust is making. While we recognise there is still much work to do, it also shows us on track to meet our ambition of being rated "good" by 2020.

"I want to thank all our staff for their dedication and hard work that made these improvements to patient care possible."

£1.4m investment in electronic prescribing

Our staff will move away from handwritten prescriptions next year thanks to a £1.4m investment in electronic prescribing. The Department of Health will give £700,000 to make the scheme possible.

The new system will be provided by our existing electronic patient record provider and interface with the pharmacy system.

Electronic prescribing will be phased in over 18 months with the first areas going live by the early summer. Working this way saves time and benefits patients by:

- Reducing medication errors by up to 30% compared with paper systems
- Ensuring fast access to potentially lifesaving information on prescribed medicines
- Building up a complete, single electronic record to reduce duplication of information-gathering

Electronic prescribing will also mean information about patients' medicines can be more easily and reliably shared between all the clinical professionals a patient comes into contact with, including general practitioners.

Further improvement is mortality performance

I am pleased to report the latest national figure for SHMI, the Standardised Hospital Mortality Indicator, showed the Trust performing better than expected at 99.62.

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

The result is particularly pleasing given the Trust was a national outlier for SHMI less than a year ago. It is also a tribute to the dedication, commitment and hard work of staff across organisation that we have made such a dramatic improvement to patient care.

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

CQC Children's and young people's survey

The latest Care Quality Commission (CQC) children and young people's survey shows what our patients already know – we have a great team caring for children at Ormskirk hospital.

One hundred and fifty-three patients responded to the annual national survey. It found the children's team provided care that was as good or better than the other trusts surveyed. Staff introducing themselves to patients, giving them sufficient privacy and explaining procedures were particularly noted in the survey.

Honorary professorship for Dr May Ng

Congratulations to Dr May Ng who has been awarded the title of Honorary Associate Professor from the University of Liverpool. This is in recognition of her commitment to reduce variation in care for diabetes and her outstanding delivery of education and training in paediatric endocrinology and diabetes.

Dr Ng, a Consultant Paediatrician who is Associate Medical Director for Specialist Services, has received numerous national awards for her leadership roles and has a wide research portfolio of more than 120 publications as well a best-selling book, A Journey With Brendan, documenting an autism journey with her son.

In brief …

Chief Executive. Trish Armstrong-Child joined the Trust as Chief Executive on Monday 2 December.

Flu vaccinations. As we approached the end of November, 83% of frontline staff had been vaccinated – this includes 98% of all allied health professionals such as therapists. Many non-clinical colleagues have also received their jab.

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. The most recent awards were made to:

- The Anaesthetic team
- Lynne Finnigan, diabetic nurse
- Matt Parry, casting manager

Therese Patten Acting Chief Executive
December 2019

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB203/19a**	**Report Title**	**Quality Improvement Report**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality Bridget Lees, Deputy Director of Nursing		
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 Improvements and the proposed single reporting template which will be used for assurance for both internal and external requirements.

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

QUALITY IMPROVEMENT PLAN UPDATE DECEMBER 2019

1. PURPOSE OF REPORT

This paper provides the Board of Directors 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, the work streams include:

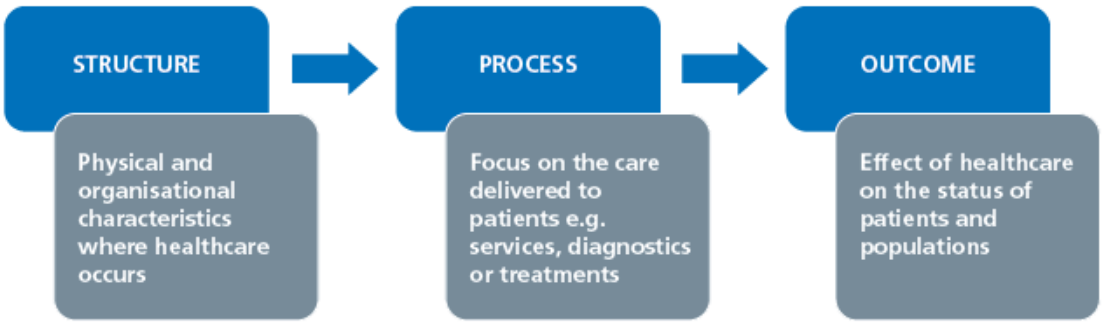
- Clinical Workforce Development (incorporating clinical education, medical staffing numbers and professional standards)
- Quality Standards Compliance (Quality Improvement and CQC preparation and delivery of Quality Improvement Plan)
- Patient Experience and Engagement
- Patient Safety (complaints and Risk Management)
- Safeguarding (Improve training compliance and documentation regarding Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
- Safe and Effective Discharge
- Documentation

The work streams will be reviewed again following publication of the 2019 CQC Report.

3. FUTURE REPORTING POSITION

The Quality Priority Programme Leads have been allocated a dedicated programme resource, the PMO support are developing full standardised suite of programme documentation including Driver Diagrams, Programme Initiation Documentation (PID), Highlight Report and Gantt Charts, these will be completed and signed off ready for committees in January 2020.

For each of the four quality priorities, the Programme Leads are developing improvement measures to monitor improvement and provide assurance, these will include structure, process and outcomes. Any areas for improvement identified during the recent CQC inspections associated to the four quality priorities will be incorporated into the reporting framework.



The Deteriorating Patient summary below provides as example of how the new Quality Priority reporting dashboard will As advised at the meeting this report template for quality improvement is being modified to provide assurance and demonstrate a continuous cycle of improvement.

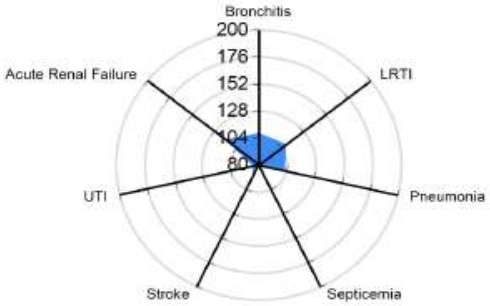
Southport & Ormskirk NHS Trust Deteriorating Patient Dashboard November 2019

Southport & Ormskirk Hospital NHS

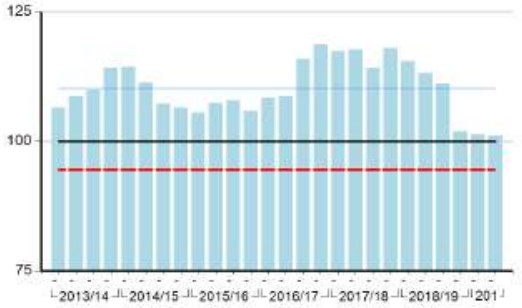
Dr Foster National Mortality Statistics

Rolling 12 Month HSMR

Local HSMR June 2019/20

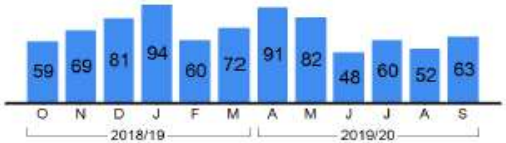


SHMI



Trust Mortality Statistics

In Hospital Deaths



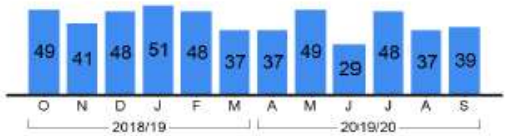
YTD Deaths of Patients with Learning Difficulties: 3

0.76% ▲

YTD Deaths of Patients with GSF Alert: 61

15.4% ▼

Deaths Post Discharge - 30 Days

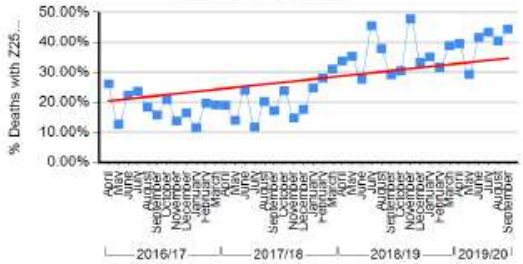


Avg Spell LOS whilst admitted: **15.6**

Avg Days to death post discharge: **11.8**

YTD Deaths of Patients with GSF Alert: 78 — **32.6%** ▼

Palliative Care Coding %



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

Primary Diagnosis Name	This Month	
Pneumonitis due to food and vomit	5	▶
Congestive heart failure	4	▲
Sepsis, unspecified	4	▼
Fracture of neck of femur closed	3	▲
Lobar pneumonia, unspecified	3	▼

Mortality Reviews

	2018/19						2019/20					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Screens Completed	31	40	41	60	37	34	32	27	28	53	44	56
Screens %	52.5%	58.0%	50.6%	63.8%	61.7%	47.2%	35.2%	32.9%	58.3%	88.3%	84.6%	88.9%

Overall Assessment Rating Outcomes - Last 12 Months

Deteriorating Patient Dashboard

Southport & Ormskirk Hospital NHS
NHS Trust

Structure	Process	Outcome

Indicator Name	Description	Threshold	Trust	Planned Care	Urgent Care	Specialist	Performance	Trend
Depth of Coding	No. Diagnoses for 1st FCE	4.8	5.8	5.0	7.1	2.8		
Co morbidities	% Comorbidities on 1st FCE	60.00%	62.13%	68.17%	72.43%	12.06%		
Palliative Care Coding	% Spells with a Z515 Palliative Care Code	12.00%	44.44%	15.38%	52.00%	0.00%		

Deteriorating Patient Dashboard

Southport & Ormskirk Hospital NHS
NHS Trust

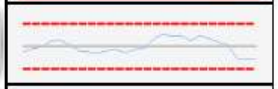
Structure	Process	Outcome

Indicator Name	Description	Threshold	Trust	Planned Care	Urgent Care	Specialist	Performance	Trend
Mortality Screens - Number	Number of mortality reviews completed in month	77	56	12	43	0		
Mortality Screens - %	% of Deaths with a completed mortality review	90.00%	88.89%	92.31%	86.00%	0.00%		
SJRs	No. Structured Judgement Reviews Done	0	12	3	9	0		
2nd Review	No. Second Reviews Done	0	0	0	0	0		
SIs	No. Serious Incidents	0	0	0	0	0		
Observations Compliance Deaths	Compliance of observations recording for patients who died	80.00%	54.42%	44.47%	57.03%	0.00%		
Observations Compliance Discharges	Compliance of observations recording for all patients	80.00%	57.82%	54.95%	59.36%	22.77%		

Deteriorating Patient Dashboard

Southport & Ormskirk Hospital NHS
NHS Trust

Structure	Process	Outcome

Indicator Name	Description	Threshold	Trust	Planned Care	Urgent Care	Specialist	Performance	Trend
Rolling 12 Month HSMR	Hospital Standardised Mortality Ratio, for rolling 12 month period	100.0	94.4					
Monthly HSMR	Hospital Standardised Mortality Ratio for single month	100.0	61.5					
SHMI	Summary Hospital-Level Mortality Indicator, rolling 12 month period reported quarterly	100.0	101.1					
Local HSMR Bronchitis	Diagnosis Level HSMR	100.0	108.7					
Local HSMR LRTI	Diagnosis Level HSMR	100.0	109.6					
Local HSMR Pneumonia	Diagnosis Level HSMR	100.0	102.6					
Local HSMR Septicemia	Diagnosis Level HSMR	100.0	74.6					
Local HSMR Stroke	Diagnosis Level HSMR	100.0	94.9					
Local HSMR UTI	Diagnosis Level HSMR	100.0	85.2					
Local HSMR Acute Renal Failure	Diagnosis Level HSMR	100.0	116.2					

Executive Summary

The Month by Month Hospital Standard Mortality Ratio is inherently unstable. It is affected by the number of deaths in that month and the case mix, which changes. It does however allow analysis of what the underlying contributors are. These are the causes of demand capacity mismatch. This month (HSMR 61.5) discharge and AED flow improved dramatically – thus the system could cope better with demand.

The Rolling HSMR and SHMI give a better indication of direction of travel. The trend of both is towards improvement, again reflecting the investment made in quality.

Capacity and Demand must be actively managed, should demand increase, commensurate increases in capacity are required to maintain safety. This is not just attendance at AED, but can be across different parts of the system including inpatient wards – what is our surge plan and how is it governed / activated?

Mortality screening rates remain around 90%, 117 SJRs were performed in 2018-2019, which is the target and has been met. The challenge now is using this information to identify and propose improvement work. The first areas will be end of life care, AKI and fractured Neck of Femur.

RISKS (Potential risk which will impact the project, has not yet occurred which	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 position 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.

4. CURRENT POSITION

Whilst improvement measures are being developed, the table below provides a summary update in relation to the four quality priorities

Care of the Older Patient: Mouth Care Matters launched on Ward 14B 04/11/19 Falls bundle now on all wards at both Southport and Ormskirk sites. Cognitive impairment risk assessment and care plan now on all wards at Southport and Ormskirk sites. Revised nutritional screening policy has been rolled out on Ward 10B with demonstrable improvement. Dietetic lead now in post and will continue this piece of work. The training programme for Care of Older People has continued to be delivered with excellent feedback. 170 people are booked to undertake the programme by the end of 2019. The first member of the Dementia and Delirium Team in post 04.11.19 and the Admiral Nurse due in post 16.12.19 Continence project is being revised with a focus on 1 specific ward (7b) to enable greater focus and pace.
Infection Prevention and Control (IPC): Priorities in relation to policy updates is ongoing E Coli Bacteraemia: YTD reduction by 2 cases in September when compared with last year's data. The trust has enrolled with AQuA: Action on Anti-Microbial reduction programme starting in November which will further support E coli reduction Spinal Centre refurbishments and deep cleaning: - Patient room and bathroom refurbishment nearing completion - Domestic hours increased to correspond with national guidelines - A Public Health England (PHE) Assurance visit of national experts took place on 12 November to provide advice and verify adequacy of processes undertaken, the Trust are awaiting the final report Influenza: 14B Influenza cases x 3 - all contacts reviewed and no transmission and minimal impact on operational capacity Management of Seasonal Influenza policy passed by policy group Table top exercise completed in Oct 19 using the influenza policy conducted by Emergency Planning Point of care Influenza testing analyser now installed in Southport lab; staff currently being trained, but should come on-line mid-November
Medicines Management: Medicines Management Business Case approved at Board 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, after been through SIRG

Focus remains on improving 7 day working, staffing and Electronic prescribing

Two new additions to the improvement plan include a 6 month plan and assurance tracker. Ward checklists now in place, however anecdotal feedback is that compliance is poor. Weekly audits commenced 21 October and outcomes are to be fed into the tracker to provide assurance against compliance and identify any gaps.

The funding application of £700,000 for EPMA (Electronic Prescribing and Medicines Administration) has been approved by NHSE/I

5. RECOMMENDATION

The Board are asked discuss progress identified in this report in relation to the Quality Improvement and to approve a single reporting template which will be used for assurance for both internal and external requirements.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB203/19b**	**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 September 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
- End of life
- Admission/transfers/discharge procedure
- Communication
- Date for appointment

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

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

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

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

October 2019

1.0 Introduction

This report provides a breakdown on the number of compliments, complaints, concerns received in the month of October, 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, cleanliness & hospital facilities, transport and also related to Privacy & dignity.

Planned care received the most compliments with 43 in total and General Surgery – Colorectal (11A) receiving 15 compliments in the month.

The Urgent Care Business Unit received 19 Compliments, with the Short Stay Unit reporting 6 compliments.

The Women & Children's Business Unit received 6 compliments, of which all 6 related to Paediatric ward.

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 30 formal complaints were received in October.

Urgent Care received 16 complaints, with Ward 10A (EAU) accounting for 4 and A&E 2. Planned Care received 6 complaints, in 3 different areas. Specialist Services received 7 complaints, of which 2 related to Maternity. 1 complaint was received by Estates and Facilities and related to Security.

The following themes were identified:

- Clinical Treatment – in particularly co-ordination of medical treatment
- Staff attitude/behaviour
- End of life
- Admission/transfers/discharge procedure
- Communication
- Date for appointment

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 18 complaints closed during the month of September, 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 have met with a number of complainants and offered apologies for nursing care and attitude of staff. The changes in practice are limited this month but are as follows:-

- Following a complaint about feeling rushed and wasting the physiotherapist time, the physiotherapy department are reviewing their communication processes.
- A complaint has been received from a patient's son who is complaining about the care given to his father and disagrees with the clinician's assessment that he patient requires a PEG feeding tube. After several meeting with the family the Trust is pursuing a Court of Protection order in the patient's best interest for a PEG tube to be placed.

Planned care
Prior to the closure of complaints the Business Unit have met with complainants and apologised for the poor care and pressure ulcers a patient experienced. A review of discharge processes is underway across the Trust.

Specialist Services

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

- Review of environment and processes with parents when seeing children in the community paediatrics.
- Matron and Lead midwife is liaising and supporting a patient who complained about the attitude of a midwife. The concerns have eben shared with the midwife.

Concerns

There have been a total number of 57 concerns raised this month. 11 were requests for information, 8 related to oral communication and 13 related to appointment dates.

3.0 Conclusion

There has been an increase in the number of complaints received this month but they are comparable with the numbers received last year in October, overall the complaints and concerns are decreasing. The same themes are coming through. The themes are subject to going key areas of improvement work within the Trust.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
4 December 2019

Agenda Item	**TB203/19c**	**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 Committee is asked to receive the report for assurance the measures for mortality alongside detail of the activity supporting the improvement of quality of care and performance.

1.0 Executive Summary

2.0 Mortality Indicators

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

3.0 Mortality Improvement Activity

4.0 Learning from Deaths: Structured Judgement Reviews (SJRs)

5.0 National Learning

6.0 Conclusions & Recommendations

7. 0 Appendices:

Appendix 1: The External Mortality Review Board Assurance Action Plan: November 2019
Appendix 2: Recognition and Care of the Deteriorating Patient Project Highlight Report

Appendix 3: Mortality Dashboard.(Dr Foster Mortality Data) November 2019
Appendix 4: Distribution Performance Graph, May 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		☐	Policy

If there is an impact on E&D, an Equality Impact Assessment **must** accompany the report)	☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	

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

1. Executive Summary

- The Month by Month HSMR is inherently unstable. It is affected by the number of deaths in that month and the case mix, which changes. It does however allow analysis of what the underlying contributors are. These are the causes of demand capacity mismatch. This month (HSMR 61.5) discharge and AED flow improved dramatically – thus the system could cope better with demand.
- The Rolling HSMR and SHMI give a better indication of direction of travel. The trend of both is towards improvement, again reflecting the investment made in quality.
- Capacity and Demand must be actively managed, should demand increase, commensurate increases in capacity are required to maintain safety. This is not just attendance at AED, but can be across different parts of the system including inpatient wards – what is our surge plan and how is it governed / activated?
- Mortality screening rates remain around 90%, 117 SJRs were performed in 2018-2019, which is the target and has been met. The challenge now is using this information to identify and propose improvement work. The first areas will be end of life care, AKI and fractured Neck of Femur.
- 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. Mortality indicators

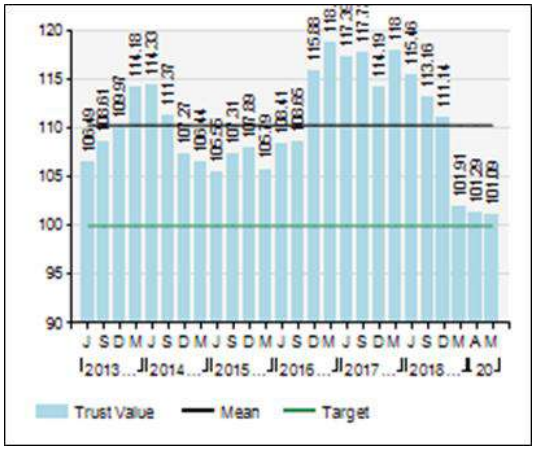
2.1 Performance Indicator Chart: Key National and Local Mortality Indicators

	2018/19						2019/20						Target
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Rolling 12 Month HSMR	112.8	112.3	112.0	102.9	98.7	94.8	96.3	97.4	94.4				*100.0*
Monthly HSMR	75.7	91.3	105.3	84.7	81.5	82.8	121.0	96.8	61.5				*100.0*
SHMI			111.1			101.9	101.3	101.1					*100.0*
Local HSMR Bronchitis	136.6	136.6	138.1	133.0	118.4	105.9	116.2	111.4	108.7				*100.0*
Local HSMR LRTI	137.6	137.4	138.9	134.1	119.5	106.8	120.8	112.3	109.6				*100.0*
Local HSMR Pneumonia	121.7	122.1	120.1	112.6	104.8	103.7	110.2	107.1	102.6				*100.0*
Local HSMR Septicemia	89.9	89.7	90.2	81.1	79.1	80.0	79.5	75.0	74.6				*100.0*
Local HSMR Stroke	107.9	110.1	112.0	100.3	100.2	103.5	105.5	96.8	94.9				*100.0*

Local HSMR UTI	114.9	123.5	120.0	106.2	109.0	80.0	84.2	91.2	85.2				*100.0*
Local HSMR Acute Renal Failure	96.1	107.4	128.8	126.8	115.0	101.3	112.8	112.4	116.2				*100.0*
Mortality Screens - %	300.00%	150.00%	151.85%	249.46%	113.33%	425.00%	105.49%	121.95%	312.50%	528.81%	253.85%	88.89%	*90.00%*
SJRs	21.0	13.0	7.0	13.0	4.0	9.0	6.0	4.0	10.0	11.0	13.0	12.0	*0.0*
2nd Review	2.0	2.0	0.0	2.0	1.0	0.0	0.0	0.0	1.0	1.0	1.0	0.0	*0.0*
In Hospital Deaths	59.0	69.0	81.0	94.0	60.0	72.0	91.0	82.0	48.0	60.0	52.0	63.0	*77.0*
In Hospital Deaths Crude Rate	17.5	20.6	24.5	27.5	19.2	21.6	30.2	25.6	16.0	17.8	15.4	19.4	*31.0*
LD Deaths	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0	*1.0*
Steis Incidents	10.0	2.0	3.0	4.0	6.0	3.0	4.0	5.0	5.0	6.0	8.0	4.0	*5.0*

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

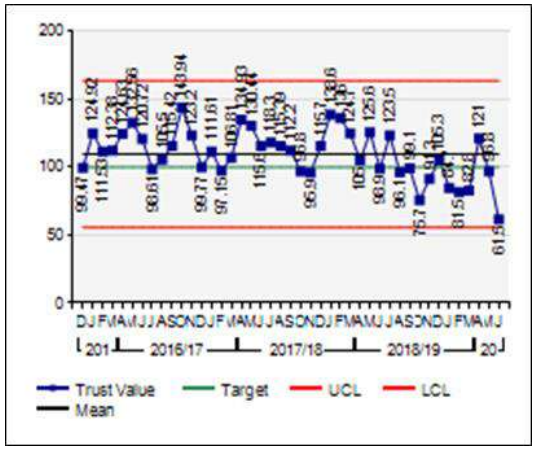
2.2 SHMI (*to May 19*)



The SHMI is now being reported monthly by NHS digital and is therefore now presented as such. SHMI is calculated as observed deaths over expected deaths as predicted by a risk adjustment model. This figure includes deaths within 30 days of discharge and deaths of patients receiving palliative care. Compared to the same time period in previous years, we have less deaths in total and more deaths are 'expected' on the SHMI risk adjustment.

The trusts SHMI is within the expected range, meaning that our mortality rate as measured in this model is 'as expected'.

2.3 HSMR - Hospital Standardised Mortality Ratio (*Monthly June 19*)



The in-month HSMR for June (most recent month with data available) is 61.5 (previous two months 96.8 and 121) This reflects the inherent volatility in mortality rates when viewed monthly in isolation. Comparing May to June, the data suggests that the improved figure is driven by improved harm free care (i.e. increased clinical quality) reduced time spent in the A&E department - which implies more efficient diagnosis and treatment, and a reduction in deaths after discharge and days spent waiting for discharge once clinically stable. HSMR is also produced as an observed mortality over expected. This model excludes patient deaths of those receiving palliative care. Palliative care rates are currently around 40% of all deaths. This will influence the HSMR figure, but not the SHMI.

2.4 HSMR - Hospital Standardised Mortality Ratio (*Rolling to June 19)*

Rolling HSMR to June 2019 is 94.4. This is again within the expected range. Rolling HSMR is averaged over 12 months and is therefore less prone to in-month variation. Consistent factors affecting HSMR over the past 12 months are metrics of AED flow – particularly arrival to departure times. This probably reflects clinical teams being able to assess, diagnose and treat better and more effectively when clinical capacity and demand is matched across the organisation from admission to departure. It is important to realise that

deterioration in AED flow my represent issues that have not been dealt with further down the inpatient or community pathways.

2.5 Diagnosis Groups

Respiratory: LRTI and Acute bronchitis have a low risk of death. Analysis of these cases shows that these patients frequently have high co-morbidity burdens and this is not being captured as the primary diagnosis. These are now subject to clinical review to ascertain the appropriate diagnosis. Pneumonia continues to be the subject of improvement work, establishing and embedding the pneumonia clinical pathway and performing appropriate diagnostics are the foci.

Renal Failure: A task and finish group is operational to lead AKI work. This is following the AQ indicators of clinical quality, supported by the AKI pathway and 12 hourly AKI alerts.

3. 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	The Surgical Ambulatory Emergency Care Project Group are working on a pathway for improved, appropriate GP referrals to the Surgical Assessment Unit. Members of the Emergency Department are working with Strata Networking Solutions to design an electronic GP referral system directly into the Ambulatory Care 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. There is a currently delay in securing resource from the IT Team to complete the fixes required to finalise the electronic functionality for roll out.

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. The scoping session of the 1st November was supported by attendance and input from the Advanced Quality Alliance (AQUA). New areas of focus have been incorporated into the work stream include: IV and Fluid Balance, Insulin, Abdominal Pain Pathway, Fractured Neck of Femur and Gastro-Intestinal Bleed.
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. Changes to reporting are with System C to realign 'breach' and 'overdue' parameters with Trust protocol to produce accurate reporting in line with revised timeframes. Training requirements are being scoped in order to ensure that all relevant employees have the most up to date training in management of the deteriorating patient. (Acute Illness Management Training (AIMS) and Red Day Training in particular for which funding will be required to deliver.
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. The project team is yet to understand from Strata to what level the model will be delivered under the existing contract.
Learning from Deaths	The Trust has a total of 40 SJR level one reviewers across all specialities that are key to the success of the process. An increased focus of thematic reviewing of deaths from the SJR process will support the dissemination of learnings. The first thematic presentation to the Grand Round will be given on 29th November by Dr MacDonald on End of Life deaths. The revised Learning from Deaths Board Report 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. Learning from Deaths: Structured Judgement Reviews (SJR)

4.1 Screening

Screening

Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review	No reviewed	% reviewed
Oct-18	59	31	52.5%	22	71%	10	45%
Nov-18 *Change of Criteria for review	68	40	58.8%	13	33%	12	92%
Dec-18	81	41	50.6%	7	17%	7	100%
Jan-19	94	60	63.8%	13	22%	10	77%
Feb-19	60	38	63.3%	4	11%	4	100%
Mar-19	72	32	44.4%	9	28%	9	100%
Apr-19	91	33	36.3%	6	18%	5	83%
May-19	82	27	32.9%	6	22%	6	100%
Jun-19	48	26	54.2%	9	35%	7	78%
Jul-19	59	53	89.8%	11	21%	9	82%
Aug-19	52	44	84.6%	13	30%	9	69%
Sep-19	63	57	90.5%	18	32%	7	39%
Oct-19	75	68	90.7%	19	28%	1	5%

The above table details the screening process and rates. This demonstrates improved screening with September and October 2019 meeting the 90% target.

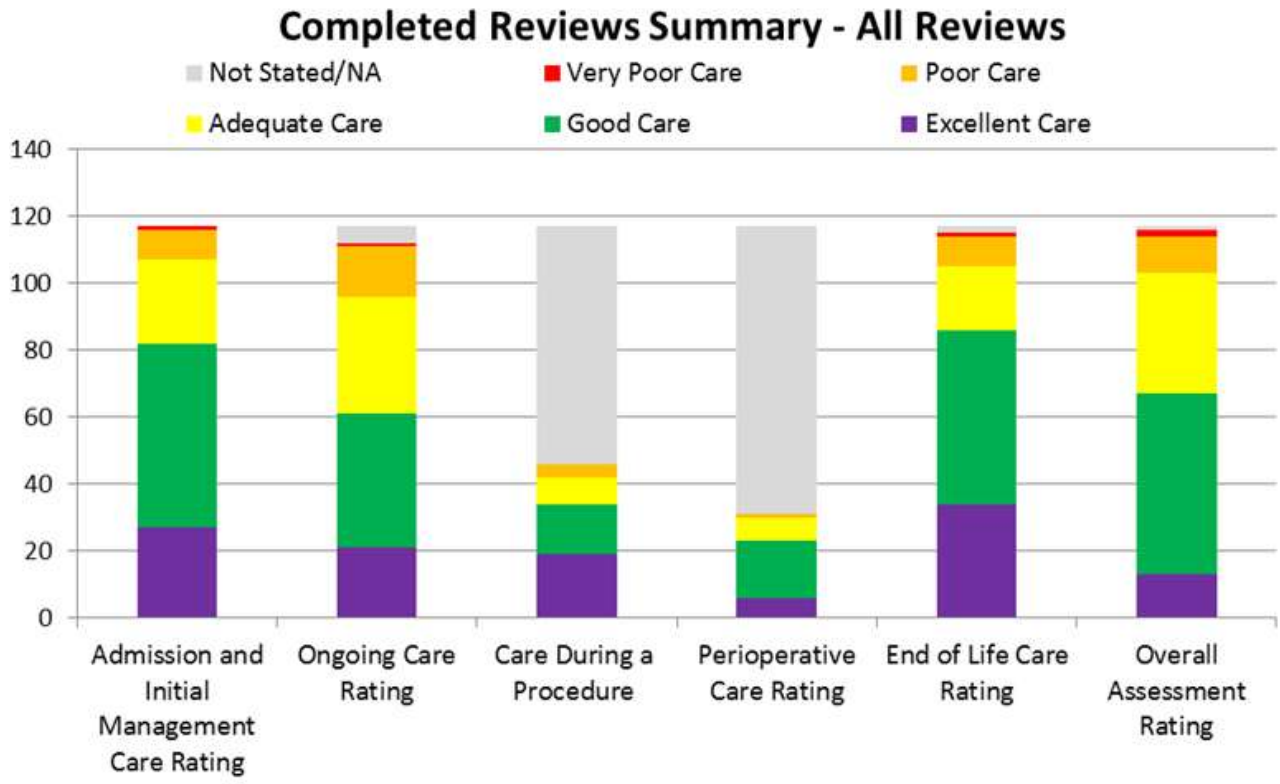
Within 3 months, on average 80% of reviews have been completed. There are delays in terms of the availability of case notes for review, and the timeliness of allocation of a reviewer. These process issues are under investigation to try and make reviewing more timely.

4.2 First Structured Judgement Review

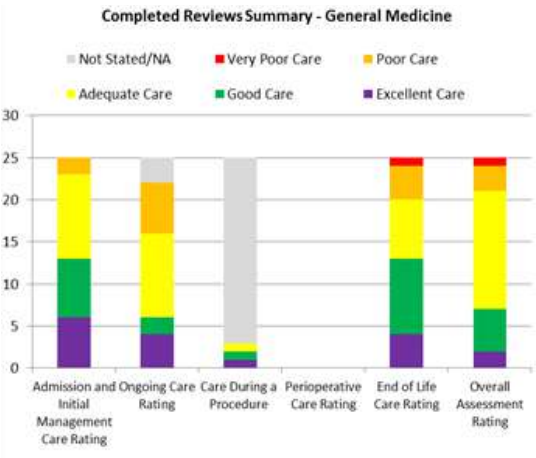
Completed First Structured Judgement Reviews

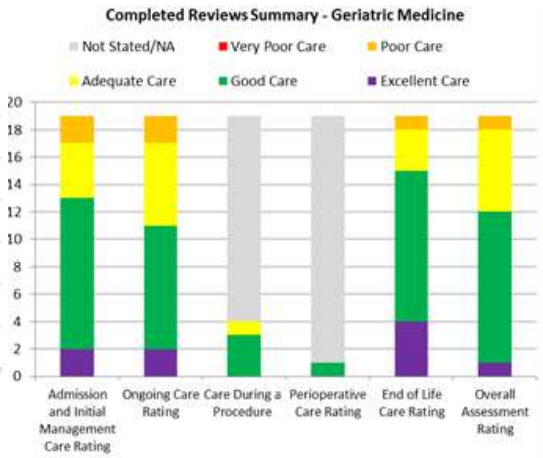
	Date of Review																
	2018						2019										Grand
Specialty	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Total
General Medicine				4	4	1	1	1	3	2				2	5	2	**25**
Geriatric Medicine			1	3	1	2	1	3	2		1		1	1	3		**19**
Intensive Care/Coronary Care/High Dependency	1	2	1	3	1	1			3		1	2	1		2	1	**19**
Trauma & Orthopaedics		1	1	1									1		6	5	**15**
Respiratory Medicine/Thoracic Medicine				1	1				2	2		1		2	3	1	**13**
Cardiology				2	1							2	1	1	2		**9**
Stroke						2						1		1	1		**5**
Gastroenterology							1			1						2	**4**
Urology								1				1	1		1		**4**
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**	**7**	**5**	**10**	**24**	**11**	**117**

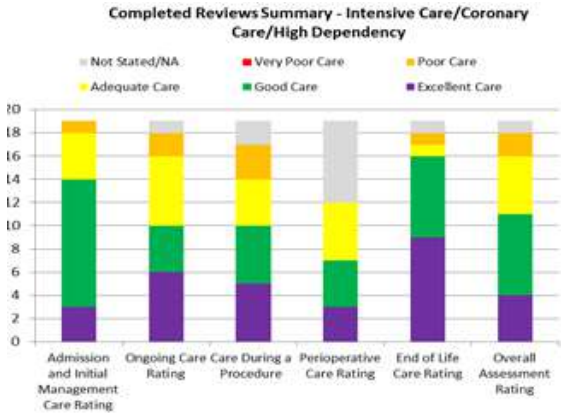
The number of reviews completed is gradually increasing. 117 reviews have been completed for 2018/19, meeting our target of 10% of all inpatient deaths.



Graphical presentation of all reviews performed demonstrates that ongoing (or ward based) care, in the opinion of our reviewers, is where a patient is most likely to experience 'poor' or at best 'adequate' care. Improvement focus should be targetted at this area of the patients journey, which is reflected in the senior ownership and correct pathways of care aspects of the Deteriorating Patient Project.







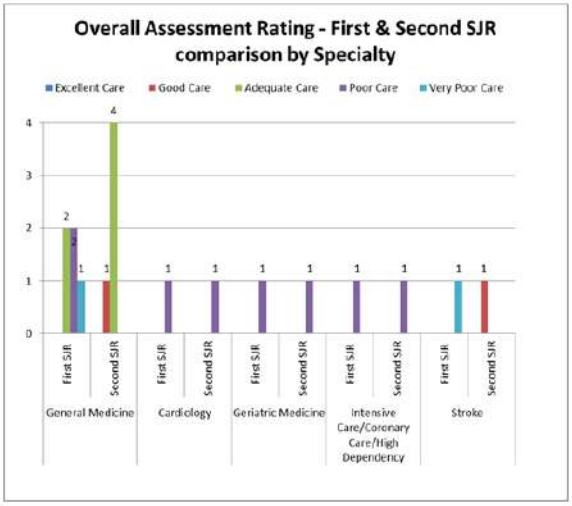
When broken down further by clinical areas with 18 or more reviews it can be seen that the situation with ongoing care is most acute in the general medical population. Also of note is a higher proportion than overall of adequate, poor or very poor end of life care. Critical Care reviews have a higher proportion of excellence overall, but have 3 cases of poor care around a procedure, which is a higher proportion than other clinical areas.

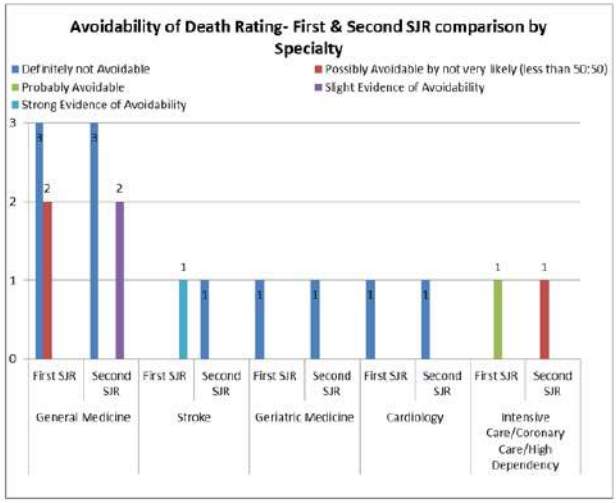
Analysis of individual cases in individual clinical areas is required for further insights.

4.3 Second Structured Judgement Review

	Number of completed First SJR's	Number requiring a second SJR	Number of completed Second SJR's
General Medicine	23	6	5
Intensive Care/Coronary Care/High Dependency	20	2	1
Geriatric Medicine	19	1	1
Respiratory Medicine/Thoracic Medicine	12	1	
Trauma & Orthopaedics	10	2	
Cardiology	9	1	1
Stroke	4		
Urology	3		
Gastroenterology	2		
A&E	2		
Urgent Care	1		
Endocrinology	1		
Grand Total	**106**	**13**	**8**

This table shows the conversion rate by specialty from 1st to 2nd SJR. The criteria for this is 'poor' or 'very poor' care in the overall category. To date 8 second reviews have been completed. All second reviews are presented to the Mortality Operational Committee.





The data above demonstrates the change in the assessment of overall care and the change in avoidability judgement between first and second SJR. In 5/9 cases the care judgement remains the same, in 3 further cases the judgement has changed by one category, and in a further case the judgement has changed dramatically from, 'very poor' to 'good'. These cases are all discussed at MOG to allow the rationale to be presented by the reviewers.

An avoidability assessment is made by the first reviewer using the Hogan scale. This assessment is then made again by the second reviewer. The case is presented at the MOG and a committee decision is made on avoidability. Should the committee agree that the death is more likely than not to be avoidable (definite or probable) then this case is referred to SIRG for appropriate action. To date 2 cases have been identified as avoidable by first reviewers, this judgement has been upheld in one case, which was referred to SIRG, underwent a full RCA, and the findings have been shared with the Sefton Coroner's office.

4.6 Lessons Learned: Process & Activity

The trust will hold 3 Grand Rounds a year based on the finding from SJRs. The first of these will be held on the 29th of November and facilitated by Dr McDonald. The discussion will focus around decision making at the end of life using case examples from the past 12 months.

A Lessons Learned Bulletin is produced in order to communicate out important points from the MOG, including relevant findings from SJRs. This is produced on a monthly basis by Janette Mills, Head of Audit and Effectiveness.

We have cross referenced data from coding and SJR to identify ten cases of death from AKI. These cases will be reviewed for learning to add extra information to the AKI improvement work.

Further work is planned to use our SJR database to provide an information source to design improvements going forward such as in the case of femoral neck fractures.

5. Conclusions & Recommendations

Successive mortality reports have stressed the link between AED flow and mortality rates. This report also makes this point. However, the association is with the whole system and not just AED. AED flow deteriorates when whole system capacity is outstripped by demand. When this occurs the system becomes less safe and mortality rates rise.

Our hospital population is a population which does not have a large degree of physiological resilience, either due to frailty or multi-morbidity, thus, variations in the capacity / demand equation are particularly dangerous.

The equation is affected by the number of patients arriving, the number departing and the capacity of the staff within the system (vacancies, stress, sickness, training and experience in the organisation).

Better balancing these demands by increasing staffing and their skill set, standardising processes of care and working to provide alternatives to hospital admission - were appropriate, has reduced our headline mortality figures and improved the safety of our care.

Recent events demonstrate that sudden increases in demand, without commensurate increases in capacity threaten safe patient care. This can either be predictable (winter) or unpredictable.

Recommendations

Proactive monitoring of capacity and demand within the system occurs; those performing this monitoring must be clear that decisions taken to manage surges in demand have real consequence on patient mortality.

Continue to evaluate and invest in activity which provides capacity to manage serious illness quickly and aggressively to reduce complications and length of stay.

Encourage and support interventions which support staff to work reliably and consistently, with minimal variation, such as through the adoption of appropriate IT or best practice pathways which are clear and available.

Support ward processes and ward care with the same intention as supporting AED in order to improve the quality of patient care and thereby improve flow and improve safety. Start by engaging with ward teams such as junior medical staff and junior nurses to understand the issues they face.

7.0 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.
Learning from Deaths	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.
Specialist	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	13th November 2018 for Hospital Management Board 21st November 2019

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

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

The Month by Month Hospital Standard Mortality Ratio is inherently unstable. It is affected by the number of deaths in that month and the case mix, which changes. It does however allow analysis of what the underlying contributors are. These are the causes of demand capacity mismatch. This month (HSMR 61.5) discharge and AED flow improved dramatically – thus the system could cope better with demand.

The Rolling HSMR and SHMI give a better indication of direction of travel. The trend of both is towards improvement, again reflecting the investment made in quality.

Capacity and Demand must be actively managed, should demand increase, commensurate increases in capacity are required to maintain safety. This is not just attendance at AED, but can be across different parts of the system including inpatient wards – what is our surge plan and how is it governed / activated?

Mortality screening rates remain around 90%, 117 SJRs were performed in 2018-2019, which is the target and has been met. The challenge now is using this information to identify and propose improvement work. The first areas will be end of life care, AKI and fractured Neck of Femur.

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.

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

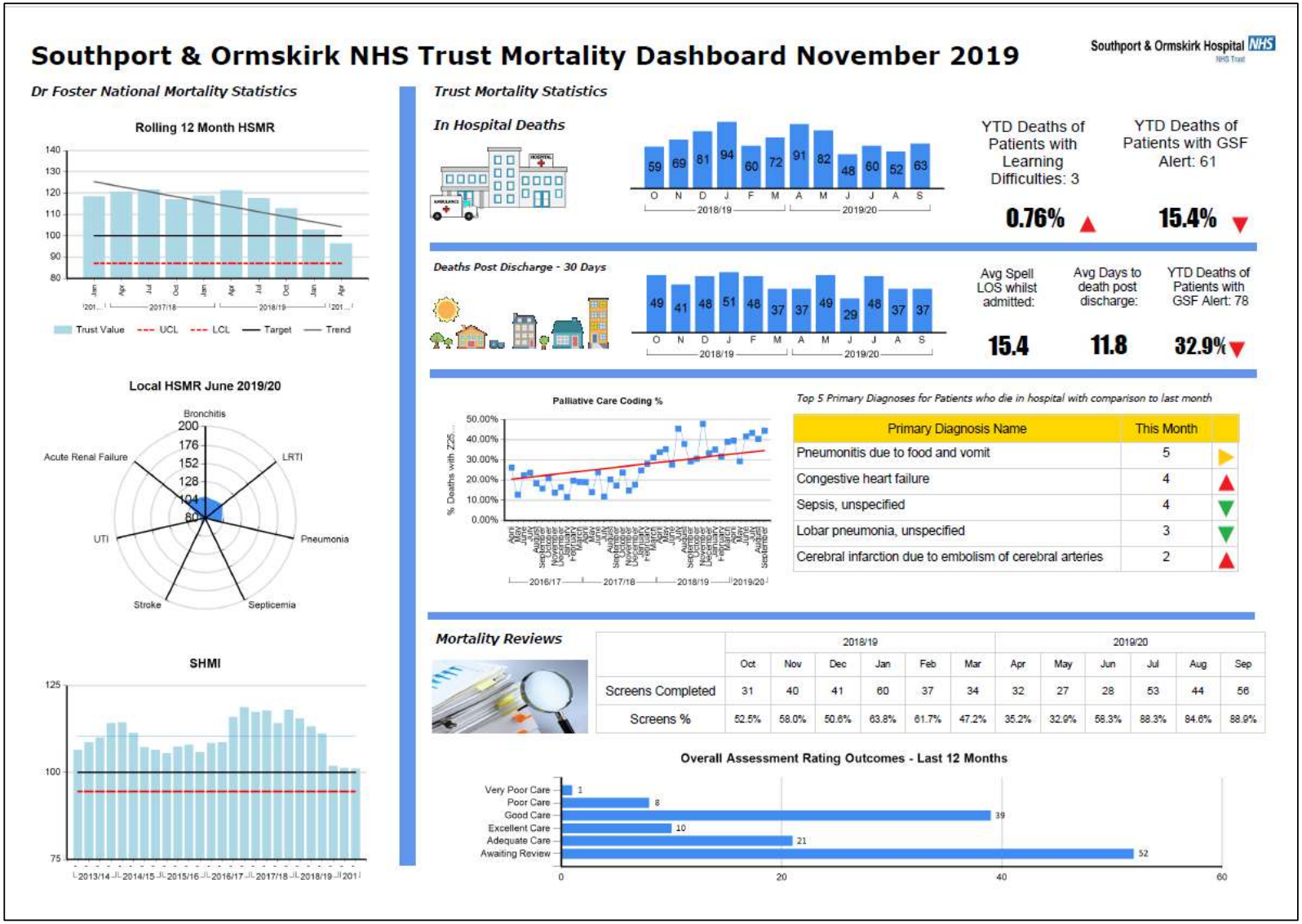
To devise continuous self- improvement structures which proactively identify clinical deterioration within our community so that by March 2021:
Mortality indictors sit premanently within confidence intervals (SHMI, HSMR & Local SMR)
All end of life patients to have an Anticipatory Clinical Management 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.

MILESTONE / WORK STREAM / KEY ACTIVITY	Start date	End date	Owner / Lead	Completion %	BRAG	LATEST UPDATE FOR HIGHLIGHT REPORT
Project Rescoping						
	21/10/2019	15/11/2019	R Flood-Jones	85%	A	5 of 6 required re-scoping sessions have now been held and documented. Driver Diagrams are with workstream groups for feedback ahead of second session for feedback.
Senior Ownership & Appropriate Escalation						
Electronic Ward Board Round *PDSA Pilot on Gastro Ward*	03/06/2019	30/03/2020	AMD Patient Safety	20%	R	**There remains a blockage which has caused a 2 month delay to date : 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	**There is a requirement for the Trust Documentation Programme to be scoped in line with the Operational Strategy in line with Vision 2020** 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.
OBSERVATIONS & ESCALATIONS:						
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 being extended onto Ward 14B** 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.
Red Day & AIMS Training	01/11/2019	30/12/2020	M Pinnington	5%		PMO have met with M Pinnington who is lead for the redesign of the nursing training plan. There are no funds to support the coordination or delivery of training. A risk paper is to be written for escalation through the Trust's governance arrangements, Discussion required with Work Stream Group to confirm whether this is to be brought into the scope of the Project,
Future Care Planning						
Advance Care Planning: supporting discussions with Patients and Families	01/04/2019	30/09/2020	Project Manager / Frailty Practitioner	5%	R	Strata Networking Solutions have proposed a paperless solution for a single electronic ACMP - there are issues with the governance and pace under which Strata are currently slowly delivering progress. There is concern that they will only provide a basis proof of concept by the end of the contracted period and that there will be considerable cost to the Trust to purchase the fully required product in line with expectations.
Learning from Deaths						
Structure Judgement Review Method	01/04/2019	30/03/2020	AMD Patient Safety	70%	R	The Screening of deaths increased to 90.7% for October 2019 . 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.
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.

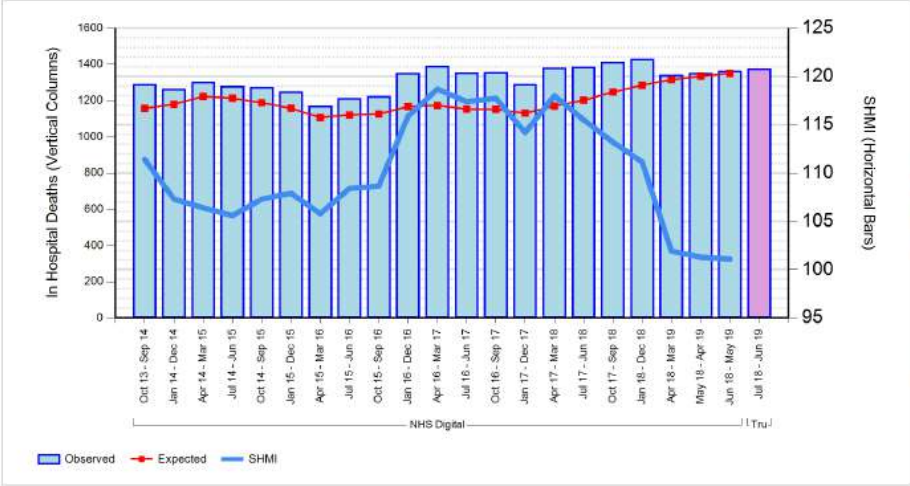
RISKS (Potential risk which will impact the project; has not yet occurred which will	RAG	Mitigation Activity	RAG After Mitigation	Comments
Electronic Ward Boards - IT Development	R	At time of reporting all IT support for the Electronic Ward Board PSDA has been put on hold due to staffing levels. Discussions 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.

Appendix 3: Mortality Monthly Data Report



SHMI Breakdown

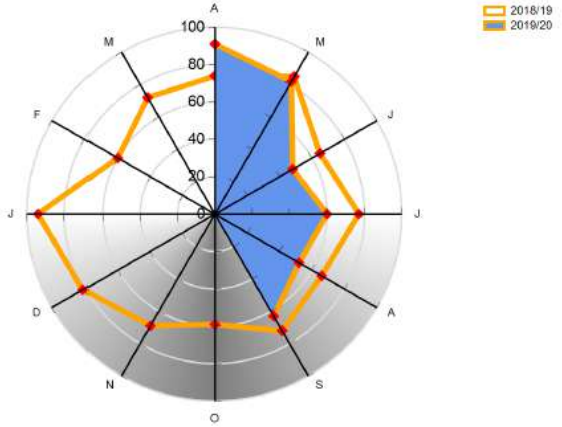
Southport & Ormskirk Hospital NHS
NHS Trust



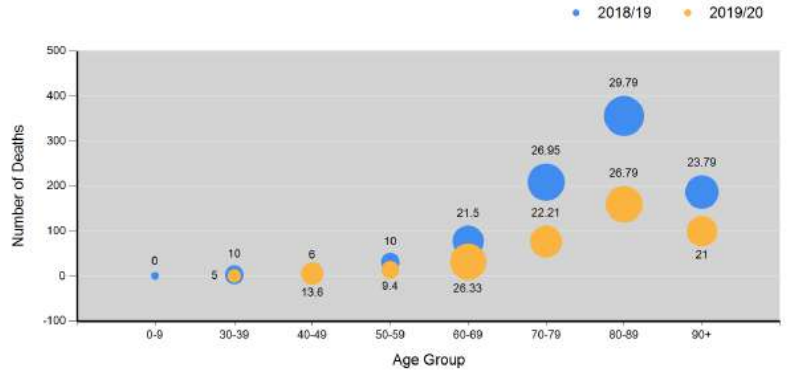
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

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

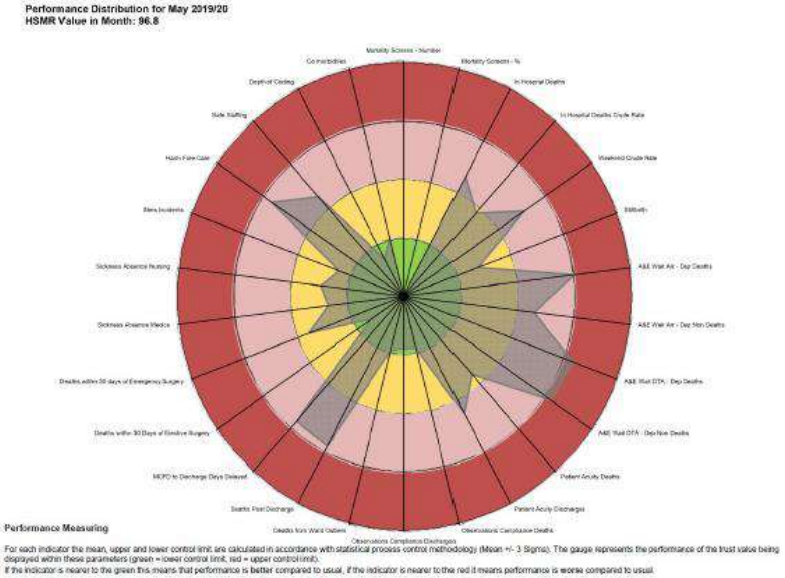


In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



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 May & June 2019



The in month HSMR in May 2019 was 96.8, there were 82 deaths.

The performance distribution chart (left) takes key indicators from the mortality report and displays their relative value on a scale of green (good) to red (bad).

The indicators this month which could explain the HSMR value are mainly the A&E indicators which show there were longer than average waits in the department from arrival to decision to admit and arrival to departure for patients who ultimately died.

The harm free care indicator was also stretching towards red.

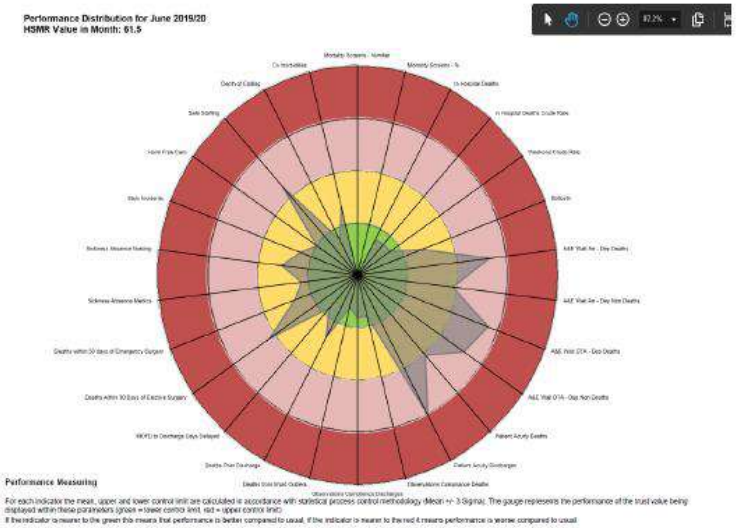
Although the deaths post discharge indicator is near the red area (49 deaths) this will not effect the HSMR only the SHMI.

The in month HSMR in June 2019 was 61.5, there were 48 deaths and this is a large decrease from the previous month.

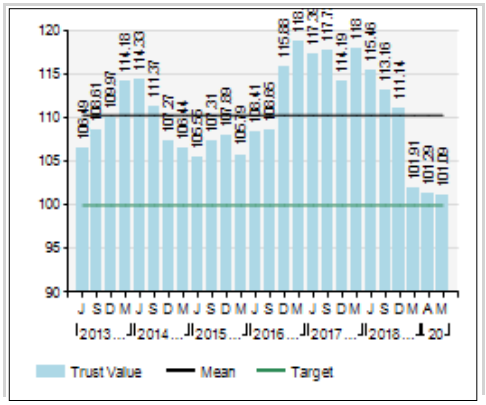
There are no indicators this month which are in the dark red shaded area which shows good performance across all areas.

The worst performing indicator is the acuity of patients who are discharged (patients who did not die in hospital). The relevance of this indicator to the SHMI is that it shows the Trust had a lot of patients in the month who were very sick, which increases the number of 'expected' deaths in the month (the denominator). Coupled with a low number of actual deaths (the numerator) it gives a very low HSMR.

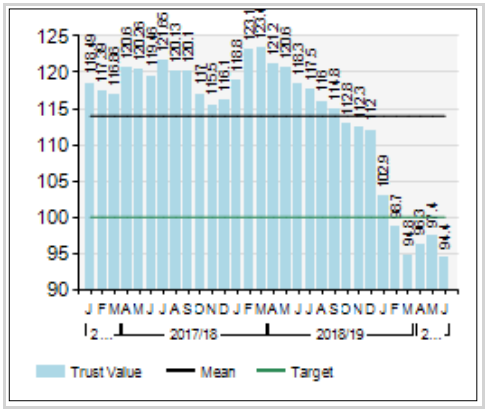
It is also important to note that the harm free indicator which was red the previous month (when it was 96.2%) is now green in June with a value of 99.2%.



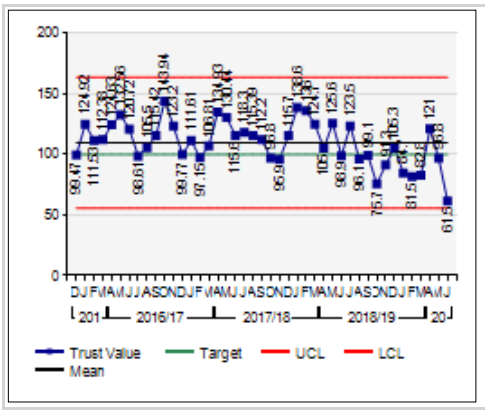
SHMI - Summary Hospital Level Mortality Indicator



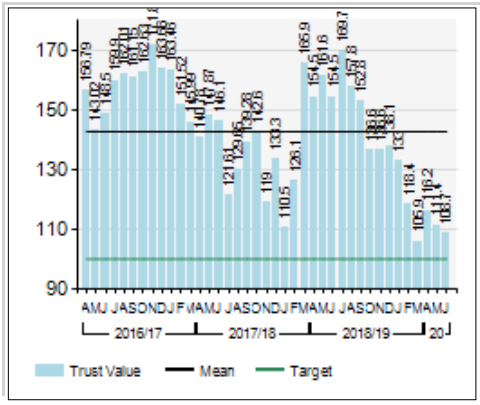
HSMR - Hospital Standardised Mortality Ratio (*Rolling 12 month*)



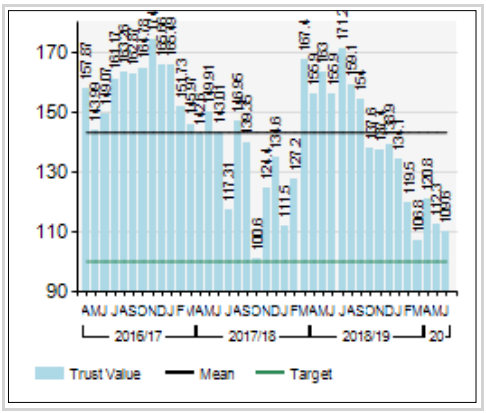
HSMR - Hospital Standardised Mortality Ratio (*Monthly*)



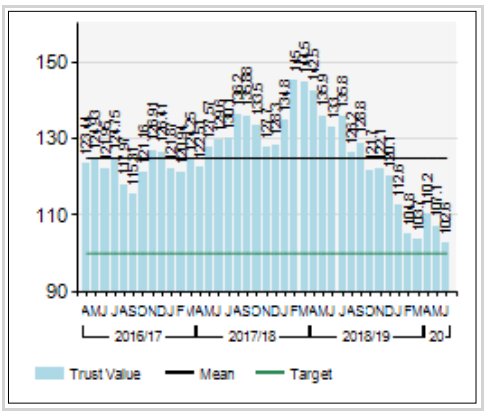
Local HSMR Bronchitis



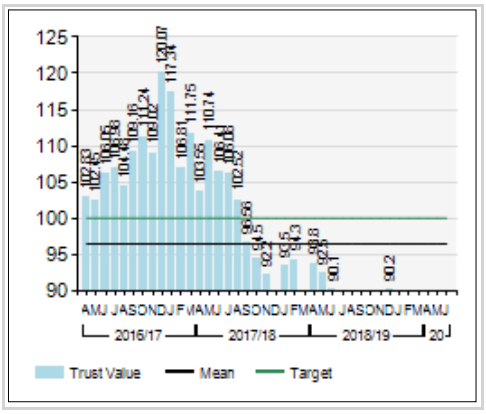
Local HSMR Lower Respiratory Tract Infection



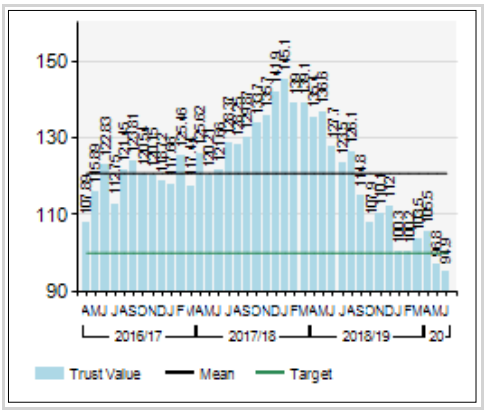
Local HSMR Pneumonia



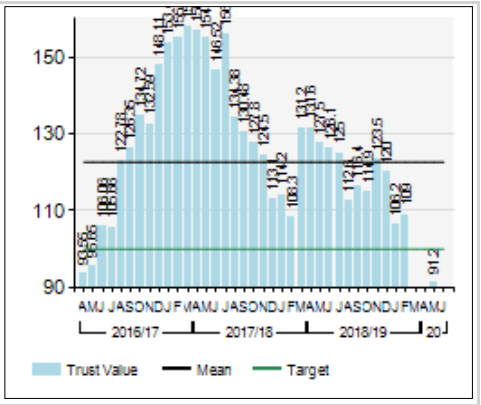
Local HSMR Septicemia



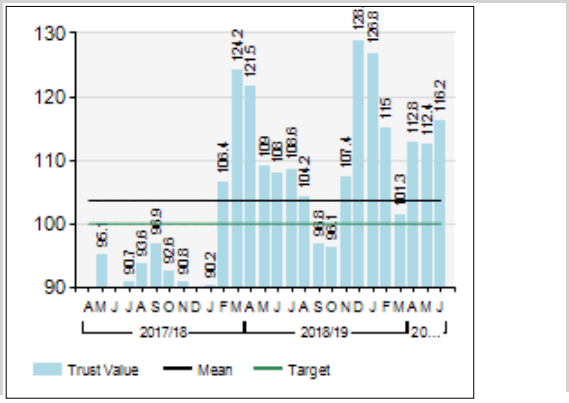
Local HSMR Stroke



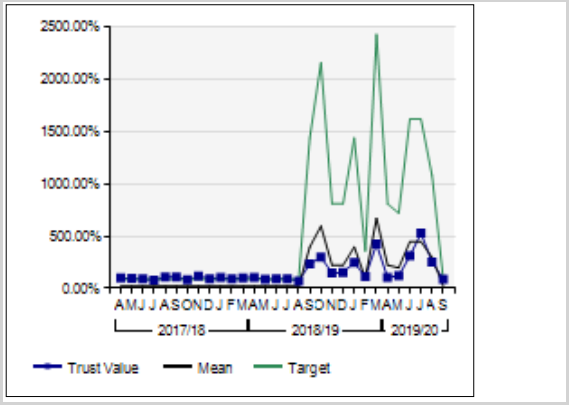
Local HSMR Urinary Tract Infection



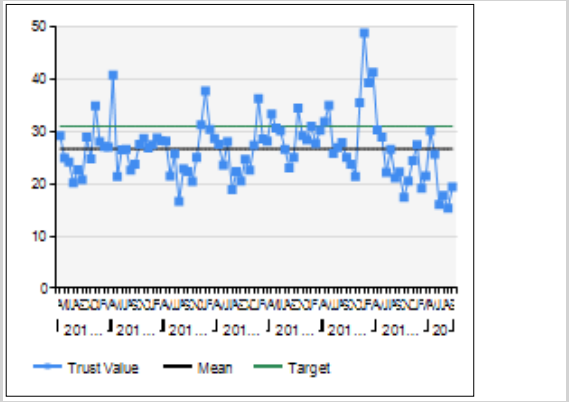
Local HSMR Acute Renal Failure



Mortality Screens - % Deaths Screened



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



Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB203/19d**	**Report Title**	**Monthly** Safe Nurse & Midwifery Staffing Report – October 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 October 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 October 2019.

Alert

- For the month of October 2019 the Trust reports safe staffing against the national average (90%) at 92.3%.

Advise

- Care Hours per Patient Day (CHpPD) reporting remains under review to support accuracy of data reporting. Trust CHpPD reports at 8.3
- The Nursing Safe Staffing report is under reconstruction with a revised report anticipated in January 2020. The review includes workforce dashboard reporting and triangulation against clinical outcomes.
- The Trusts reporting to UNIFY has been reviewed to assure the Safe Staffing reporting includes the staff allocated on arrival of shift to clinical areas from the flexible workforce pool. Retrospective review has identified slight uplift to the trust safe staffing % reporting and an application to resubmit this data to UNIFY has therefore been requested by the trust.

Assure

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

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

	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

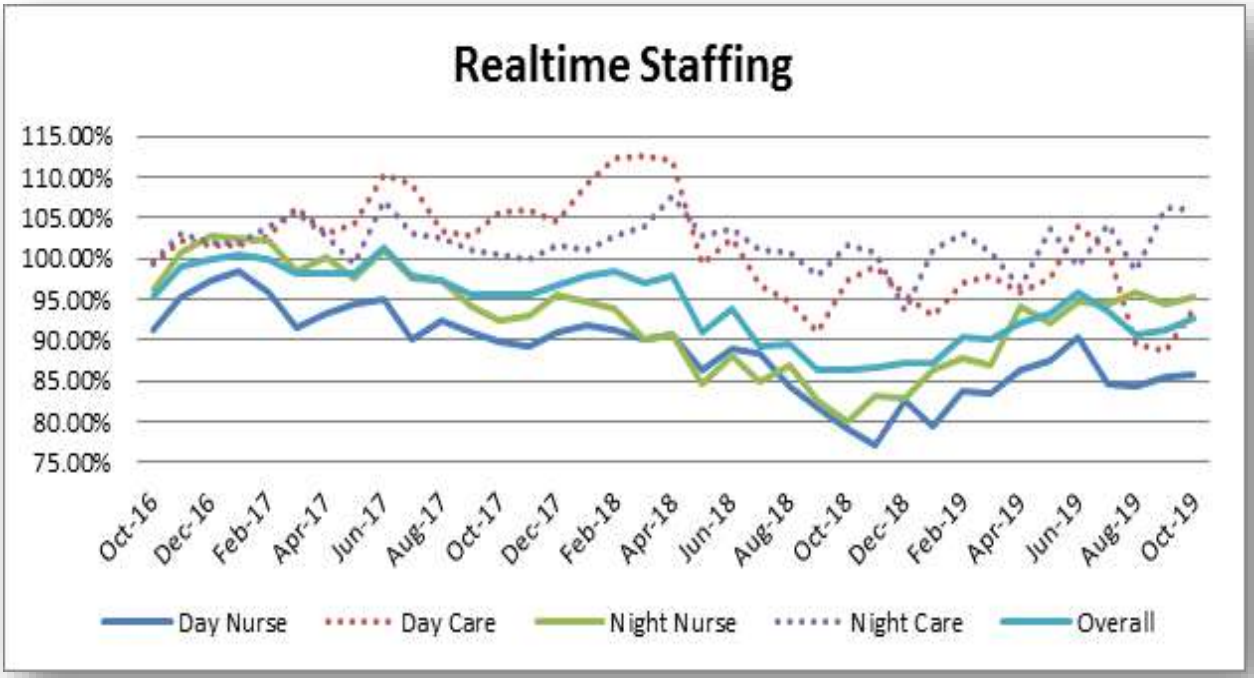
Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

1. Introduction
This report provides an overview of the staffing levels for October 2019.

Overall fill rate for October 2019 was 92.3% (appendix 1).

- 91.01% Registered Nurses on days
- 86.04% Registered Nurses on nights
- 97.14% Care staff on days
- 98.72% Care staff on nights



The Board is advised the Trusts reporting to UNIFY has been reviewed to assure the Safe Staffing reporting includes the staff allocated on arrival of shift to clinical areas from the flexible workforce pool. Retrospective review has identified slight uplift to the trust safe staffing % reporting and an application to resubmit this data to UNIFY has therefore been requested by the trust. The Board will be kept appraised on this outcome and any change to the trusts Safe Staffing % reporting.

The overall CHpPD for the Trust has remained static in month reporting at 8.3 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. .

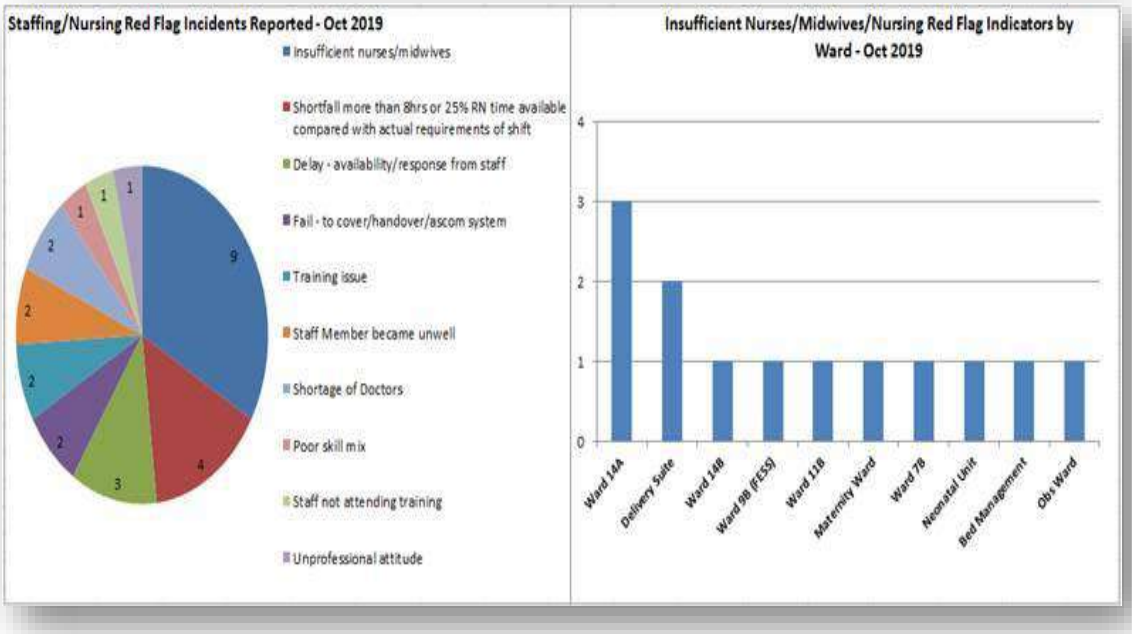
Planned care clinical business unit (CBU) report overall 10.3, Urgent Care CBU 6.6 and Women's and Children's 13.0 overall.

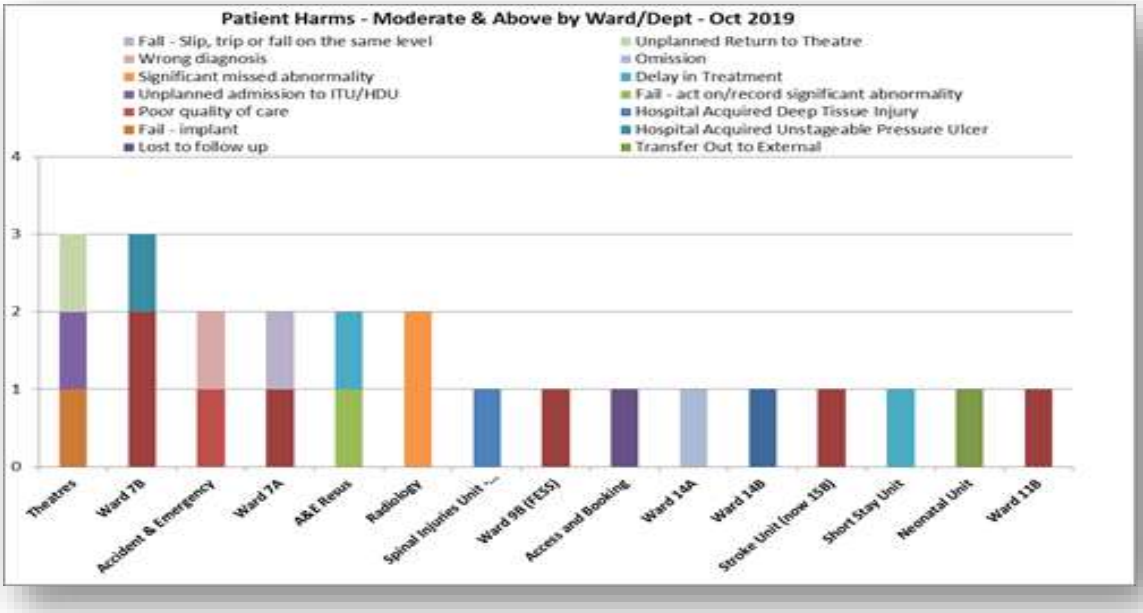
2. October Safe Staffing
Trust whole time equivalent (wte) funded establishment versus contracted for October 2019 below finance figures:

	Funded WTE	Contracted WTE	Vacancy
Registered	950.41	791.46	158.95
Non-registered	447.71	367.03	80.68
Total	1,398.12	1,158.49	239.63

3. Staffing Related Reported Incidents October 2019

27 staffing incidents/nursing red flags were reported in October, 12 less than the previous month. 13 of these incidents highlight insufficient nurses/midwives or nurse shortfalls, 16 less than September. 3 of these relate to Ward 14A (red flags) and a further 2 to Delivery Suite. No harm was caused to patients as a result of these incidents.

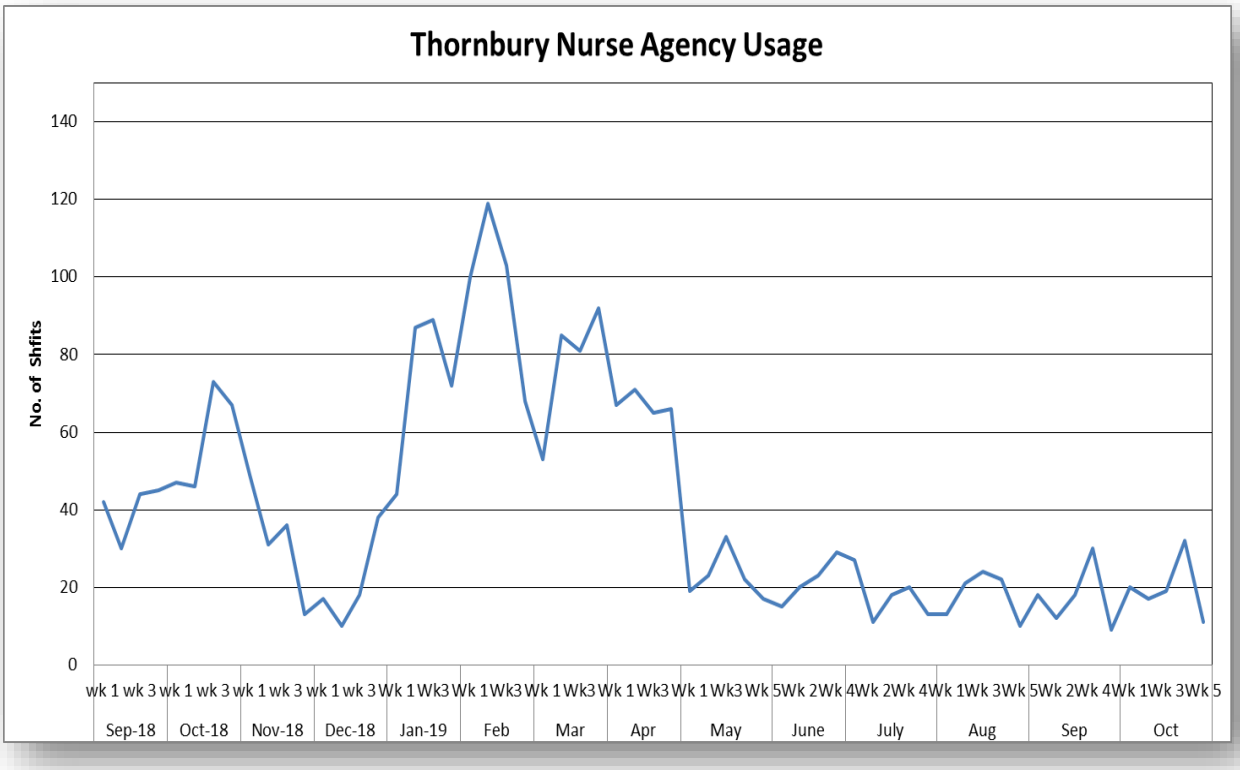




In October there were 4 nursing red flags reported in month, 3 on ward 14A, 1 on ward 7b. All incidents have been supported and managed through trust process and there has been no reported correlation with patient harm.

4. Non Framework Nurse Agency Usage

The Trust continues to proactively review and consider options for additional staffing resource as an interim and longer term substantive position.



October reports a 3.7% increase in off framework agency usage compared to 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) – October 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	1,476.75	1,382.98	1,512.50	1,299.98	1,106.50	1,233.50	1,139.50	1,063.50	835	93.65%	85.95%	111.48%	93.33%	3.1	2.8	6.0		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	739.50	726.50	370.50	341.00	732.00	741.67	360.75	383.25	263	98.24%	92.04%	101.32%	106.24%	5.6	2.8	8.3		
E A U	300 - GENERAL MEDICINE	1,748.98	1,566.48	1,318.75	1,237.92	1,086.53	1,199.53	867.50	967.25	595	89.57%	93.87%	110.40%	111.50%	4.6	3.7	8.4		
FESS Ward	300 - GENERAL MEDICINE	1,674.72	1,302.22	1,639.75	1,487.20	1,093.00	1,126.00	789.50	903.17	850	77.76%	90.70%	103.02%	114.40%	2.9	2.8	5.7		
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,556.48	1,452.48	1,689.00	1,332.00	1,096.50	1,154.50	1,218.00	1,121.50	796	93.32%	78.86%	105.29%	92.08%	3.3	3.1	6.4		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,785.23	1,623.23	1,636.23	1,500.07	1,461.50	1,426.00	1,162.50	1,041.00	894	90.93%	91.68%	97.57%	89.55%	3.4	2.8	6.3		
Short Stay Unit	300 - GENERAL MEDICINE	1,509.92	1,353.25	1,526.00	1,613.48	1,098.00	1,118.00	1,114.50	1,279.00	874	89.62%	105.73%	101.82%	114.76%	2.8	3.3	6.1		
Ward 15a General Med	300 - GENERAL MEDICINE	1,556.25	1,361.25	1,673.25	1,511.17	1,106.00	1,083.50	1,093.50	1,247.17	733	87.47%	90.31%	97.97%	114.05%	3.3	3.8	7.1		
Stroke Ward	300 - GENERAL MEDICINE	1,272.25	1,295.58	1,523.00	1,295.98	1,098.98	1,092.00	733.00	799.48	583	101.83%	85.09%	99.36%	109.07%	4.1	3.6	7.7		
Rehab & Discharge Lounge	314 - REHABILITATION	1,551.25	1,264.00	1,946.07	1,690.82	1,100.00	1,098.00	1,112.50	1,134.50	826	81.48%	86.88%	99.82%	101.98%	2.9	3.4	6.3	Y	x1 incidents relating to below 25% or more than 8hrs against RN - Mitigated at time investigation ongoing
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,841.25	1,615.17	2,467.75	1,748.23	1,109.25	1,204.25	1,587.50	1,407.00	911	87.72%	70.84%	108.56%	88.63%	3.1	3.5	6.6	Y	x3 incident Related to high patient acuity ,short term sickness- managed within trust process- no patient harm. Incident closed.
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,238.25	1,246.25	1,385.25	1,223.25	723.00	724.00	367.50	378.00	451	100.65%	88.31%	100.14%	102.86%	4.4	3.6	7.9		
Ward H	110 - TRAUMA & ORTHOPAEDICS	743.50	657.00	742.00	391.50	730.50	610.50	0.00	153.50	123	88.37%	52.76%	83.57%	#DIV/0!	10.3	4.4	14.7		
Surgical Ward	100 - GENERAL SURGERY	1,073.25	1,015.42	1,109.00	992.50	737.00	749.50	367.00	367.00	474	94.61%	89.50%	101.70%	100.00%	3.7	2.9	6.6		
Spinal Injuries Unit	400 - NEUROLOGY	2,983.92	2,849.25	3,125.42	2,969.92	2,597.75	2,449.75	1,443.00	1,431.00	720	95.49%	95.02%	94.30%	99.17%	7.4	6.1	13.5		
Ward G	101 - UROLOGY	1,095.50	927.00	1,069.00	773.75	825.00	778.00	379.50	355.00	328	84.62%	72.38%	94.30%	93.54%	5.2	3.4	8.6		
TOTAL		**23,847.00**	**21,638.06**	**24,733.47**	**21,408.76**	**17,701.52**	**17,788.70**	**13,735.75**	**14,031.32**	**10256**	**90.74%**	**86.56%**	**100.49%**	**102.15%**	**3.8**	**3.5**	**7.3**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
A&E Nursing		4,195.25	4,287.00	2,607.25	1,607.75	3,652.00	3,583.50	1,108.00	748.00	0	102.19%	61.66%	98.12%	67.51%					
Ambulatory Care Unit		727.00	330.00	740.00	400.98	0.00	176.00	0.00	92.00	104	45.39%	54.19%	#DIV/0!	#DIV/0!					
TOTAL		**4,922.25**	**4,617.00**	**3,347.25**	**2,008.73**	**3,652.00**	**3,759.50**	**1,108.00**	**840.00**	**52**	**93.80%**	**60.01%**	**102.94%**	**75.81%**	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	3,979.75	3,331.75	1,215.00	1,001.50	3,692.00	3,188.50	1,116.00	538.75	386	83.72%	82.43%	86.36%	48.28%	16.9	4.0	20.9		

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	3,536.25	3,338.17	1,291.00	1,123.00	639.25	567.75	1,098.00	1,062.50	425	94.40%	86.99%	88.82%	96.77%	9.2	5.1	14.3		
MAU	501 - OBSTETRICS														#DIV/0!	#DIV/0!	#DIV/0!		
TOTAL		**3,536.25**	**3,338.17**	**1,291.00**	**1,123.00**	**639.25**	**567.75**	**1,098.00**	**1,062.50**	**425**	**94.40%**	**86.99%**	**88.82%**	**96.77%**	**9.2**	**5.1**	**14.3**		

Ward name	Specialty	Registered nurses		Care Staff		Registered nurses		Care Staff		Patients at 23:59 each day	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,152.75	1,184.50	307.50	222.75	1,153.68	1,133.75	0.00	0.00	229	102.75%	72.44%	98.27%	#DIV/0!	10.1	1.0	11.1		
Paediatric Unit	420 - PAEDIATRICS	1,928.50	1,854.50	1,389.00	1,139.25	1,870.00	1,660.00	371.50	479.50	403	96.16%	82.02%	88.77%	129.07%	8.7	4.0	12.7		
TOTAL		**3,081.25**	**3,039.00**	**1,696.50**	**1,362.00**	**3,023.68**	**2,793.75**	**371.50**	**479.50**	**632.00**	**98.63%**	**80.28%**	**92.40%**	**129.07%**	**9.23**	**2.91**	**12.14**		
PLANNED		12,955.42	11,641.84	11,113.42	9,100.65	10,414.50	9,704.50	5,260.50	4,630.25	3,393	89.86%	81.89%	93.18%	88.02%	6.3	4.0	10.3		
URGENT		14,871.33	13,327.97	14,835.05	13,309.61	10,979.02	11,272.70	9,591.25	9,939.82	7249	89.62%	89.72%	102.67%	103.63%	3.4	3.2	6.6		
W&C		6,617.50	6,377.17	2,987.50	2,485.00	3,662.93	3,361.50	1,469.50	1,542.00	1,057	96.37%	83.18%	91.77%	104.93%	9.2	3.8	13.0		
TRUST TOTALS		**34,444.25**	**31,346.98**	**28,935.97**	**24,895.26**	**25,056.45**	**24,338.70**	**16,321.25**	**16,112.07**	**11,699**	91.01%	86.04%	97.14%	98.72%	4.8	3.5	**8.3**		

Green- 80% and above

Red- Under 80%

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB204/19**	**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 (blue line on graph)
- 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 – a white box indicates 'no trajectory'
- Executive sign off, for their respective KPIs
- Ongoing data cleansing and data quality audits – data quality group set up
- HR Trajectories have been agreed and will be included going forward
- Continued support to colleagues in developing good quality and useful narrative - Peer review of IPR introduced
- Results of MIAA audit of IPR recommended stability in design to enable documentation of the data collection process, and a focus on data quality

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	✓ Workforce Committee

Committee	

Integrated Performance Report Executive Summary

September 2019, Steve Christian (Chief Operating Officer)

Governance Framework

The Integrated Performance report is reviewed monthly by the Trust Board and specific indicators are reviewed by the sub committees of the Board which report assurance, alerts and advice to the Board.

The performance report includes the Trust indicators relating to the NHS, Constitutional Standards, the 2019/20 SOF and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework.

Each indicator has a Statistical Process Control Chart (SPC) and commentary. Whilst this executive summary provides an overall view of the organisational improvements and risks, some indicators are also included as improvement measures for the four QI priorities and are covered in detail in the relevant reports.

The Executive Summary highlights key changes in Trust performance (improvement or any areas of concern) and outlines specific actions linked to the Trust's Improvement Plan and key programmes of work

Executive Summary

Domain	High Level Summary (priority KPIs by exemption)	Critical Actions (against priority KPIs)
Responsive & Efficiency	**Urgent and Emergency Care (UEC)** Demand for UEC and the ability to optimise patient flow remains a challenge for the Trust and the wider system. The continued challenges in UEC will have a negative impact on a number of KPIs within the IPR given the significant reliance on good patient flow. 4 hour performance has decreased in October to 84.6% from 88.6% in September, Southport achieving 69.94% which is a significant drop from 77.58% in September. In addition the Southport site reported 27 x 12 hour DTA Breaches. ED attendances at Southport were 5.6% higher than October last year and 4.0% higher than the previous month reaching	**UEC** Winter Planning (system wide): System winter plans have been pulled together to address the out of hospital capacity gap identified by Venn. There are risks around the ability for these schemes to deliver against the assumptions due to workforce availability in particular within the community setting and specifically across the Southport & Formby locality. Winter Planning (internal): The Trust has introduced a weekly Winter Operational Group to support implementation of the hospital winter schemes. The schemes include the opening of a 16 bedded post -operative Orthopaedic ward to support appropriate transfer of patients still under acute care that can receive their rehabilitation at Ormskirk. This in effect will release 16 beds at Southport as this current cohort of patients remain on the Southport site until

	a figure of 5003. This is the fourth time this year when Southport attendances have breached the 5000 mark. 7th October 2019 is currently the busiest day on record for the department when 224 patients arrived in one day. In addition, the Medically Optimised for Discharge (MOfD) rate continues to increase from 51 patients in April to 73 patients in October, an increase of 43%.	fit for discharge. The Trust Board has signed off the business case with recruitment and estates work commenced with a target date of opening in the first week of January. Patient Flow Improvement programme: A number of schemes are being introduced to support weekend performance. These include enhancing pharmacy presence, opening up ambulatory care and increasing senior decision makers across the inpatient wards. Patient Flow Improvement Programme (PFIP) continues to work on its actions to improve efficiency and leadership of patient management on the ward with an aspiration of established reduce all Emergency ALOS by 0.5 days. The baseline at the start of this work stream was set at average LOS 7.4 days. The results for October show an improvement of almost 1 day now at 6.5days.
	Cancer The 62 day standard was 82% against the 85% constitutional requirement. Whilst this is marked improvement against the previous month the sustainability of performance above 80% is a challenge. Endoscopy continues to appoint at the 14 day point. Haematology and Head & Neck services under intense pressures due to workforce constraints (both services have historical SLAs in place with other providers that are not performing)	**Cancer** Fortnightly Cancer Improvement meetings with Chief Operating Officer allow high level impacts and barriers to be discussed with Cancer Services. The meeting provides assurance and escalation of issues, with reporting of solutions the main focus. In addition, individual tumour sites are invited to attend this meeting to discuss in depth the risks, barriers and good practice within their own areas, which support their improvement plan. Robust cancer improvement plans for each individual tumour site and services that affect the cancer pathways, with clearly defined KPIs are now in place. Formal discussions are underway with other providers regarding Haematology and Head & Neck services.
	18 Week RTT Performance September 18-week RTT performance was 93.4%. Predictions for November show performance will remain around 93% and continue to be above the 92% threshold. There are currently 7 patients waiting over 40 weeks, a slight increase , however the number of 30+ week waiters has dropped from 99 to 88 over the past 4 weeks, these long waiters are largely due to the continuing challenges in Community Paediatrics and Gynaecology.	**18 Week RTT Performance** The Gynaecology position is predicted to recover from January 2020 as the Trust has recently appointed 4 consultants. The Community Paediatrics performance will continue to be compromised until we can appoint into the vacant community Paediatrician post.

	Diagnostics Performance for October against the 6 week wait target was 2.16% an improvement of 0.5% over the September position and in line with trajectory. Endoscopy recorded the most number of scopes in a month (on record) in October at 653 with zero sessions cancelled due to no nurses. **Theatre Utilization** Ormskirk improved in month to 73% for October by 1% against the previous month. However Southport utilization recorded a decline in performance due to high numbers of cancellations attributed to poor patient flow.	**Diagnostics (Ultrasound)** The Ultrasound backlog reduction will be delivered through an agreed SLA with Renacres, and will continue to be supported by PDS MSK Sonographers and extra in-house consultant activity. **Theatre Utilization** The improvement programme continues to show progress (5% improvement in utilization since April) through a focus on three work areas: Scheduling, Avoiding on-the-day cancellations and starting sessions on time (the Golden Patient).
Well Led	The key risks relate to workforce capacity and capability. A number of metrics including vacancy rate and turnover as well as sickness absence and appraisal are consistently below the required level. This is impacting significantly on the financial performance as the Trust has been reliant on temporary and high cost solutions in order to maintain safe staffing and the CHPPD levels. One such improving metric is the Trust's rolling year to date sickness absence rate which has consistently reduced month on month for 11 months and remains on track to attain below 5% by March 2020. However, the Trust has not felt the benefit of the reducing sickness absence rate, due to an increasing vacancy rate, which is attributed to an increasing staff turnover rate.	Priority has been given to establishing a number of task and finish groups to engage with key stakeholders to centre on: Recruitment and Retention and also Performance Development and Review (PDR). Therefore, within the next four weeks, two task and finish groups will be established, one group will focus on recruitment and retention and the other on performance development review. In addition the Trust is continuing work with an external company, Liaison, on developing their Workforce Dashboards in order to utilise artificial and business intelligence, in order that hotspot areas can be quickly and easily identified and timely interventions put into place. Work continues on the interventions to reduce agency spend below which includes an agreed formal partnership arrangement with third party organisations that can assist with in-souring to mitigate the risk regarding tax bills on pension; The development of a "medical" bank - to go live 1st December; The ongoing use of the nursing "tier 2" framework to eradicate agency usage; A system wide review of Fragile services is in place with the consideration of whole system solutions.

Safe	Positive progress has been achieved against the falls indicator (key element of the Care of Older People Improvement Priority) and FNOF indicator for time to theatre. These KPIs have been previously raised as a concern at SOIB.	Delivery of the falls aspect of the Older Peoples QI programme has achieve major milestones for introducing new risk assessment, documentation, training and undertaking RCA reviews. The Falls Strategy is on track for the launch by the end of November 2019. The Orthopaedics team continue to implement the FNOF pathway and 'Golden Patient' approach to expedite access to theatre and is aiming to achieve the target by December 2019. In addition we have improved ortho-geriatric support (3 days per week). The Trusts continues to demonstrate improving FNOF mortality rates.
Effective	Continued improvement in performance against Stroke and Sepsis indicators has been achieved supported by the Deteriorating Patient QI Priority and Patient Flow Improvement Programme (PFIP). In addition, there have been improvements in screening deaths and SJR processes which underpin the Learning from Death aspects of the programme. The HMSR and SHMI trajectory continue to improve. The next improvement focus will be on AKI and LRTI with links/interdependency with the Care of Older People programme.	Implementation of ipad facility for screening deaths and mortuary engagement has improved rates. A presentation of lessons learned from SJRs is scheduled at the November Grand Round. The Trust is also supporting two acute Trust on the development of learning from deaths as an improvement approach.
Caring	The key focus in this domain is to increase the response rate and use of information from the Friends and Family test. This is essential if the Trust is to identify key aspects of patient experience which can be improved. Whilst the trajectory for the overall number of written complaints is positive the future focus will be on improving the process, thematic analysis and evaluating the outcome from the patient/carer perspective.	SMS Text and Interactive Voice messaging went live on the 1st October to A+E Departments, Outpatients 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. The corporate nursing team is undertaking a review of the complaints process and will be leading an improvement programme.

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - October 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	0	1	0			
C-Diff	1.33	5	19	5			
Never Events	0	0	1	0			
VTE Prophylaxis Assessments	95%	96.9%	97.7%	151			
Harm Free (Safety Thermometer)	95%	98.9%	97.9%	4			
Falls - Moderate/Severe/Death	1	2	11	2			
Patient Safety Incidents - Low, Near Miss or No Harm		814	5472	814			
Safe Staffing	90%	92.3%	92%	N/A			
Fractured Neck of Femur	90%	79.3%	71.4%	23			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Percentage of Deaths Screened	100%	88.9%	60%	7			
SHMI (Summary Hospital-level Mortality Indicator)	100	99.6	100.7	N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	91	91	N/A			
WHO Checklist	100%	100%	100%	0			
Stroke - 90% Stay on Stroke Ward	80%	94.1%	71.8%	1			
Sepsis - Timely Identification	75%	100%	98.7%	N/A			
Sepsis - Timely Treatment	75%	80%	77.9%	N/A			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	14	139	14			
Written Complaints	35	30	151	30			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	91.6%	92.7%	192			

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%	84.6%	86.5%	1635			
Accident & Emergency - 12+ Hour trolley waits	1	27	62	27			
Ambulance Handovers <=15 Mins	99%	48.2%	53.1%	790			
Diagnostic waits	1.01%	2.2%	3.6%	61			
14 day GP referral to Outpatients	93%	96.4%	94.4%	30			
31 day treatment	96%	95.3%	97.5%	3			
31 day treatment (Surgery)	94%	100%	100%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	82%	78.6%	9			
62 day GP referral to treatment	85%	82%	77.4%	9			
Referral to treatment: on-going	92%	93.3%	93.4%	750			
Bed Occupancy - SDGH	93%	90%	92.1%	N/A			
Bed Occupancy - ODGH	60%	52%	48.3%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	88.9%	96.1%	1			
Duty of Candour - Evidence of Letter	100%	88.9%	95.9%	1			
I&E surplus or deficit/total revenue	-1%	-7.1%	-19%	N/A			
Liquidity	-106	-129	-129	N/A			
Distance from Control Total	0%	-0.7%	-7.9%	N/A			
Capital Service Capacity	0.21	-0.144	-3.559	N/A			
% Agency Staff (cost)	5.45%	9.3%	8.5%	N/A			
Use of Resources (Finance) Score	3	4	3	N/A			
Distance from Agency Spend Cap	0%	142%	142%	N/A			
Staff Turnover	0.76%	1.1%	6.8%	N/A			
Staff Turnover (Rolling)	10%	12.6%		N/A			
Vacancy Rate - Medical	5%	16.5%		N/A			
Vacancy Rate - Nursing	8%	17.3%		N/A			
Sickness Rate	4%	4.9%	4.9%	N/A			
Personal Development Review	85%	70.6%	71.5%	N/A			
Mandatory Training	85%	88.3%	87.2%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.3	8.4	N/A			
Time to Recruit	30	66	66	N/A			

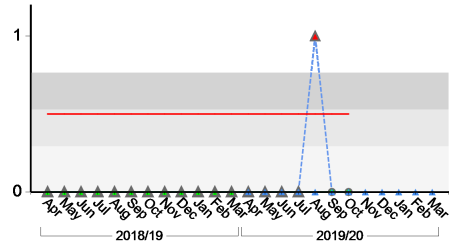
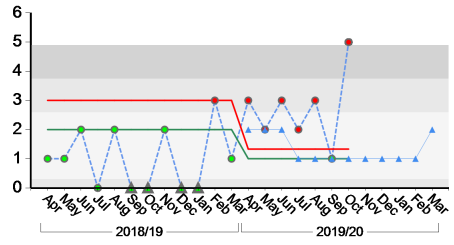
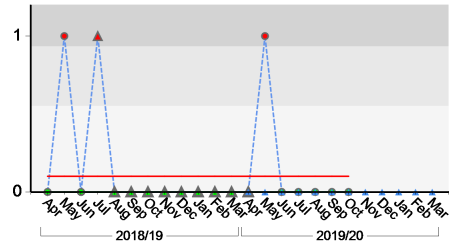
Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	73	64	73			
DTOC - Number of Beds lost per month		218		218			
Length Of Stay	6.5	6.5	7	N/A			
New:Follow Up	2.64	2.5	2.5	N/A			
DNA (Did Not Attend) rate	8%	7.2%	7.1%	1837			
Cancelled Ops	0.61%	0.4%	0.3%	8			
Theatre Utilisation - SDGH	80%	64.9%	61.3%	N/A			
Theatre Utilisation - ODGH	90%	72.3%	69.8%	N/A			
Stranded Patients (>6 Days LOS)	170	179	1247	179			
Super Stranded Patients (>20 Days LOS)	58	69	486	69			
Southport A&E Conversion Rate	20%	21%		1053			

Reporting Frequency is monthly except for SHMI which is quarterly.

Board Report - October 2019

Southport and Ormskirk Hospital NHS Trust

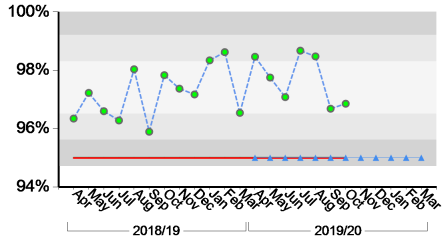
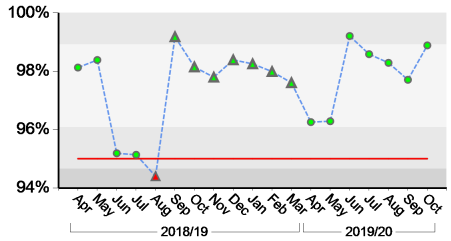
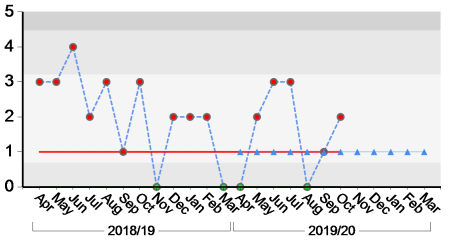
Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	There was zero MRSA bacteraemia in October - Since the MRSA bacteraemia in August, lesson learned have been included in Trust News, Mandatory training and Medical updates. In addition the affected ward has included MRSA suppression Rxing in MDT Red to Green reviews and huddles. Also, when reviewing MRSA pathways the IPC team cross reference the patient Rx chart and advise clinicians to consider Abxs effective against MRSA if the patient colonised with MRSA and is being treated for an infection.	
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.	5 C diff cases in October, however 3 of these will be appealable as no lapses in care - Regionally C diff rates have increased this year and Southport and Ormskirk are no exception. The target for 2019/20 is for no more than 16 cases and the Trust has currently had 20 cases, however 7 of these cases have been successfully appealed and a further 4 cases are eligible for appeal. Some of the issues identified as part of the RCA process were multiple prescriptions of Abxs not only in the hospital but also in the community prior to admission and frail patients with feeding tubes or long term catheters. The Consultant Microbiologist and the Antimicrobial Pharmacist are reviewing the current Antimicrobial guidelines to recommend suitable alternatives to the frequent use of cephalosporin's which have an increased risk of C diff. October's cases on wards: SSU, 14B, OBS, GP and FESS (one on the FESS cases was a community occurring hospital associated case - the typing of this case was different to the other FESS case)	
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death.	There were no never events in October - The Trust reported 1 never event in the last 12 months - in May 2019. • Signs were immediately put up across all Theatre areas in the anaesthetic Rooms, following the event to alert staff to 'Stop Before You Block' • The incident was discussed at daily Safety Huddles • Staff awareness sessions were put in place. • Training has now been put in place and this is included in the Clinical Competency training packages. • We have a new Locssip (in the SOP template) 'Procedural Verification of Site Marking' based on Natssips. • We have commenced a monthly observational audit of Stop Before You Block and there have been no other episodes. • We have a section included in Induction/competency packs around Stop Before You Block.	

Board Report - October 2019

NHS Southport and Ormskirk Hospital NHS Trust

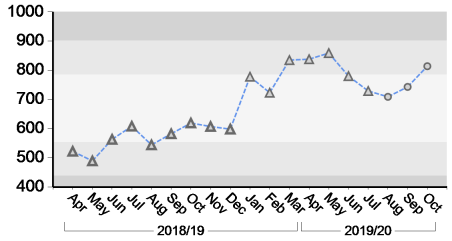
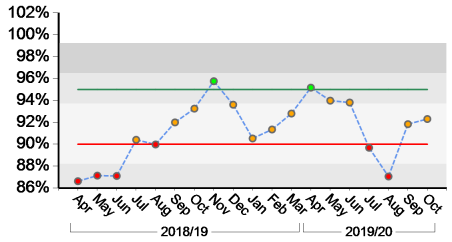
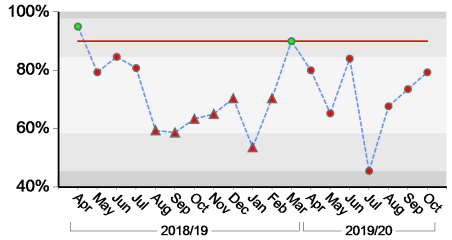
Safe

Indicator Name (Colour - Perf | Traj)	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.	Compliant - The Trust continues to achieve above the threshold of 95%	
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance remains above target - Performance for October remains good and in total the Trust reported 5 harms during October's monthly census. 2 x catheter associated urinary tract infections (7b and 9b) and 3 x new VTE's which were 2 x new DVT's (NWRSIU and 9a) and 1x new PE (9a)	
Falls - Moderate/Severe/Death	The total number of falls within the Trust were the severity of the harm was either moderate, severe or resulted in death. Threshold:0	Performance is demonstrating stable numbers of falls with harm but early demonstration of a reduction for all falls CBU specific - The falls with harm are low numbers and demonstrate a relatively stable picture, however the total falls particularly in Urgent Care appears to be in the early stages of showing a reduction and this continues to be worked on. The improvement is expected to be seen now each month. Work is underway to develop a target for all falls mapped against a trajectory which will provide more obvious evidence of improvement against the falls improvement plan. In addition, 'background work' includes increasing the ability to identify patients at risk of falls as per NICE Clinical Guidance 16, where the trust has already improved from 56% in quarter 1, to 89% in quarter 2. In addition we monitor the implementation of care plans for those identified as being at risk. This was 72% in Q1 rising to 87% in Q2 and we continue to strive towards the 95% target.	

Board Report - October 2019

NHS Southport and Ormskirk Hospital NHS Trust

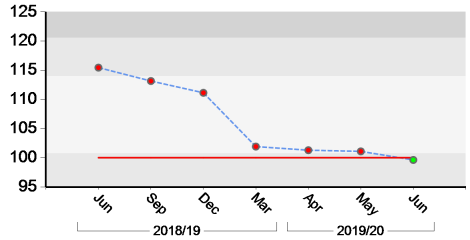
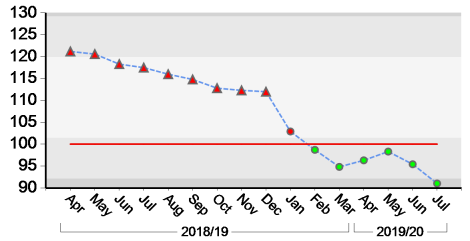
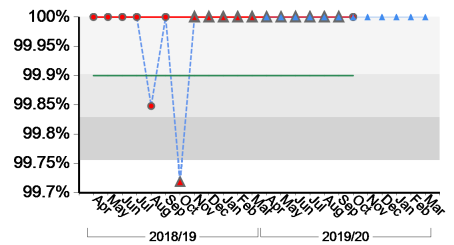
Safe

Indicator Name (Colour - Perf | Traj)	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.	Increase in reporting of No harm/Near miss/Low harm incidents by 71 - Of this increase 46 of the increased incidents are attributed to bed management. This relates to the delay in transfer of patients from the emergency areas to general wards and from theatre and Critical care to general wards to enable new patients to be admitted. This correlates with the pressure on A&E/ EAU from admissions throughout October. Another area showing a significant increase is Infection control with an increase of 15 relating to the batch import of bacteraemia patients onto datix.	
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%.	The Trust reports an improved position to safe staffing against the national average (90%) at 92.3%. - Support to improved delivery against safe staffing performance continues through flexible worker opportunities, consideration of an overseas recruitment proposal, local recruitment ongoing.	
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance is showing continuous improvement following better use of the 'golden patient' on the trauma list - There is now better use of prioritising #NOF patients as golden and silver patients on the theatre list to ensure we meet the 36hrs to theatre target. Current capacity enables us to operate on 3 NOFs in 1 theatre day. Often there is more than 3 NOF patients on a theatre list, as well as other patients, therefore where other patients have to take priority, this creates a delay to NOF patients until the following day.	

Board Report - October 2019

Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly (rolling 12 months) and is 6 months behind due to when Dr Foster publish the data.	Performance within tolerance, figure is within statistical norms. - NHS Digital now release the SHMI monthly. Performance is generally improved. As SHMI and HSMR are both risk adjusted mortality figures, the actions described in the HSMR narrative, also apply to SHMI.	
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 - - In-month achievement: 1. 4/5 workshops for the re-scoping of the deteriorating patient project are complete. 6th workstream to be scoped (information / documentation). Completed re-scoping expected by next month. 2. Two further projects to reduce harm from nosocomial infection are being devised 3. Draft report of problems in healthcare being devised from the 117 SJR reviews completed so far in the trust to allow targeted analysis of this rich data. draft report for December MOG. Ongoing work on UTI - this is now an AQ facilitated project to reduce urinary catheterisation. This is predicted to have multiple benefits including improved mobility, improved continence and a reduction in UTI and gram -ve infection. A new project has been initiated to reduce variation in IV cannula care aiming to reduce associated staphylococcal infection. The unified ACMP template to support training and use of ACMP to record decisions about appropriate ceilings of treatment is under development. This project is across multiple providers in the health economy and will facilitate the use of Anticipatory Clinical Management Plans, preventing unwanted hospital admission and improving the achievement of preferred place of death. There is development of a process to review lower respiratory tract and UTI deaths to ensure these are in the correct diagnostic groups. System devised to allow co-morbidity data identified in coding reviews to be made available to clinical staff if patient Is re-admitted to inform care of the patient.	
WHO Checklist	WHO Checklist.	WHO checklist compliance continues to achieve 100% -	

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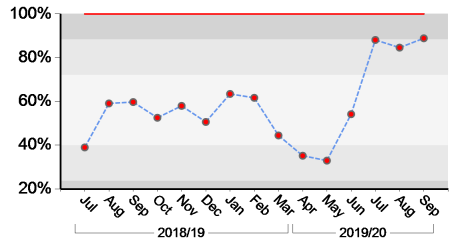
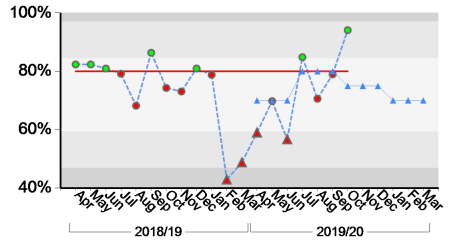
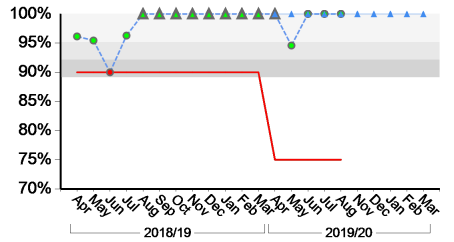
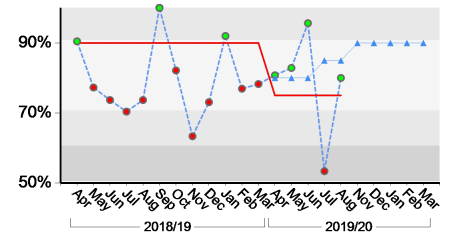
Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Percentage of Deaths Screened	Percentage of Deaths Screened - DATIX	Significant improvement is maintained - This improvement follows the implementation of the iPAD system and the reminder posters. There remains a focus on this area in order to maintain and improve performance. Screening of mortality is important to allow the trust mortality reviewers to focus their attentions on the appropriate cases for SJR. We aim for 90%+ screening to assure that the vast majority of deaths have a clinical review. We continue to monitor to ensure the process becomes embedded.	
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.	Stroke performance achieved above the 80% target in October at 94.12% - The Trust has demonstrated an improvement trend since February of this year	
Sepsis - Timely Identification	Sepsis Timely identification of sepsis in emergency departments and acute inpatient settings - National early warning score (NEWs) recorded within 1 hour of hospital arrival.	The trust continues to achieve the target for identification of Sepsis - The total number of attendance to A&E nationally in July 2019 was 2,266,913 an increase of 4% from the previous year and the highest number of attendances ever recorded since collection of figures started.	
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.	Our rolling performance between January 2019 to August 2019 for antibiotics with 1 hour is currently achieving 80%. - This is against a backdrop of the total number of attendances to A&E nationally in July 2019 which was 2,266,913 representing 4% from the previous year. This is the highest number of attendance since national data collection started. The total number of attendance to A&E nationally in August 2019 was 2,125,445.	

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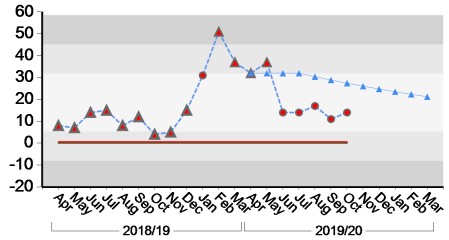
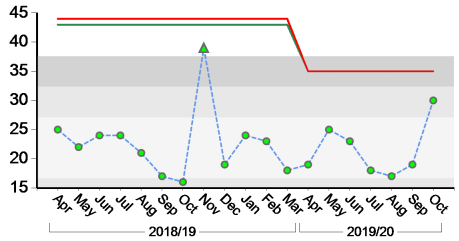
Southport and Ormskirk Hospital NHS Trust

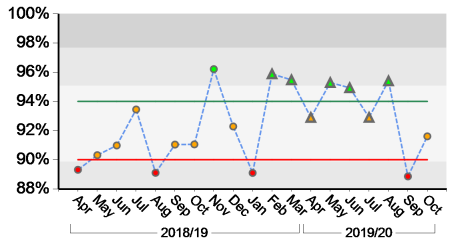
Caring

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	Breaches remain at a stable level - The majority of breaches are in HDU and Obs ward. 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 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 is to be reviewed	
Written Complaints	The total number of complaints received. A lower number is good.	There were 30 complaints in October - 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. 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. Urgent Care received 16 complaints, with Ward 10A (EAU) accounting for 4 and A&E 2. Planned Care received 6 complaints, in 3 different areas. Specialist Services received 7 complaints, of which 2 related to Maternity. 1 complaint was received by Estates and Facilities and related to Security. The following themes were identified: • Clinical Treatment – in particularly co-ordination of medical treatment • Staff attitude/behaviour • End of life • Admission/transfers/discharge procedure • Communication • Date for appointment All complaints are reviewed within the Business Units and response and relevant actions are put into place.	

Board Report - October 2019

Southport and Ormskirk Hospital NHS Trust

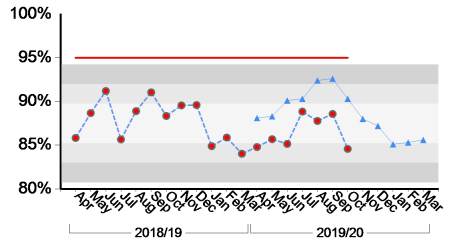
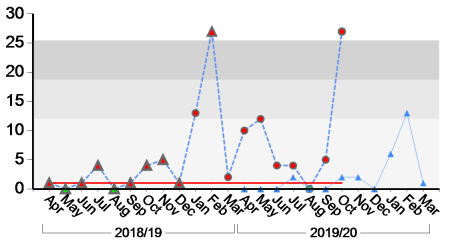
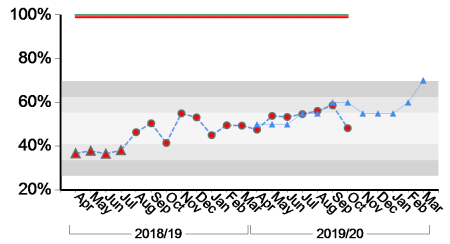
Caring

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance has slightly improved on previous months data but remails below target of 94%. - Performance improved on previous month but remains below target of 94%. October was the first month implementing the ENVOY system and the Trust has seen a significant improvement in response rates (6.48% to 21.18%) and an increase in qualitative comments supporting the ratings given. Planned care - those that would recommend has increased to 95.81% from 94.34% Urgent care- those that would recommend has increased to 88.96% from 79.67%. (This includes a score of 88% that would recommend from the Adult Emergency Department). . Maternity - those that would recommend has increased to 100% from 97.09.%. Paediatrics - those that would recommend has decreased to 92.24% from 93.33% (This includes a score of 91.92% that would recommend from the Paediatric Emergency Department). From qualitative comments received alongside negative ratings the top themes identified were staff attitude, communication, implementation of care and waiting times. All senior ward/dept staff now have the opportunity to access ENVOY for live FFT data to enable timely action to be taken at a local level in response to poor ratings /comments and the ability to identify positive/negative themes to direct local improvements. FFT data is also presented on ward/dept dashboards alongside the number complaints/concerns to support identification of any trends. From the 1st November onwards the matron for patient experience receives daily alerts for ratings of unlikely / extremely unlikely to monitor themes and action any responses that require immediate attention The Trust has now received results from all four National Patient Experience Surveys (Maternity results awaiting release from CQC). Local action plans yet to be developed by leads within the Paediatrics, Maternity and Adult Emergency Care departments . Once developed these will be presented to and monitored through the Trust Patient Experience Group. The 2020-2021 Trust patient experience strategy is currently in draft format. This will be delivered for consultation at the Jan-20 patient experience group. FFT % that will recommend will continue to be monitored and reported to wards/depts. on a monthly basis.	

Board Report - October 2019

NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	The Southport site continues to experience challenges in maintaining patient flow. This a combination of a 9.4% increase in attendances on the Southport site (an extra 418 patients) and significant bed pressures. - As a result, there was an increase in the number of patients who waited longer than 4 hours in ED (1504 patients compared to 1143 patients last year). Reviews have been undertaken to understand the reasons for the breaches (65.82% of 4-hour breaches were attributable to bed delays; 15.35% were due to ED delays, 9% were due to specialty delays, 8% were due to clinical delays). ED continues to try and strengthen staffing levels. ED now has 7 wte consultants in post (the highest number to date). Middle grade level staffing remains a challenge. Late shift staffing continues to be enhanced where possible as this is when activity levels frequently exceed capacity. A vacant ENP post is currently out to advert, which will enable the current availability of an ENP minors service to be extended. The Patient Flow Improvement Programme continues to work through high impact actions. ACU is piloting Sunday opening across a number of dates. A successful pilot was held at the end of October with 15 patients streamed from ED and 0 requiring admission. The continued bed pressures result in ongoing use of escalation areas, which negatively affects the ability to maximise streaming. A PDSA is planned in ED to test improvements in reducing triage times (wc 18/11/19)	
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 x27 12-hour breaches across the month. These were all related to inpatient bed pressures. - All breaches occurred during and immediately following weekend pressures. ED saw a 9.4% increase in attendances across the month (additional 418 patients) and 90 additional admissions. Across the majority of the month, the Trust worked against the 12 hour standard with all escalation areas open and in use, high numbers of patients bedded overnight in ED each night awaiting a bed and corridor care in use due to lack of clinical capacity in the department. Timelines have been completed for all 27 patients with assurance provided that all patients received timely and appropriate clinical care whilst in the department. The system is provided continually with updates on the Trust's escalation position. Daily huddles continue to take place with system partners to enable the reduction of length of stay. Issues around length of stay, ICB and community capacity continue to be addressed and regular discussions take place with the Programme Director for Unplanned and Emergency Care. Discharge team continues to have a presence at weekends to try and support discharges across the weekend, and staffing is routinely secured for the use of escalation areas. The Acute team have identified a number of Sundays over the coming months that they are able to open ACU to support streaming from ED in efforts to reduce the number of patients identified as requiring beds who are clinically appropriate for admission.	
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.	Ambulance handovers completed within 15 mins dropped to 48.23% - This is a reflection of the increase of 9.4% in overall attendances and the challenges in inpatient flow, resulting in high numbers of patients awaiting beds in ED and delays in timely access to ED cubicles. 83.63% of patients arriving by ambulance were handed over within 30 minutes from arrival, compared to 72.91% last October. The Trust attended the 1st NWAS Handover Collaborative on 25/10/19 and is now on a 90 day improvement programme. PDSA cycles are planned for Fit to Sit (led by NWAS) and Consultant based in triage (planned for wc 18/11/19.	

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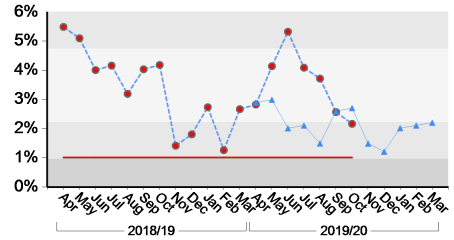
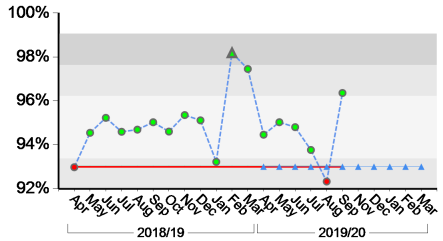
Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower.	Performance continues to improve for the fourth month in a row - Breaches are as follows: Colonoscopy 2 patients 1.6% availability/patient choice Computed Tomography 1pt 0.5% Cystoscopy 13pts 12.0% Consultant activity - specialist service - spinal service 2 patient choice. 3 breaches are theatre cases due to lack of theatre capacity due to the increase in demand for Target/Urgent cases. 7 breaches are due to Emergency leave taken by the consultant in October where the list had to be cancelled. 1 breaches are due to the Urology/Spinal Consultant that can only see the patients. Plan to accommodate alternate weekly session with Urology/Spinal Consultant within job plan going forward. Cystoscopy (Gynaecology) 1pt Capacity issues. Patient has TCI 20.11.19 Flexi Sigmoidoscopy 2pts 2.9% 2 patient choice 1 no interpreter available. Gastroscopy 2pts 1.4% 1 patient choice 1 is due to patient decision to have procedure under GA in theatre. MRI 2pts 0.6% 2 breaches both at 6 weeks Issues contacting both patients Non Obs Ultrasound 34pts 3.4% capapcity issues Urodynamics TOTAL (SPLIT OUT BELOW) 5pts 7.5% Urodynamics (treatment centre, Urology) 17pts 1 Emergency leave taken via specialist nurse - on the day 8 patient choice Urodynamics (Gyn) 4pts staff sickness Insourcing has been agreed by the trust with 'Your Medical' a company who are known to the trust and have previously delivered work for us. This work has commenced and all patients have been offered or booked in November. Numbers have decreased and show continued improvement going forward.	
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.	Performance has recovered to be compliant in September - Although the demand for appointments remained high in some tumour groups, overall number of referrals was down.	

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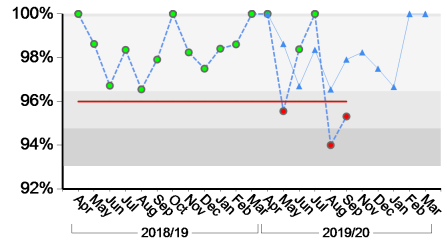
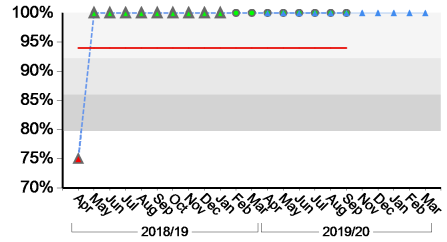
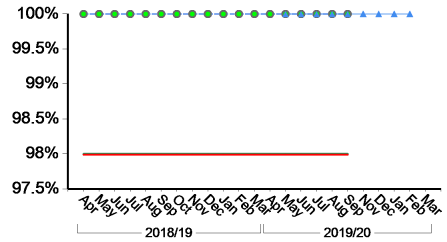
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
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.	3 breaches in August resulted in failed target - Breaches were due to capacity in colorectal theatres and dermatology patient choice.	
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').	Performance continues to be maintained at 100% - Three patients were treated in the subsequent surgery category in September, all in time.	
31 day treatment (Anti-cancer drugs)	Percentage of patients receiving first definitive anti-cancer drug treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Compliance maintained at 100% - Only 1 patient was treated in this category in September.	

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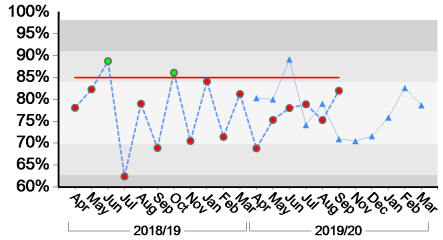
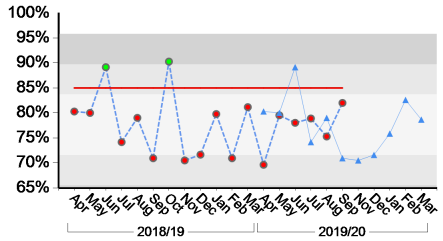
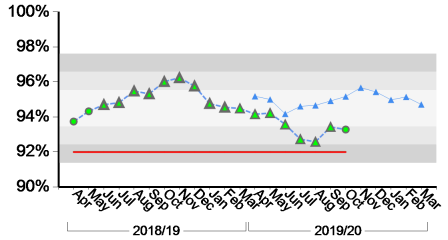
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Some improvement seen in performance - 50 accountable patients were treated in September. There were 9 breaches in total. this occurred in the following tumour sites; Haematology 0.5 Head & Neck 0.5 Colorectal 3 Other 1 Urology 4	
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.	September closed at 82% - September's performance closed at the highest position since October last year. There were 50 accountable treatments and 9 breaches.	
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.	The trust continues to maintain compliance with RTT - 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 tax issues have meant this is no longer a solution. The impact is being assessed in order to address this.	

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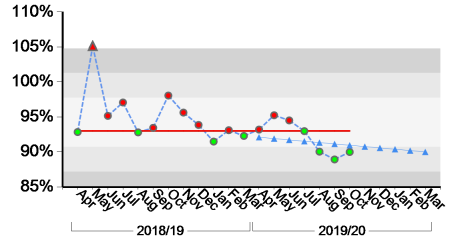
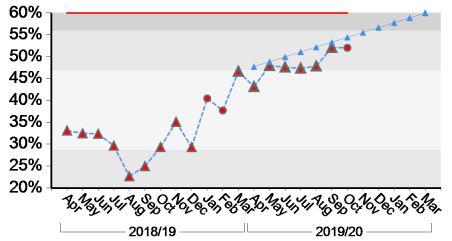
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	October saw a slight increase in occupancy for Southport site but the trust achieved target for the fourth month in a row - target level was achieved at 89.99% - 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 remained stable in month 52.04% and is slightly below 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. HBS contract has also been negotiated to enable anaesthetic cover. October saw cancellation of lists as a result of theatre staff sickness.	

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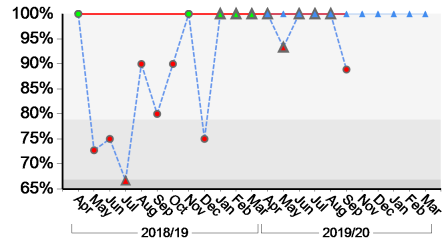
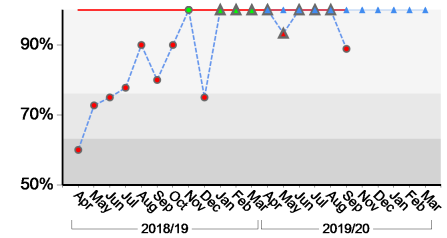
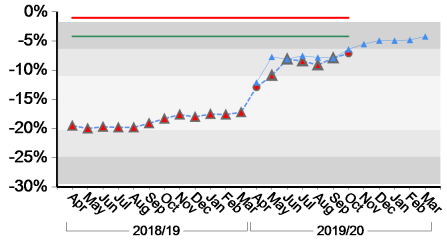
Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	89% compliance - 1 breach in month - There was 1 breach of the Duty of Candour regulation in September. This was within the Urgent Care CBU. The harm level was incident was incorrectly downgraded by the CBU. This was subsequently changed back to moderate harm and the patient was contacted, but after the 10 day timescale. There has been a review of the downgrading process and an amendment has been made to Datix to capture the rationale when incidents are downgraded.	
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.	89% compliance - 1 breach in month - There was 1 breach of the Duty of Candour regulation in September. This was within the Urgent Care CBU. The harm level was incident was incorrectly downgraded by the CBU. This was subsequently changed back to moderate harm and the letter was sent, but after the 10 day timescale. There has been a review of the downgrading process and an amendment has been made to Datix to capture the rationale when incidents are downgraded.	
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Performance improving - The percentage deficit has improved this month. However, this has been driven by higher monthly income in October (as planned) resulting in a lower deficit than September. The target deficit percentage year to date for October is -6.4% and the Trust achieved -7.1% resulting in the Trust being adversely away from plan.	

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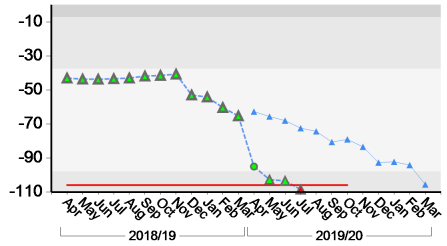
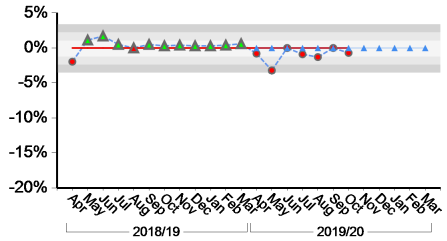
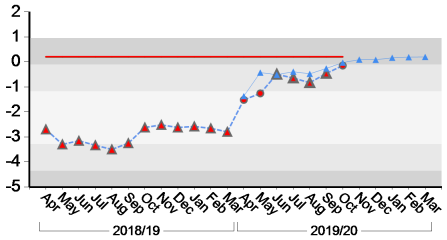
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Downward trend continues - Loans are re-classified as current liabilities when they are due within 12 months. This re-classification has occurred in October and significantly affects the calculation of the metric resulting in a deterioration in liquidity. Liquidity days is calculates as follows: (Current assets – current liabilities – inventories)/(operating expenses + amortisation + depreciation) X number of days in the year to date reporting. Month 7 liquidity days is -£69.258m / £114.573m * 214 days = -129.36 days	
Distance from Control Total	Distance from Control Total.	Performance deteriorated in October - The Trust achieved the control total at the end of Quarter 2 with non recurrent support. At month 7 the Trust is currently behind plan but has plans to mitigate this risk and meet the Quarter 3 control total.	
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 improved in October - The main reason for the improvement in this metric is that the Trust repaid DHSC loans for £2.741 million. There's no change to the rating of this metric which due to it being negative remains at a 4. Performance needs to be a positive 1.25 to achieve a use of resources score of 3 for this aspect.	

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Southport and Ormskirk Hospital NHS Trust

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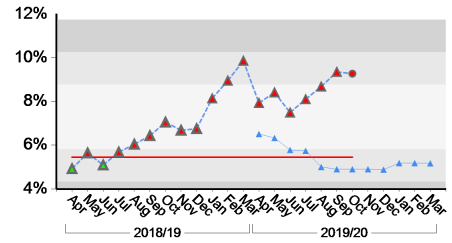
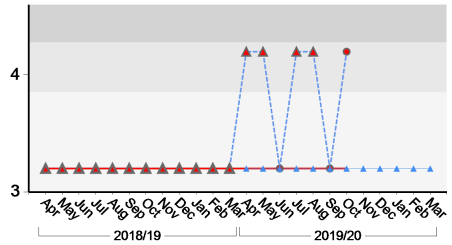
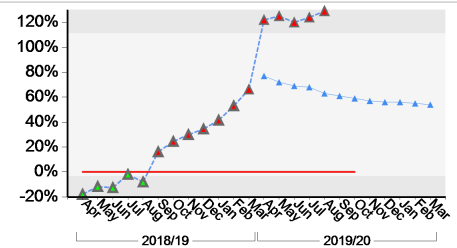
Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	Performance deteriorating - Agency spend remains high as a percentage of total pay cost. Agency spend is slightly up on September (£1.1m against £1.05m last month). Total pay spend is also higher this month than last month. So both the numerator and denominator in this calculation has increased but the overall result is a slight reduction in percentage. Performance by staff group is: Consultants 16% Other medical 14% Nursing & Midwifery 9% Scientific/tech/therapeutic 2% Other staff 5%	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Performance deteriorated in October - Overall score has increased from a 3 last month to 4 this month. The main change has been on the distance from plan metric which is now a 2 (last month 1) as the Trust is adversely away from its plan at the end of October. 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.	Performance deteriorated - Although the Trust did not agree to the agency cap the target for month 7 YTD is £2.882 million. The actual month 7 YTD agency spend is £6.978 million. October has seen the highest in month agency spend with monthly nurse agency at its highest level. Band 5 nurses have a vacancy rate of 25% and not all these can be filled with bank staff which results in the Trust having to pay a premium for agency nurses.	

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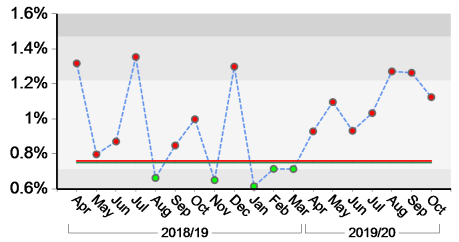
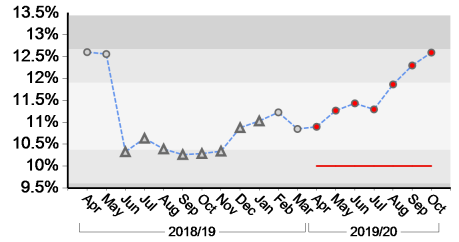
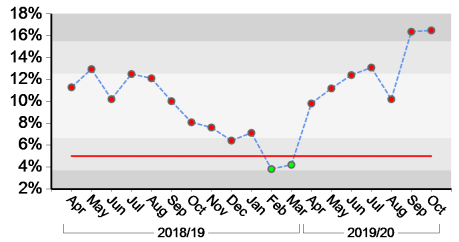
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	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.	October saw a monthly decrease in turnover to 1.12% however the rolling rate is still increasing due to the overall increase in staff turnover. - The number of leavers reduced slightly in month to 34 from 38 in September and August. The Trust had established a Nursing Recruitment and Retention group which initially saw a significant decrease in nursing turnover however the group is under review following the appointment of the New Deputy Director of Nursing for Workforce. Due to the deteriorating Trust position in relation to staff turnover (increased rolling figure) a new workforce dashboard is being created. The dashboard will provide greater business intelligence into staff turnover to identify hotpots in order that appropriate interventions can be put into place. Work will be reported at a weekly Workforce Improvement work stream which will report into the Trust's Workforce Improvement Group. A draft dashboard will be available for review from January 2020.	
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 October 2019 at 12.6% compared to 12.3% in September 2019. - The number of leavers reduced slightly in month to 34 from 38 in September and August. The Trust had established a Nursing Recruitment and Retention group which initially saw a significant decrease in nursing turnover however the group is under review following the appointment of the New Deputy Director of Nursing for Workforce. Due to the deteriorating Trust position in relation to staff turnover (increased rolling figure) a new workforce dashboard is being created. The dashboard will provide greater business intelligence into staff turnover to identify hotpots in order that appropriate interventions can be put into place. Work will be reported at a weekly Workforce Improvement work stream which will report into the Trust's Workforce Improvement Group. A draft dashboard will be available for review from January 2020.	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The medical vacancy rate saw a further increase in October to 16.5% - 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 hospitalprogramme board and Workforce Improvement Group. Medical establishment control implementation - Process to be implemented to identify recruitment areas	

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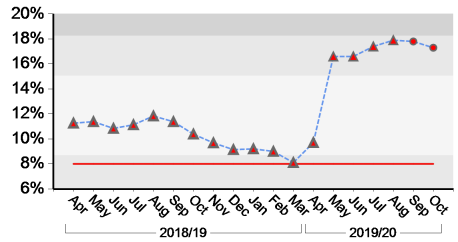
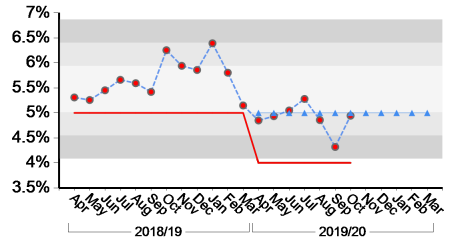
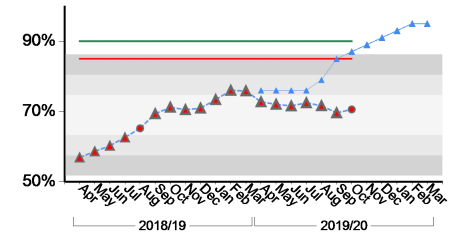
Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Nursing Vacancy rate remains static - Although the vacancy figures remain static the trust has seen in October 25.67 FTE new starters (RN x13 HCA x12) Leavers for Oct totals 13.49 FTE (RN X6.8 HCA X6.69). Local recruitment continues to support the trust vacancy position.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 4%. Lower is better.	Octobers 2019's monthly sickness absence rate has increased in month to 4.94% however remains under the 5% trajectory for the year - 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 11 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% Oct-19 – 5.20% The Trust monitors attendance levels on a monthly basis and remains committed to supporting staff's attendance to work to be 'Happy, Healthy Here'. The Trust continues to be part of the NHSi Health and Wellbeing (HWB) programme and recently attended the NHSi Health and Wellbeing Summit (Reducing sickness absence) in November, where all trusts on the programme shared their experience and progress to date. Consequently the HWB action plan will be reviewed in order to evaluate and consider the good practice and ideas that were shared at that event. This will support the Trusts ongoing assurance to delivering the HWB action plan. Performance against the action plan is monitored at Workforce Committee and Workforce Improvement Group to ensure progress and give assurance. In addition to the above The Trust has embarked upon a 6 month review of the Supporting Attendance policy with staff side and key stakeholders within the Trust. An initial meeting has taken place, with a further meeting planned before the end of the year to agree the review of the policy. Partnership has flourished during this piece of work and discussions have been well structured, productive and meaningful. Consequently there is a belief that we can get to a position where both staff side and management side consider the Trust has a policy in place that supports all staff.	
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance increased slightly in month to 70.56% in October. - CBU's continue to set trajectories to increase appraisal rates to 85% but have been unable to meet them. Over the last few months a targeted approach by the OD team has been taken to improving the quality of appraisals and a myth buster has been developed and shared at departmental/ward visits in order to try to tackle this issue. This work has seen a slight improvement in the compliance rate by nearly 1% since last month. Multiple factors have been identified throughout the year in understanding the barriers to improving compliance and subsequent interventions have been established to address the matter. A collective targeted approach is being taken to look at how best to address this KPI in December's Workforce Improvement Group.	

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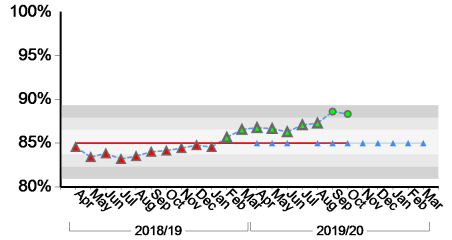
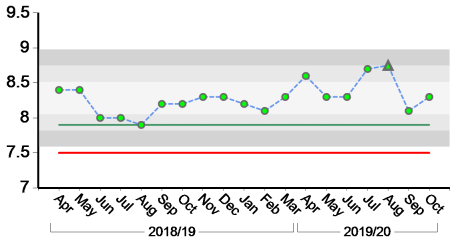
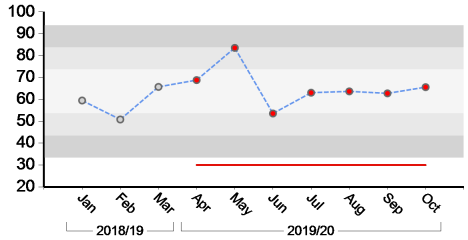
Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Core mandatory training remains above the Trust's 85% at 88.34% - A Task & Finish Group in Nov/Dec2019 will focus on a review of core mandatory training with a specific focus on Resuscitation Training at all levels.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	The overall CHpPD for the Trust has remained static in month reporting at 8.3 hours - Current reporting remains slightly above the national average of 7 hours CHpPD, The Trust current reporting for CHpPD includes Registered Nurses/Registered Midwives. . Planned care clinical business unit (CBU) report overall 10.3, Urgent Care CBU 6.6 and Women's and Children's 13.0 overall.	
Time to Recruit	The number of working days from Advert Close to Start Date. Please note that candidates requiring a Visa are included.	-	

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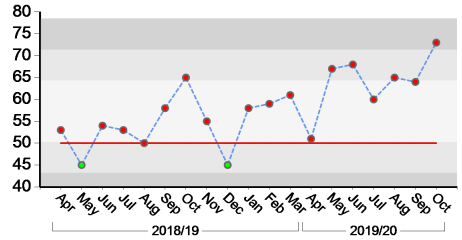
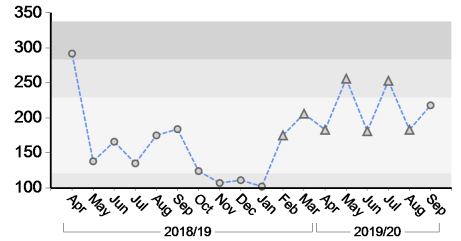
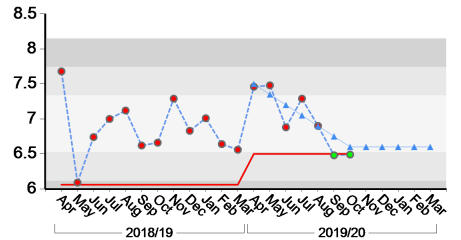
Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	Average Number of Daily Beds Lost In Month.Taken from A Daily Snapshot Of Patients Medically Fit For Discharge. Lower is better.	Increase in month - improvements in recording of data on medway is giving a more correct measure to work with. We continue to work with community and LA teams to support movement of patients from acute care once medically fit. There remains a proportion of patients who require on-going therapy which can not be supported in the community due to the level of dependency. Daily huddles continue with information from the discharge facilitators from Red2Green board rounds; SAFER engagement events have occurred at ward level. new weekly DTOC meeting commenced to formalise reports; circulation of new board round SOP and red2green poster is helping to focus all staff on flow	
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.	218 bed days lost - There is continued work with partners from Community and LA supporting discharges through daily huddle and weekly long stay review. From October of formal DTOC meetings take place with both LAs 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.	sustained at <6.5 days - 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; introduction of board round SOP to support implement improved red2green; continued daily review through discharge huddle with system partners with delays identified through ward red2green board rounds on all in-patient wards; head of patient flow and CCG for Sefton working closely together to support reducing LoS with focus on super stranded and stranded patients	

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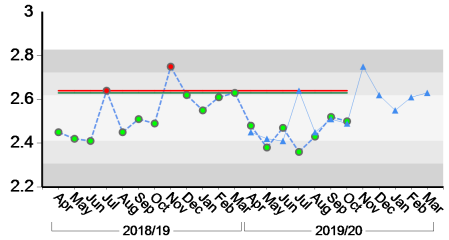
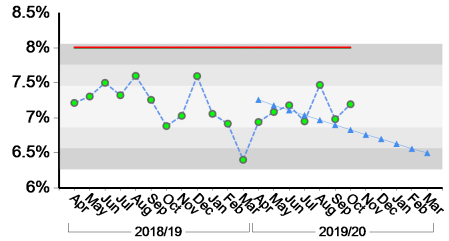
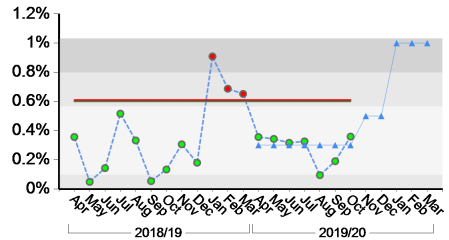
Efficiency

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	The trust continues to consistently achieve target -	
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	Whilst the DNA rate remains below target, the trust continues to look for solutions to improve - The Trust is currently reviewing electronic solutions to assist in the management of this and the associated problems of late cancellations	
Cancelled Ops	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	Data reported is in reference to cancelled emargency cases within 24hrs. - On day cancellations of elective patients is 45 at ODGH and 13 at SDGH. Issues at SDGH are around occupancy on this site and elective admissions being cancelled due to bed pressures. At ODGH, the issues are a mix of cancellations with 60% being due to unavoidable clinical reasons. 4 were due to the cancellation of a list due to surgeon sickness. Review of cancellations due to lack of theatre time is under review and is generally as a result of the late start of afternoon lists. KPI for cancelled electives being developed to include within IPR	

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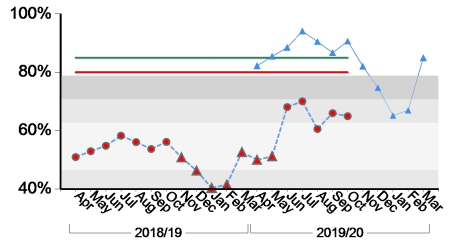
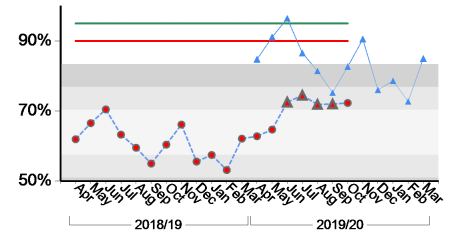
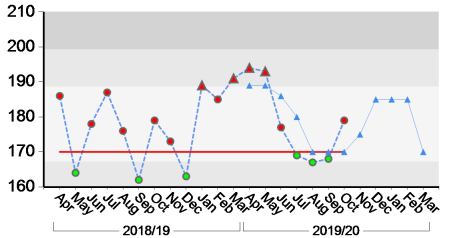
Southport and Ormskirk Hospital NHS Trust

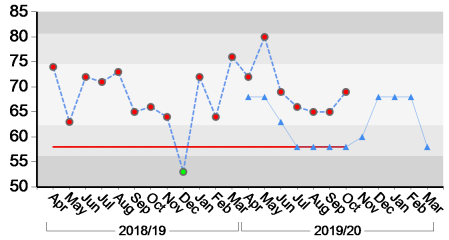
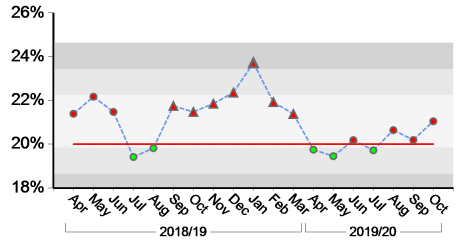
Efficiency

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	This matrix reports on overall theatre utilisation at SDGH including emergency and trauma lists. - Emergency and trauma list utilisation is by the nature of the term variable dependant on demand. Improvement of the trauma list continues to be seen with the implementation of the gold and silver patient process introduced in the theatre efficiency programme. Excluding trauma and emergency the theatre utilisation is 68.37%. This was impacted with 13 on the day cancellations due to lack of beds.	
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Slow improvement in utilisation which is currently being impacted by on day cancellations. - Theatre utilisation was 73.06%. This was impacted by 45 on the day cancellations. Following successful pilot of the 48hr pre admission calls, these have now commenced across all specialities. Cancellations for clinical reasons have increased to approx. 60%, however, there is a clear impact of late running afternoon lists which is under investigation. HBS are offering a solution to the lack of anaesthetic cover, however staff sickness in theatre has also impacted during October.	
Stranded Patients (>6 Days LOS)	Patients who spend 7 days or more as an inpatient.	Increased noted in stranded in October - The SAFER roll out has been reviewed and although red2green compliance has improved it is recognised that more work is required to support SAFER. SOP to support red2green board rounds completed and poster developed to be circulated; red2green monitoring is improving and weekly audits identify areas for additional support. The development of flow activity reports for wards is in the early stages	

Board Report - October 2019

Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Super Stranded Patients (>20 Days LOS)	Patients who spend 21 days or more as an inpatient.	increase in month continues - 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; relaunch of red2green in November with SOP to support wards; additional reviews of stranded patients to identify upstream any complex patients	
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 October at 21.05% - The Trust has worked hard to ensure that alternative pathways to admission wherever clinically appropriate are adopted. October saw an additional 90 admissions via ED compared to last year against an increase of 418 attendances. Demand for side rooms during October was high resulting in patients admitted straight to wards without going through assessment areas. This was in addition to patients requiring admission to dedicated wards to meet their clinical need (particularly respiratory ward for NIV, cardiac monitoring beds on SSU and ward 7A). ED continues to have specialty in-reach into ED. This ensures that patients identified as requiring a bed clinically need admission and are not suitable for alternative pathways. The use of streaming to CDU, SAU and ACU continues. The models are in line with best practice and have been designed in conjunction with ECIST (national in-house NHS expert consultancy for UEC). Across October, there was heavy reliance on escalation bed usage to try and bridge the gap between admissions and discharges, and ACU was used as an escalation area for the majority of the month, reducing opportunities to maximise streaming. As weekends are a particular pressure point, ACU has opened on 3 Sundays streaming a total of 32 patients and only 1 being admitted. SAU has presented a model to redesign the pathway for GP referrals and are looking into weekend working, which would contribute to reducing the conversion rate from ED.	

Activity Summary – October2019

Southport and Ormskirk Hospital NHS Trust

Indicator Name	October 2018	September 2019	October 2019	Trend
Overall Trust A&E attendances	10,060	10,429	10,327	▲
SDGH A&E Attendances	4,437	4,795	4,877	▲
ODGH A&E Attendances	2,480	2,480	2,473	▼
SDGH Full Admissions Actual	978	1,003	1,078	▲
Stranded Patients AVG	175	168	179	▲
Super Stranded Patients AVG	65	65	69	▲
MOFD Avg Patients Per Day	65	64	73	▲
GP Referrals (*Exc. 2WW*)	3,012	2,131	2,324	▼
2 Week Wait Referrals	770	752	777	▲
Elective Admissions	232	181	197	▼

Activity Summary – October 2019

Southport and Ormskirk Hospital NHS Trust

Indicator Name	October 2018	September 2019	October 2019	Trend
Elective Cancellations	38	20	24	▼
Day case Admissions	1,935	1,944	1,890	▼
Day Case Cancellations	50	51	45	▼
Total Cancellations (on the day)	15	4	0	▼
Outpatients Seen	23,044	22,481	22,520	▼
Outpatients Cancellations	4,286	4,235	4,050	▼
Theatre Cases	678	637	617	▼
General & Acute Beds Avg. Per Day	378	404	404	▲
Escalation Beds Avg. Per Day	11	2	6	▼
In Hospital Deaths	58	63	74	▲

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
4 December 2019

Agenda Item	**TB205/19**	**Report Title**	**Director of Finance Report – Month 7 2019/20**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ☑ To Receive	

Executive Summary

In the latest System Financial Recovery Plan the Trust is forecasting a year end overspend of £3.6 million against the deficit plan of £26.6 million (excluding PSF/FRF), after achieving the plan at the end of Quarter 2 with non- recurrent assistance thus securing £3.654 million PSF/FRF funding.

The Month 7 financial plan was not achieved with expenditure higher than the trajectory allowed to achieve the forecast outturn. The main reasons for this are; pay spend with both monthly agency and bank levels at their highest levels; CIP delivery to date and a forecast gap at the end of the year of £2.0 million (previous month was £1.7 million).

The overall System financial position is forecasting an over spend of £24.53 million against the £25.6 million deficit control total (excluding PSF/FRF)

The Board is asked to receive the Finance Report – Month 7 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	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*

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	*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 7 2019/20

1. Purpose

1.1. This report provides the Board with the financial position for Month 7 (October 2019) and the progress on delivery of the Trust's control total.

1.2. It also provides an update on the Trusts' forecast outturn alongside the overall System position.

1.3. 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).

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

2. Executive Summary

2.1. The month 7 (YTD) position is a deficit after PSF/FRF of £8.106 million against a plan of £7.235 million resulting in £869,000 worse than plan. Before PSF/FRF the YTD deficit is £16.328 million.

2.2. The month 7 (in month) positon is a deficit after PSF/FRF of £0.545 million against a surplus plan of £0.315 million resulting in £0.861 million worse than plan. Before PSF/FRF the in-month deficit is £2.372 million.

2.3. The Trust's forecast outturn, based on month 6 performance and shared with NHSI/E on 1 November 2019, is £3.6 million overspend against the deficit plan.

2.4. Month 7 expenditure is higher than the trajectory used to achieve this forecast outturn.

2.5. The 2019/20 CIP programme is £1,350,000 behind plan at month 7; the forecast outturn is £4.3 million against the £6.3 million plan leaving an unidentified gap of £2.0 million.

2.6. If material cash reducing CIP schemes cannot be transacted during the remainder of the year then any pressure on the expenditure run rate will not be mitigated.

2.7. The table below is the I&E statement for October:

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	165,513	97,340	97,208	(131)	14,463	14,279	(184)
PP, Overseas & RTA	1,094	640	453	(187)	92	53	(39)
Other Income	12,174	7,271	7,662	391	1,030	1,026	(3)
PSF & FRF	18,271	8,222	8,222	0	1,827	1,827	0
Total Operating Income	**197,052**	**113,473**	**113,545**	72	**17,411**	**17,185**	(226)
PAY	(140,012)	(82,273)	(82,544)	(271)	(11,610)	(11,961)	(351)
NON PAY	(53,220)	(31,355)	(32,032)	(677)	(4,453)	(4,775)	(322)
Total Operating Expenditure	**(193,232)**	**(113,628)**	**(114,577)**	**(948)**	**(16,064)**	**(16,735)**	**(673)**
EBITDA	**3,820**	**(155)**	**(1,032)**	**(876)**	**1,348**	**450**	**(899)**
Net Financing Costs	(12,149)	(7,109)	(7,112)	(3)	(1,019)	(999)	20
Retained Surplus/Deficit	**(8,329)**	**(7,264)**	**(8,144)**	**(879)**	**329**	**(549)**	**(879)**
Technical Adjustments	33	28	38	10	(14)	4	18
Break Even Surplus/(Deficit)	**(8,296)**	**(7,235)**	**(8,106)**	**(869)**	**315**	**(545)**	**(861)**
Less PSF/FRF Funding	(18,271)	(8,222)	(8,222)	0	(1,827)	(1,827)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(15,457)**	**(16,328)**	**(869)**	**(1,512)**	**(2,372)**	**(861)**

2.8. The YTD deficit in the above table (£16.328 million) equates to a monthly average of £2.3 million.

2.9. As previously highlighted a number of non recurrent items were actioned in Quarters 1 and 2.

2.10. It is estimated that the current underlying deficit remains in the region of £2.7 million per month excluding PSF/FRF which is an underlying annualised deficit of £32.0 million.

3. 2019/20 Contract Position

3.1. The value of the Southport & Formby CCG contract is £74.9 million.

3.2. The contract is a "Cost based contract" which has a number of "conditional income" elements.

3.3. These conditional elements, and performance to date, are shown in the table below:

	Annual Plan	M7 YTD Plan	M7 YTD Actual	M7 YTD Var
	£	£	£	£
Repatriation	600,000	350,000	0	(350,000)
Business Cases	1,300,000	758,333	402,027	(356,306)
CQC Contingency	300,000	175,000	7,200	(167,800)
BPT	850,000	495,833	23,732	(472,101)
Contingency - Other Conditional	450,000	262,500	0	(262,500)
Total	**3,500,000**	**2,041,667**	**432,959**	**(1,608,707)**

3.4. The Trust is assuming that it will achieve the £3.5 million at the year end and, therefore, is accruing the full £2.041 million in the above table in the month 7 YTD position.

3.5. An additional £200,000 has been accrued in the month 7 YTD position (current expected year

end contract over performance of £1.1 million results in a contract payment of £76.0 million). This is based on expected year end contract performance and is reviewed monthly.

3.6. Latest projections indicate that if Southport & Formby CCG was on a PbR contract value the year end projection is in the region of £78.8 million.

3.7. Apart from the Sefton CCGs, all other CCG contracts are on a PbR type contract.

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

- £51.0 million for West Lancashire CCG; based on month 7 activity performance, and planned recovery of the elective plan, this is forecast to be achieved.
- £74.9 million for Southport & Formby CCG; the Trust is currently underperforming against the conditional elements of the contract but the contract is expected to overachieve.

4. **Income**

4.1. Elective activity performance has been improving over the last few months. It should be noted that this improvement has had an adverse impact on outpatient activity as cancelled elective sessions were previously replaced with outpatient work.

4.2. Non elective activity has once again overperformed in month.

4.3. Trust activity and income performance at month 7 YTD is as follows:

- Elective – activity is 3.9% below plan; £435,000 loss of income.
- A&E – activity 5.5% above plan; £353,000 of additional income.
- Non Elective – activity is 2.4% below plan; £2,567,000 additional income due to case mix
- Outpatients – activity is 3.9% above plan; £627,000 of additional income

4.4. Not all of the above activity performance is payable in 2019/20 due to:

- the application of the “blended tariff” adjustment means that only a proportion of the non-elective value is payable
- Sefton CCG’s contract applies the “blended tariff” to all points of delivery.

4.5. The Trust’s commissioning income for month 7 YTD position assumes the following:

- Southport & Formby CCG will overperform against the contract at the year end (full year contract value is £74.9 million; overperformance of £1.1 million).
- £200,000 of this overperformance was bought into the month 6 income position and this has also been accrued at month 7.
- All other commissioning income is paid in line with the agreed contract.

5. Expenditure

5.1. Please refer to attached appendices for more detailed information regarding expenditure and Whole Time Equivalent (WTE).

5.2. Underlying expenditure levels over the last few months have been fairly consistent but have increased in month 7.

5.3. The Board will recall that a number of non-recurrent expenditure reductions were applied in month 3 in order to achieve the Quarter 1 control total.

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

5.5. In month 7 no adjustments have been made and this has contributed to a deteriorating performance.

5.6. The most material increase in expenditure is within nursing staff with October 2019 seeing the largest monthly nurse expenditure and WTE date. Although the substantive WTE has seen a welcome increase this month (from 1,102 to 1,121 WTE) both bank and agency have also increased.

5.7. It is important that substantive staff increase and vacancies reduce from both a quality and finance perspective. Whilst bank is financially preferable to agency staff it is apparent that the premium associated with bank is also significant as the majority of shifts covered are evenings and weekends.

5.8. Further review of this will take place alongside the 2020/21 budget process.

5.9. Non pay areas have also seen a slight increase with some of this attributable to the additional elective work now taking place.

6. Bank/agency spend

6.1. The Trust spent £2.052 million in October on bank and agency staff.

6.2. Monthly agency spend has increased in October to £1,109,000 (9.3% of the pay bill); Medical staff £511,000; Nursing staff £458,000

6.3. Month 7 YTD agency spend is £6.978 million (8.4% of the pay bill); Medical staff £3.717 million; Nursing staff £2.619 million

6.4. The agency target cap of £4.891 million set by NHSI for 2019/20 was breached in month 6.

6.5. Bank spend is consistent with previous months; October is £944,000 (8.3% of the total pay bill) bringing YTD spend to £6.533 million (7.9% of the total pay bill).

6.6. As referred to above both bank and agency attract 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 is mainly dependent on expenditure reduction.

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

	Annual	Annual	Month 6			YTD				
	Plan £000	Budget £000	Budget £000	Actual £000	Var £000	Budget £000	Actual £000	Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	355	118	(237)	2,094	959	(1,135)	1,377	1,015
19/20 Plan - Expenditure (non pay)	1,724	1,724	160	83	(77)	910	737	(173)	1,143	996
19/20 Plan - Income (other op income)	325	325	39	25	(14)	128	242	114	343	66
19/20 Plan - Income (BPT)	1,800	300	26		(26)	156		(156)		
19/20 Plan - Total	**6,314**	**6,314**	**580**	**226**	**(354)**	**3,288**	**1,938**	**(1,350)**	**2,863**	**2,077**

7.4. The forecast outturn against the £6.314 million target has reduced to is £4.359 million leaving an unidentified gap of £1.955 million.

8. Forecast Outturn

8.1. The Trust has been signalling that it will not achieve its financial plan based on current financial performance.

8.2. Despite the achievement of the Quarter 2 plan a large element of the income and expenditure adjustments will impact in Quarter 4.

8.3. The Trust's expenditure levels in the first half of the year, together with assumptions on CIP delivery and future impact of agreed business cases, derived a predicted £5.1 million overspend against the plan.

8.4. This was included in the System Recovery plan submitted to NHSI/E on 18th October 2019 and discussed at this Board's October meeting.

8.5. Following review the System was instructed to find further schemes to reduce the forecast gap from control totals.

8.6. The Trust has identified a further improvement of £1.49 million and is now predicting an overspend of £3.61 million against the £26.6 million deficit plan. NHSI/E is monitoring the Trust's performance against this forecast on a weekly basis.

8.7. The table below shows the control total and current forecast for all System partners:

	S&O NHST	SS CCG	SF CCG	Winter	Total
	£m	£m	£m	£m	£m
2019/20 Control Total (excl PSF/FRF)	(26.60)	1.00	0.00	0.00	(25.60)
Winter	0.00	0.00	0.00	(1.10)	(1.10)
Forecast overspend	(3.61)	(9.12)	(10.70)	0.00	(23.43)
Forecast Outturn (excl PSF/FRF)	**(30.21)**	**(8.12)**	**(10.70)**	**(1.10)**	**(50.13)**

8.8. Month 7 expenditure levels were in the region of £0.2 million above the Trust's trajectory to achieve £3.61 million adverse against plan.

8.9. The pressure on the expenditure run rate as vacancies are filled (including agreed business cases) is not being mitigated by real expenditure reductions form the CIP programme.

8.10. Based on current expenditure levels and CIP performance it is highly likely that the Trust will not achieve the Quarter 3 deficit plan without significant CCG support and, therefore, will not be in receipt of the PSF/FRF for that quarter (£5.481 million).

9. Cash

9.1. The previous large cash balance (October's opening balance was £7 million) has now been fully utilised with November closing cash balance £1.1million which is in line with the terms and conditions of our revenue support loans..

9.2. Performance against the cash plan in October 2019 was on target overall, however, cash outflows needed controlling to ensure the target was met.

9.3. Quarter 2 FRF funding of £2.961 million was received on 15th November 2019; it was not forecast to be received until December 2019.

9.4. The uncertainty of timing around PSF and FRF funding has made forecasting a challenge

9.5. The Trust is not achieving the Better Payment Practice Code (BPPC) target, however, a focus on delivering the e-invoicing target will help with both the BPPC and reduce the risk of additional contractual penalty charges by NHS Shared Business Services.

10. Debtors

10.1. Debt levels have increased from £3.8 million at the end of September 2019 to £4.9 million at the end of October 2019.

10.2. Greater than 90 day debt has increased from £1,466,998 last month to £2,021,405 this month.

10.3. The majority of this increase is in NHS debt and is linked mostly to a revoked credit note to NHS England for -£364,000.

10.4. There has been some increase in non NHS debt and this is entirely due to Local Authority invoices (Lancashire County Council) which are on SBS (Shared Business Services) dunning levels.

10.5. A monthly debt management call takes place with SBS and this includes a review of the top 10 debtors (NHS and non-NHS) over 31 days and by dunning responsibility.

10.6. The majority of >90 day debt is NHS related (as per table above) and it can be difficult to chase as this debt can't be referred to external debt recovery.

11. Capital

11.1. Actual spend in month 7 was higher than month 6, at £535,000 bringing the cumulative actual spend to date to £2,098,000 against a planned spend year to date of £4,027,000.

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. Commitments have increased in the month to £1,137,000, partly IT, but mainly Medical Equipment on order which has recently been approved at Capital Investment Group (CIG).

11.4. Medical Equipment has the highest level of commitments, closely followed by IT which is mostly connected with the Windows 10 rollout and Careflow Connect.

11.5. Taking actual and committed spend together at £3,087,000 (excluding donated and GE radiology assets) and comparing this against the annual plan, £5,103,000, then the Trust is at 60.5% of the plan at the end of October 2019.

11.6. The first 5 wards of the Southport ward upgrade project will be completed before Christmas with a 6th planned for completion before the end of the financial year.

11.7. Work is near completion in the Spinal Injuries Unit on the Isolation work and the bathroom upgrades which were required as a result of the Klebsiella outbreak.

11.8. IM&T contingency scheme at £450,000 was originally intended for the datacentre, however, this is unlikely to be implemented in 2019/20 and a re-utilisation of these monies to other IT projects planned for next year is reflected in the revised plan.

11.9. The Trust has been successful in receiving £700,000 funding for ePMA (Electronic Prescribing

and Medicines Administration) system.

11.10. NHSE/I has supported the Trust to apply for a capital loan of £935,000 to address the high risk items identified in the six facet survey. This could be received in 2019/20.

11.11. The Board approved a revised capital plan on 6th November and included the authorisation to proceed with the development of additional bed capacity at Ormskirk hospital as part of the winter plan at a forecast cost of £350,000.

11.12. However, the full cost of these works is now £495,000 which includes backlog maintenance.

11.13. Under the new scheme of delegation Finance Performance and Investment Committee approved the additional cost of the scheme.

11.14. This week confirmation was received that capital funding for winter planning of £500,000 had been awarded; the relevant paperwork is awaited (Memorandum of Understanding) and once signed off an application will be made to draw down public dividend capital.

11.15. Based on current information the MRI scanner project is back on track in and this scheme will be delivered by the end of March 2020 as originally planned.

12. **Recommendations**

12.1. The Board is asked to receive the Finance Report – Month 7 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. **WTE run rate by month**
5. **Statement of Financial Position (Balance Sheet)**
6. **Capital Expenditure**
7. **Cashflow Forecast**

1. Activity run rate by month

	2018/20						2019/20						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
AandE	7,309	7,328	6,896	7,269	6,756	7,595	7,176	7,446	7,162	7,783	7,224	7,393	7,471
Day Case	1,906	1,984	1,444	1,878	1,731	1,854	1,707	1,706	1,605	1,815	1,801	1,825	1,849
Elective	212	189	138	180	175	179	144	187	183	177	175	153	194
Non Elective (Including Short Stay)	2,654	2,679	2,644	2,741	2,480	2,646	2,368	2,505	2,340	2,662	2,707	2,559	2,781
Non Elective Non Emergency	239	233	285	241	254	262	75	78	60	76	62	69	73
Outpatients (Including Procedures)	16,515	15,871	12,855	14,926	14,462	15,302	15,075	15,615	14,366	16,778	14,066	15,228	15,881

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

I&E (Including R&D)	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioning Income	165,513	97,340	97,208	(131)	14,463	14,279	(184)
PP, Overseas & RTA	1,094	640	453	(187)	92	53	(39)
Other Income	12,174	7,271	7,662	391	1,030	1,026	(3)
PSF & FRF	18,271	8,222	8,222	0	1,827	1,827	0
Total Operating Income	**197,052**	**113,473**	**113,545**	72	**17,411**	**17,185**	(226)
PAY	(140,012)	(82,273)	(82,544)	(271)	(11,610)	(11,961)	(351)
NON PAY	(53,220)	(31,355)	(32,032)	(677)	(4,453)	(4,775)	(322)
Total Operating Expenditure	**(193,232)**	**(113,628)**	**(114,577)**	**(948)**	**(16,064)**	**(16,735)**	**(673)**
EBITDA	**3,820**	**(155)**	**(1,032)**	**(876)**	**1,348**	**450**	**(899)**
Net Financing Costs	(12,149)	(7,109)	(7,112)	(3)	(1,019)	(999)	20
Retained Surplus/Deficit	**(8,329)**	**(7,264)**	**(8,144)**	**(879)**	**329**	**(549)**	**(879)**
Technical Adjustments	33	28	38	10	(14)	4	18
Break Even Surplus/(Deficit)	**(8,296)**	**(7,235)**	**(8,106)**	**(869)**	**315**	**(545)**	**(861)**
Less PSF/FRF Funding	(18,271)	(8,222)	(8,222)	0	(1,827)	(1,827)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(15,457)**	**(16,328)**	**(869)**	**(1,512)**	**(2,372)**	**(861)**

3. Expenditure run rate by month

RUN RATE Month on Month - £(000)

As at 31st October 2019

Southport and Ormskirk Hospital NHS Trust

Class	STAFF GROUP	STAFF TYPE	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
PAY	Consultants	Substantive	(1,319)	(1,299)	(1,319)	(1,395)	(1,324)	(1,118)	(1,238)	(1,239)	(1,234)	(1,321)	(1,235)	(1,396)	(1,282)
		Bank	(50)	(40)	(70)	(101)	(78)	(104)	(98)	(70)	(65)	(112)	(65)	(75)	(84)
		Agency	(110)	(154)	(187)	(179)	(206)	(272)	(279)	(279)	(201)	(275)	(266)	(341)	(264)
	Consultants Total		(1,479)	(1,494)	(1,577)	(1,675)	(1,608)	(1,494)	(1,615)	(1,587)	(1,500)	(1,708)	(1,566)	(1,812)	(1,630)
	Other Medical	Substantive	(1,243)	(1,202)	(1,263)	(1,319)	(1,307)	(1,256)	(1,337)	(1,305)	(1,327)	(1,297)	(1,313)	(1,431)	(1,328)
		Bank	(129)	(163)	(142)	(137)	(115)	(167)	(165)	(167)	(195)	(155)	(174)	(171)	(146)
		Agency	(226)	(217)	(208)	(244)	(273)	(316)	(256)	(257)	(277)	(288)	(255)	(235)	(247)
	Other Medical Total		(1,597)	(1,581)	(1,612)	(1,699)	(1,695)	(1,739)	(1,758)	(1,730)	(1,799)	(1,740)	(1,742)	(1,837)	(1,722)
	Nurses & Midwives	Substantive	(3,628)	(3,604)	(3,571)	(3,704)	(3,672)	(3,388)	(3,954)	(3,818)	(3,797)	(3,745)	(3,722)	(3,771)	(3,749)
		Bank	(529)	(565)	(543)	(595)	(588)	(684)	(609)	(637)	(645)	(632)	(671)	(656)	(684)
		Agency	(367)	(294)	(262)	(427)	(415)	(436)	(372)	(397)	(319)	(303)	(400)	(370)	(458)
	Nurses & Midwives Total		(4,524)	(4,463)	(4,375)	(4,726)	(4,675)	(4,508)	(4,935)	(4,852)	(4,761)	(4,680)	(4,793)	(4,796)	(4,891)
	Scientific, Technical & Theraputic	Substantive	(1,331)	(1,330)	(1,307)	(1,320)	(1,319)	(1,260)	(1,437)	(1,349)	(1,329)	(1,323)	(1,348)	(1,372)	(1,384)
		Bank	(11)	(13)	(12)	(9)	(12)	(12)	(7)	(7)	(7)	(8)	(6)	(5)	(5)
		Agency	(16)	(20)	(15)	(12)	(8)	(14)	(4)	(8)	(20)	(35)	(26)	(72)	(28)
	Scientific, Technical & Theraputic Total		(1,358)	(1,363)	(1,334)	(1,341)	(1,339)	(1,286)	(1,448)	(1,364)	(1,355)	(1,366)	(1,380)	(1,449)	(1,417)
	Other Staff	Substantive	(2,010)	(2,040)	(1,981)	(1,965)	(2,008)	(1,731)	(2,284)	(2,156)	(2,147)	(2,090)	(2,115)	(2,150)	(2,120)
		Bank	(31)	(7)	(28)	(27)	(19)	(34)	(38)	(17)	(27)	(34)	(40)	(28)	(24)
		Agency	(63)	(51)	(58)	(59)	(50)	(54)	(59)	(54)	(48)	(64)	(78)	(34)	(112)
	Other Staff Total		(2,105)	(2,098)	(2,067)	(2,051)	(2,077)	(1,818)	(2,381)	(2,227)	(2,223)	(2,188)	(2,232)	(2,213)	(2,256)
	Pay Reserves	Substantive	0	35	184	232	798	(176)	(57)	(56)	149	(191)	(54)	914	(0)
	Pay Reserves Total		0	35	184	232	798	(176)	(57)	(56)	149	(191)	(54)	914	(0)
	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	(39)	(44)	(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)	(46)
	Apprenticeship Levy Total		(39)	(44)	(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)	(46)
PAY Total			(11,102)	(11,008)	(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)
NON-PAY	Supplies & Services Clinical		(2,317)	(2,290)	(2,228)	(2,249)	(2,227)	(2,413)	(2,263)	(2,325)	(2,259)	(2,420)	(2,264)	(2,227)	(2,382)
	Supplies & Services General		(204)	(214)	(200)	(203)	(199)	(212)	(186)	(172)	(173)	(164)	(189)	(219)	(211)
	Non-Executive Directors								(6)	(6)	(6)	(8)	(4)	(6)	(6)
	Establishment Expenses		(288)	(352)	(295)	(298)	(292)	(268)	(191)	(226)	(232)	(221)	(245)	(242)	(237)
	Premises & Fixed Plant		(990)	(943)	(993)	(953)	(917)	(775)	(1,018)	(1,035)	(991)	(985)	(1,055)	(948)	(1,061)
	Miscellaneous		(616)	(632)	(659)	(638)	(654)	(595)	(717)	(720)	(716)	(735)	(717)	(666)	(740)
	Services From Other NHS Bodies		(279)	(293)	(209)	(287)	(253)	(328)	(103)	(61)	(69)	(145)	(188)	(136)	(137)
	Non Pay Reserve		0	0	0	0	0	0	(7)	7	0	0	0	0	0
	Non Pay CIP		0	0	0	0	0	0	0	0	0	0	0	0	0
NON-PAY Total			(4,695)	(4,725)	(4,583)	(4,628)	(4,543)	(4,590)	(4,491)	(4,538)	(4,446)	(4,678)	(4,662)	(4,443)	(4,775)
NON-OPERATING EXPENDITURE			(920)	(939)	(942)	(939)	(940)	(479)	(1,031)	(1,023)	(1,037)	(1,006)	(1,042)	(1,016)	(998)
Grand Total			**(16,717)**	**(16,672)**	**(16,346)**	**(16,868)**	**(16,119)**	**(16,137)**	**(17,761)**	**(17,418)**	**(17,009)**	**(17,608)**	**(17,506)**	**(16,694)**	**(17,733)**

PAY SUMMARY BY STAFF TYPE

PAY	Substantive	(9,570)	(9,485)	(9,296)	(9,511)	(8,871)	(8,975)	(10,351)	(9,964)	(9,723)	(10,016)	(9,822)	(9,248)	(9,908)
	Bank	(749)	(788)	(795)	(869)	(813)	(1,001)	(918)	(898)	(940)	(942)	(956)	(936)	(944)
	Agency	(782)	(735)	(730)	(920)	(952)	(1,092)	(970)	(995)	(864)	(966)	(1,024)	(1,050)	(1,109)
PAY Total		(11,102)	(11,008)	(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)

4. WTE run rate by month

WTE worked

As at 31st October 2019

STAFF GROUP	STAFF TYPE	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Consultants	Substantive	100	103	102	94	99	97	96	95	94	94	95	95	95
	Bank	2	2	4	4	5	5	5	5	3	5	3	3	4
	Agency	25	8	9	8	10	12	12	12	9	12	12	13	14
Consultants Total		127	114	115	107	114	114	114	111	106	111	110	111	113
Other Medical	Substantive	207	207	215	218	224	225	225	226	217	228	225	217	216
	Bank	10	11	10	10	10	11	13	11	9	12	12	9	12
	Agency	65	19	18	21	24	28	20	23	24	22	20	20	21
Other Medical Total		281	236	242	249	258	264	258	260	250	263	257	246	249
Nurses & Midwives	Substantive	1,097	1,101	1,098	1,094	1,101	1,110	1,106	1,121	1,110	1,109	1,107	1,102	1,121
	Bank	161	171	161	172	176	208	178	185	186	189	196	187	197
	Agency	48	44	42	62	59	69	63	60	54	57	66	65	75
Nurses & Midwives Total		1,305	1,315	1,302	1,329	1,336	1,387	1,347	1,367	1,350	1,355	1,369	1,354	1,394
Pay Reserves	Substantive	-	-	-	-	-	-	-	-	-	-	-	-	-
Pay Reserves Total		-	-	-	-	-	-	-	-	-	-	-	-	-
Scientific, Technical & Theraputic	Substantive	410	403	402	402	407	402	405	400	387	395	400	408	406
	Bank	3	2	2	2	3	2	2	2	1	2	2	1	1
	Agency	13	4	3	3	2	2	1	1	4	6	5	6	5
Scientific, Technical & Theraputic Total		426	410	407	406	411	407	408	403	392	403	407	415	412
Other Staff	Substantive	775	774	771	760	772	773	810	802	805	797	803	804	824
	Bank	12	14	12	9	11	14	15	13	10	14	14	13	12
	Agency	11	15	11	7	10	8	8	10	13	10	12	9	11
Other Staff Total		799	803	793	777	793	795	833	825	828	821	829	826	848
Grand Total		**2,938**	**2,878**	**2,860**	**2,868**	**2,912**	**2,967**	**2,959**	**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**
SUMMARY BY STAFF TYPE														
	Substantive	2,589	2,589	2,588	2,569	2,603	2,608	2,642	2,643	2,613	2,623	2,630	2,626	2,663
	Bank	187	200	190	198	205	240	213	215	210	222	227	213	226
	Agency	162	90	82	101	104	119	103	108	103	107	115	113	126
Grand Total		**2,938**	**2,878**	**2,860**	**2,868**	**2,912**	**2,967**	**2,959**	**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**

5. Statement of Financial Position (Balance Sheet)

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	31/10/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	121,087	(1,980)	(38)
Other assets	966	1,537	571	(31)
TOTAL NON CURRENT ASSETS	**124,033**	**122,624**	**(1,409)**	**(69)**
CURRENT ASSETS				
Inventories	2,382	2,315	(67)	105
Trade and other receivables	11,678	13,868	2,190	2,733
Cash and cash equivalents	1,042	1,119	77	(6,100)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**17,302**	**2,200**	**(3,262)**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(22,358)	413	(1,931)
Provisions	(199)	(212)	(13)	0
PFI/Finance lease liabilities	(1,153)	(1,153)	0	0
DH revenue loans	(20,487)	(53,547)	(33,060)	(2)
DH Capital loan	(411)	(400)	11	0
Other liabilities	(1,025)	(6,575)	(5,550)	1,108
TOTAL CURRENT LIABILITIES	**(46,046)**	**(84,245)**	**(38,199)**	**(825)**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(66,943)	(35,999)	**(4,087)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**55,681**	**(37,408)**	**(4,156)**
NON CURRENT LIABILITIES				
Provisions	(207)	(160)	47	20
DH revenue loans	(82,953)	(55,026)	27,927	2,743
PFI/Finance lease liabilities	(13,831)	(12,938)	893	645
DH Capital loan	(1,000)	(600)	400	200
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(68,724)**	**29,267**	**3,608**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(13,043)**	**(8,141)**	**(548)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,214	0	0
Retained earnings	(112,432)	(120,573)	(8,141)	(548)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(13,043)**	**(8,141)**	**(548)**

Southport and Ormskirk Hospital NHS Trust

In month material movements are as follows:

Cash has reduced by £6.1 million as it has been utilised to pay down some of the DHSC loans (£2.743 million) and cope with less monies from the Commissioners as they are clawing back previously paid monies over the last 6 months of the year.

The increase in trade and other receivables is a combination in an increase in aged debt (£1.1 million) and an increase in income accruals.

Trade and other payables has also increased with the majority (approx. £1.5 million) associated with unpaid purchase invoices.

6. Capital

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M7 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Original Plan	Revised Plan	Actual	Variance	Actual	Actual	Revised Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0090	1,000	125	287	(162)	28	431	1,000	746	254
	Beds / Trolleys	G0060						31		31	(31)
	Sub total MEDICAL DEVICES		**1,000**	**125**	**287**	**(162)**	**28**	**462**	**1,000**	**777**	**223**
IM&T	Electronic Patient Record Bluespier	G0100	111								
	Electronic Patient Record PDS	G0101	69						69		69
	Electronic Patient Record Careflow	G0102	149	127		127		277	462	277	185
	Vitalpac	G0007	10		25	(25)			25	25	
	Patient Service Signposting	G0103	184	138	106	32			184	106	78
	eDMS Evolve	F6447	80	40	43	(3)			43	43	
	SQL Server Upgrades								95		95
	Windows 10 Project	G0104	318	259	441	(182)		57	473	498	(25)
	Telephony System Replacement	G0059	50						50		50
	Baby Tagging	G0105	50	50		50		48	50	48	2
	Cyber Security	G0071	80	60	23	37			22	23	(1)
	Fixed Network Infrastructure	F6498	120	70	43	27			120	43	77
	PAS Replacement	F6409			6	(6)		1		7	(7)
	Data Storage Infrastructure	G0106	25						61		61
	Wireless Network Upgrade	G0073			2	(2)				2	(2)
	IM&T Contingency	G0107	450	220	99	121		56	42	155	(113)
	Sub total IM&T		**1,696**	**964**	**788**	**176**		**439**	**1,696**	**1,227**	**469**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	350	350		350	1		350	1	349
	6 Facet Survey	G0150	90	90	49	41			90	49	41
	Nurse Call System	G0151	100								
	Upgrade Ventilation Plants	G0152	100								
	Fire compartmentation	G0052	100		4	(4)				4	(4)
	Fire Precautions - Fire Doors	G0019	100		2	(2)				2	(2)
	Legionella Prevention	G0153	50								
	Spinal Lift & Ramp	G0154	85								
	Spinal isolation works	G0099	150	201	295	(94)		4	252	299	(47)

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M7 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Original Plan	Revised Plan	Actual	Variance	Actual	Actual	Revised Plan	Actual	Variance
ESTATES	SDGH Ward Upgrades	G0155	600	693	206	487		34	972	240	732
	Library Extension	G0156	145	145		145			145		145
	Capital Team	F6305	160	93	101	(8)			160	101	59
	CCTV	G0157	50								
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,080**	**1,572**	**657**	**915**	**1**	**38**	**1,969**	**696**	**1,273**
	ESTATES CONTINGENCY										
	Estates Contingency Fund								45		45
	Ward E										
	Y Block (approved CIG 07/19)								20		20
	Doctors Mess (18/19)	F6420			(1)	1			(1)	(1)	
	Spinal Ward Bathrooms & Storage	G0158			162	(162)	2	22	188	186	2
	UPS Theatre	G0053		15	15				15	15	
	Southport A&E	G0068		13	13				13	13	
	Sexual Health Accommodation	G0079		(1)	(1)				(1)	(1)	
	Car Parking Scheme										
	Waste Management	G0080									
	EBME Lift										
	HR Move - Further Alterations to LRC	F6301		25	13	12			34	13	21
	Sub total ESTATES CONTINGENCY SCHEMES			**52**	**201**	**(149)**	**71**	**22**	**313**	**294**	**19**
	Sub total ESTATES SCHEMES		**2,080**	**1,624**	**858**	**766**	**72**	**60**	**2,282**	**990**	**1,292**
FACILITIES	Catering equipment	G0026	75	62	18	44	69		102	87	15
	Vehicle Replacement	G0145	50	(12)		(12)			23		23
	Sub total FACILITIES		**125**	**50**	**18**	**32**	**69**		**125**	**87**	**38**
	CONTINGENCY	**F6301**	**202**		**(1)**	**1**		**8**		**7**	**(7)**
	Capital plan excluding donations and IFRIC 12		**5,103**	**2,763**	**1,950**	**813**	**168**	**969**	**5,103**	**3,088**	**2,015**
OTHER	Donated assets	000000	100	50	50				100	50	50
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,214	1,214	98	1,116			1,214	98	1,116
	Sub total Donations and IFRIC 12		**1,314**	**1,264**	**148**	**1,116**			**1,314**	**148**	**1,166**
	TOTAL CAPITAL SPEND		**6,417**	**4,027**	**2,098**	**1,929**	**168**	**969**	**6,417**	**3,236**	**3,181**

7. 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	Actual 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	(122)	482	(89)	612	(15)	912	(3,202)
Income recognised in respect of capital donations	(9)	1	0	(34)	0	0	(8)	0	(33)	0	0	(17)	(100)
Depreciation and Amortisation	594	593	601	571	572	572	573	581	581	598	598	599	7,033
Impairments and Reversals	0	0	0	0									0
(Increase) in Inventories	59	(86)	200	(143)	(74)	216	(105)	(50)	30	25	18	30	120
(Increase) in Trade and Other Receivables	(949)	(2,096)	(1,115)	1,143	1,947	1,011	(2,702)	(2,454)	1,200	(2,758)	(2,758)	3,136	(6,395)
Increase in Trade and Other Payables	3,517	(1,123)	(1,871)	(1,887)	5,822	(512)	514	(1,559)	(2,894)	(3,865)	170	(1,165)	(4,853)
Increase in Provisions	1	(8)	(3)	10	0	(14)	14		(25)			(42)	(67)
Net Cash Inflow/(Outflow) from Operating Activities	1,620	(3,724)	(2,214)	(1,433)	6,876	1,399	(1,836)	(3,000)	(1,230)	(5,388)	(1,987)	3,453	(7,464)
Cash Flows from Investing Activities													
Interest Received	3	4	5	5	8	17	(1)	6	6	6	6	7	72
(Payments) for Intangible Assets	(57)	0	(2)	(152)	127	0	(2)	(92)	(112)	(83)	(80)	(237)	(690)
(Payments) for PPE and investment property	(190)	(117)	(186)	40	(1,144)	(325)	(189)	(391)	(570)	(667)	(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			8		33			17	100
Net Cash Inflow/(Outflow) from Investing Activities	(235)	(114)	(183)	(73)	(1,009)	(308)	(184)	(477)	(643)	(744)	(365)	(1,283)	(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	0	3,693	3,155	6,434	3,081		24,842
Loans repaid to DH	(200)	0	0	0	0	0	(2,941)		(697)			(1,236)	(5,074)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(596)		(24)		(240)	(24)	(932)
Capital element of PFI, LIFT	(16)	(15)	(118)	(16)	(15)	(119)	(15)	(16)	(118)	(16)	(15)	(119)	(598)
Interest Paid	(190)	(234)	(225)	(195)	(228)	(545)	(207)	(238)	(234)	(205)	(236)	(540)	(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)	(4,080)	3,358	1,873	6,132	2,352	(2,128)	13,082
NET INCREASE/(DECREASE) IN CASH	**3,347**	**(2,718)**	**(571)**	**374**	**5,535**	**210**	**(6,100)**	**(119)**	**0**	**0**	**0**	**42**	**0**
Cash - Beginning of the Period	1,042	4,389	1,671	1,100	1,474	7,009	7,219	1,119	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**	**1,119**	**1,000**	**1,000**	**1,000**	**1,000**	**1,042**	**1,042**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**PB206/19**	**Report Title**	**Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Interim Head of Risk Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

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

- **2122** – Medicines Management (15). This risk has been added as a result of concerns raised by CQC. A Medicines Management Improvement Plan has been developed with actions underway.

Discussions have taken place at Risk & Compliance Group to add an additional two risks onto this risk register. These relate to 'Fragile Services' and 'Medical Staffing'. These will be drafted for approval at Risk & Compliance Group in December.

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

There are currently 8 risks on the High Level Risk register. These are:

- **1688** - Inadequate Staffing Levels in Anaesthetic Department (will be consolidated into Medical Staffing risk)
- **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
- **2122** – Medicines Management

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

NOVEMBER 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 26/11/2019

Risk ID	Principle Objective(s)	Risk	Executive Lead	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-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	20↑	=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↓↓
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	12↓	=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	=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	=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↓	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	=16
2122	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services	Medicines Management	Executive Medical Director						!15

TRUST RISK PROFILE AS AT 26/11/2019

	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)					**2122 – Medicines Management**
Unlikely (2)					
Rare (1)					

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services		Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**	
14/11/2019	2122	Executive Medical Director	John Williams	Medicines Management	
Description	If the trust cannot guarantee Safe and Secure Handling of Medicines and Clinical Pharmacy Service then there is a risk of patient harm through lack of timely medicines reconciliation, supply of critical medicines to patients, correct prescribing and administration of medicines and risk of patients going home without the correct take home medication.				
Controls	Pharmacist clinical check for all non-stock items during opening hours. Late night rota for Pharmacy staff and on-call service. Access to Emergency Store out of hours Weekend opening times limited to an emergency service Electronic discharge, including links to PharmOutcomes Locum cover for some vacancies Patients own medicines stored in bed side lockers Self administration of medicines, Controlled Drug and Medicines Optimisation Policies Weekly top up and date checking from pharmacy staff in cupboards for most clinical areas; Electronic Checklist for resus trolleys to ensure items are in date		**Gaps in Controls**	Insufficient Staff within Pharmacy Department to provide medicines reconciliation within 24 hours. Unable to ensure timely discharge medication due to insufficient staff resulting in insufficient opening times Impact on patient flow due to delayed discharges as a result of delayed discharge medication not being prescribed in a timely fashion Insufficient resource for in-patient/discharge counselling impacting poor in-patient survey results, and ability for patients to self-administer. Risk of patients missing critical medicines/therapy. Unable to ensure continuity of supply of critical medicines due to insufficient ward based services including ward based pharmacy technicians. Medicines Trolleys unfit for purpose. Inadequate system for pre-pack medicines control in all areas Lack of CD destruction at ward level due to lack of ward based technicians. Aseptic unit QCNW external audit noted major concerns regarding Quality Review systems Limited opening hours of Pharmacy Monday- Friday 9-5, and reduced service and staffing 3 hours Sat and Sun. Effect on Pharmacy staff well-being and sickness rates due to workload pressure. Lack of central wireless monitoring system for temperatures in drug storage areas. Lack of EPMA (electronic prescribing) trust wide. Anti-coagulant clinics run on minimal staffing Unable to update to Drug Library for IV pumps in a timely manner Poor uptake of medicines management training to multidisciplinary team. Poor completion of documentation.

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review	
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	4	Moderate risk	21/11/2019	12/12/2019	
Assurance	Drug and Therapeutic Committee provides Medicines Governance and meets monthly Medicines Safety Committee meets monthly. Review of drug alerts and medicines incidents. Most low/no harm. Pharmacist intervention monitoring Pharmacy Governance monthly meeting. Review of Dispensing errors SOCCAS ward accreditation system highlights areas of good practice and areas for improvement in medicines management CD audits						**Gaps in Assurance**	Out of date medicines, poor drug storage and temperature monitoring within existing treatment rooms. Poor medicines reconciliation within 24 hours. CD Policy requires review Poor attendance at Medicines Management training		
Action Plan	PMO support provided to the Medical Director, Chief Pharmacist, Pharmacy and Nursing staff to complete the Medicines Management Development Project in line with NHSI, CQC and internal assessments to close the Gaps in assurance						**Action Plan Due Date**	01/11/2021	**Action Plan Rating**	Moderate Progress Made
Latest Month Progress	The pharmacy business case for workforce was approved at the trust board 7th November2019 (for extended weekend working, AED Consultant pharmacist and ward pharmacy assistants). Any changes to working hours will be subject to staff consultation with support of HR. The trust has been successful in securing £700k of funding from NHS England Integrated Digital Care Fund to implement an electronic prescribing and medicines administration (EPMA) system over the next 18 months which will support patient safety and the discharge process.									

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	2 Non RTT validators have commenced in Trust to review high risk pathways in Urology and Ophthalmology Report re missing outcomes in suite of PTL reports to allow monitoring 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 Non RTT trackers lack capacity to review pathways. The process puts the onus on the patient GP's may not alert the loss to follow up in all cases. Staff complete training package End Dec 2019 which means potential for further issues currently ongoing.
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	18/11/2019	18/12/2019
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	Weekly meetings continue to take place to update on the action plan with CCG representation fortnightly at these meetings. CCG confirm that updated action plan is presented at the Joint Quality and performance meeting. SOPs have been agreed and circulated. Stage 1 of training has now been completed with Stage 2 to be completed by end of December 2019. This is recorded on ERS to enable monitoring. Second tracker is now trained and tracking report as above is a live document, with daily updates. Business case has been written for substantive posts and will go to BDISC Dec 12th.In light of current CCG engagement and reporting, Trust request reporting into contract meeting by exception only.								

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 Registered 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 Contract booking for RN agency to support fill rate on day shifts during winter pressured months						**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	18/11/2019 / 16/12/2019
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 Wd managers/Matrons of final e roster rota						**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

	Upload new templates Smart sheets has detailed plan - Recruitment Identify HR recruitment team to support recruitment process Advertise relevant posts (RN, HCA, B4) Monthly review of vacancies, turnover & progress through R&R Steering group 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	Contract booking for RN agency to support fill rate on day shifts during winter pressured months started w/c 18/11/19- approximately 20 WTE. Table top establishment reviews have commenced.				

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

Opened	ID	ADO/Exec Lead	Risk Lead	Title
19/09/2018	1902	Director of Nursing & Quality	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 Factual Accuracy Checking Completed and submitted within timescales and signed off by Interim Chief Executive	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	18/11/2019	23/12/2019

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 Factual Accuracy Checking Completed and submitted within timescales and signed off by Interim Chief Executive	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	Action Plan Due Date	17/07/2019 28/02/2020	Action Plan Rating	Completed Little or No

	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 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 30/09/2019 28/06/2019 22/10/2019 29/11/2019		Progress Made Completed Completed Completed Actions Almost Completed Moderate Progress Made
Latest Month Progress	The Trust is currently awaiting the CQC report which is expected by the end of November. This risk will be updated on receipt of this report.				

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire		Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**	
13/06/2019	2052	Director of Nursing & Quality	Megan Langley	Older Peoples Care	
Description	If there is continued poor quality care delivered in particular to older people in Southport & Ormskirk NHS Trust, continue then harm may be caused to our older patients impacting negatively on their quality of life, function and experience. The areas of concern relate to specific practices: •Deconditioning of patients •The inappropriate use of bed rails •Poor mouth care •Poor nutrition assessment and management •Poor hydration management •Poor continence assessment and management •Lack of interaction and social/cognitive stimulation increasing confusion and delirium • A lack of education and training specifically in caring for older people • A lack of end of life care education strategy within the Trust •Limited availability of Geriatricians to provide holistic comprehensive assessment and advanced care management plans for patients in addition to limited clinical support for the Frailty Practitioners •Inability to discharge patients home due to lack of resource to support at home particularly care and rehabilitation provisions in the community •Poorly established pathway for patients with spinal fractures •An environment not conducive to stimulating people and enabling them to maintain and maximise their function •The lack of a formally agreed frailty pathway and model			
Controls	Red2Green rolled out - Therapy developing a competency and training for staff to be equipped to chair and challenge in a consistent way sustaining the Red2Green principles at board rounds across the Trust. Nutrition - New policy approved, New E-learning module provided to RNs on ward 10B with new care plans being tested - in addition to this, additional Dietetic support is being offered to this ward while they implement the new practices. Business Intelligence are working on a new collection of KPIs to measure and monitor improvement. Mouth Care- 5 staff completed Mouth Care Matters Train the Trainer programme- currently developing new policy, care plans and product availability. Dementia & Delirium - New cognitive risk assessment and care plan being trialed on 6 wards with new patient information leaflets and reporting of FAIR nationally on a new proforma as the screening tool has been changed. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Falls - 6 wards using new risk assessment, care plan and daily checklist with new e-learning module accessible to staff for completion. This is being reviewed after 1 month (end of June) for any amendments and further roll out. Bedrails- 6 wards trialing new risk assessment, care plan and daily check - being reviewed after 1 month (end of June) for any amendments and further roll out. (Education included in falls e-learning module) Frailty Team delivering service M-F in AED and in-reaching - continuing to work on competencies particularly around CGA completion. As part of the Red2Green, EndPJparalysis Get Up, Get Dressed, Keep Moving was introduced - this will be formally launched as a project in July as part of the Trust's QI work.		**Gaps in Controls**	Care plans not always used appropriately and not all care plans are appropriate - these are being reviewed by the documentation group Falls and bed rails new risk assessment and care plans in 6 wards being trialed - need to continue roll-out. Inability to consistently staff additional care bay Training for staff re: older people risks not currently provided - New Training Programme to be launched end of July. Environment not conducive to reabling patients and maintaining function, social interaction or orientation. Environment not wholly adapted for additional/enhanced care needs eg dementia Lack of understanding of the impact of patients remaining in bed, in pads, with cot sides, not eating/drinking - New Training Programme to be launched end of July. Lack of pathway/service availability to support patients with enhanced needs returning home- i.e. lack of 24hour care in community to step down - Work underway with CCG, Community and LA colleagues to redesign pathway, Homefirst and Delirium/Dementia. Not yet commenced mouth care roll-out Documentation not conducive to providing person-centred care, this is to be reviewed as an entity July 2019 (particularly care plans and risk assessments) Clinical supervision for the frailty team lacking- exploring use of Leeds Buddy arrangement to support. Continence project not yet commenced- scoping session 25/6/19 to plan improvement work

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	18/11/2019	18/12/2019

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. To establish a pathway for adults in the acute setting to provide timely screening for delirium/dementia, ask the case finding question, ensure appropriate further assessment, care, follow-up and support for the patient, carer and family. To enable this - provide staff the appropriate education.	**Action Plan Due Date**	28/02/2020 31/01/2020 30/04/2020 31/12/2019 31/03/2020 31/03/2020 28/02/2020	**Action Plan Rating** Moderate Progress Made Actions Almost Completed Actions Almost Completed Completed Moderate Progress Made Moderate Progress Made Moderate Progress Made
Latest Month Progress	Dates have been set for 2020 for the Older People's Care Training Programme. Falls risk assessment and care bundle on all wards except Intensive Care and will be in Intensive Care by the end of November, when the old care plans will be removed from the intranet. The new post-falls assessment is still being tested on 2 wards with the intention of launching on all wards at the end of November. A Falls reporting dashboard is being developed, following this the data will need to be reviewed and then cleansed. The Falls Strategy was reviewed at NMG and following a few amendments will be approved and launched in the form of an 'Improvement Plan' by the end of November. The Dementia resource boxes are being discussed with procurement and infection control, once agreed a charitable funds bid will be created to make the purchases. These will then be used in conjunction with the activity planners and the endPJparalysis initiative to get patients up, dressed and moving. This piece of work has been initiated on one ward and a roll out plan is being developed. Dementia and Delirium Team approved in business case, one member in post, Admiral Nurse to start 16/12/19 and final post to commence before end of February 2020. Team commencing immediate work on identifying cognitive impairment, and rolling our risk assessment and care plan - this is in all areas with the exception of Intensive Care and will be in all areas by the end of November 2019. 8 Members of staff have now completed the Health Education England Train the Trainer course for Mouth Care. The project team are testing the new assessment, education, care plan and product range on ward 14B with a roll-out plan established for the remaining wards. Education being provided at ward level during ward out and also monthly on the Older Peoples Care Training Programme. Refresh of the Continence project is underway with new focus of targeting one ward (7A &B) to test new range of products, assessment, care plan and onward referral/pathway. Demonstrable improvement on dashboard for MUST screening feedback to the ward. Further roll-out now being scheduled as the new Dietetic lead has commenced in post and is prioritising this piece of work. Prior to further roll-out however their intention is to tweak the care plan to align again to best practice and the new templates being used on the wards currently. Staff are receiving education on the Older Peoples Care Training Programme and a TNA is underway to add the e-learning module for BAPEN Nutrition to appropriate profiles for staff to commence completion.			

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	13/11/2019	13/12/2019
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 13/12/2019	**Action Plan Rating**	Completed Moderate Progress Made
Latest Month Progress	Recruited to 1 substantive Consultant and 2 Trust locum Consultant fixed term posts. Substantive commenced 11.11.19 and 1 of the Trust locums commenced on 04.11.19. The 3rd Trust locum was only appointed 12/11 (internal), but this will create a further SAS Dr post. We have appointed 3 x SAS Dr's and pre -employment checks underway. We still have 3 x ICU Consultant and 1 Pain Management vacancies, 3 x SAS Dr Vacancies and 1 Clinical Fellow. The risk is to remain extreme until all posts are recruited to as the ICU element is still extreme.								

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	Worked with the system to provide NHSE/I an update on our 2020/21 plan. The modelling shows that the Trust would need an £8.5M CIP if it continued to contract with the Sefton CCG's on a cost basis and a £3.5M CIP if it was on a PbR contract.								

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	Submitted an improvement plan to reduce the current deficit gap by £1.5M in Q3/Q4.									

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB207/19**	**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 nine risks rated as red with a further six 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 received, factual accuracy complete and submitted to CQC on time within office hours. Expected publication date November / December 2019. A review is currently being undertaken to incorporate any incomplete actions and key themes from the draft inspection report into the quality improvement plan.

The Medicines Development Plan continues to be monitored and updated on a weekly basis. Two new additions to the improvement plan include a 6 month plan and assurance tracker. Ward checklists now in place, weekly audits commenced 21 October and outcomes are to be fed into the tracker to provide assurance against compliance and identify any gaps.

The funding application of £700,000 for EPMA has been approved by NHSE/I (Meds and Pharmacy Improvement).

SONAAS - The assessment programme continues to be rolled out across the Trust. 5 wards have been assessed, 2 rated bronze and 3 silver in the first assessment. The first reassessment of the bronze wards took place w/c 28 October and one ward improved their overall rating from Bronze to Silver. A review of the SONAAS process is taking place w/c 5 November to ensure the process is delivering measurable improvements for patients. This will assist in informing the final version of the SOP, currently in draft form.

Spinal Centre refurbishments and deep cleaning
- Patient room and bathroom refurbishment nearing completion
- Domestic hours increased to correspond with national guidelines
- PHE Assurance visit of national experts scheduled for 12 November 2019 to provide advice and verify adequacy of processes undertaken.

Older People's Programme
- The training programme for Care of Older People has continued to be delivered with excellent feedback. 170 people are booked to undertake the programme by the end of 2019.
-The first member of the Dementia and Delirium Team in post 04.11.19 and the Admiral Nurse due in post 16.12.19

SAFE STAFFING

Overall fill rate for September 2019 was 91.83% (against the national average of 90%), an increase on previous month. 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.

QUALITY & SAFETY GOVERNANCE

Complaints process mapping review and incident process mapping exercise completed with subsequent actions developed, a further complaints review incorporating patient experience led by the Deputy Director of Nursing has commenced in November 2019, 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 35.76% April 2019 - October 2019 compared to 23.08% in April 2018 - October 2018

Key Achievements/Progress in Month – Quality & Safety

CQC Inspection completed, awaiting final report

Work relating to the 4 quality priorities continues to move forward

Key Risks/Issues	Mitigating Actions	RAG
Inability to release clinical staff to participate in Mouth Care Matters projects	Secured 3 additional places for Mouth Care Matters programme in London 15th November 2019	A
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

Cancer 62 Day
Performance for September 2019 was 82% an increase on the August position of 75.3% and the best performance since October 2018.
There are just five trusts nationally that are delivering an improvement in cancer performance, within the region we are the only service showing improvements in performance.

18 Week RTT Performance
September 18-week RTT performance was 93.4%
Predictions for October show performance will remain around 93% and continue to be above the 92% threshold.
There are currently 7 patients waiting over 40 weeks, a slight increase, however the number of 30+ week waiters has dropped from 99 to 88 over the past 4 weeks, these long waiters are largely due to the continuing challenges in Community Paediatrics and Gynaecology.
The Gynaecology position is predicted to recover from January 2020 as the Trust ahs recently appointed 4 consultants
The Community Paediatrics performance will continue to be compromised until we can appoint into the vacant community Paediatrician post

Diagnostics
Performance for October against the 6 week wait target was 2.16% an improvement of 0.5% over the September position and in line with trajectory set with NHS I / CCG
Non-obstetric Ultrasound and Cystoscopy remain the areas of most concern, with 34 and 13 waiters over 6 weeks, all other modalities have single figure waiters.
Endoscopy recorded the most number of scopes in a month (on record) in October at 653 with zero sessions cancelled due to no nurses.

Length of Stay
Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 6.3 days in October an improvement from the September position, with patients on assessment wards staying an average of 8 hours, which is the same as September.
There were 185 stranded patients in October 2019, an increase from the previous month.
Super Stranded patients also increased to 70
The key in-month progress is the reintroduction of the senior lead supporting R2G and the introduction of a Board Round SOP

A&E 4 Hour Performance
The Trusts reported 4 hour A&E performance in October was 84.6% a 4% decrease from the September position of 88.6%
This is due to a significant decrease in Southport performance which has dropped from 77.6% in September to 70% in September 2019.
The Southport it site is experiencing significant demand pressures with attendances and admissions up by 17% against the same time period of last year.

Winter planning
The Trust has introduced a weekly Winter Operational Group to support implementation of the hospital winter schemes. The schemes include the opening of a 16 bedded post operative Orthopaedic ward to support appropriate transfer of patients still under acute care that can receive their rehabilitation at Ormskirk. This in effect will release 16beds at Southport as this current cohort of patients remain on the Southport site until fit for discharge. The Trust Board has signed off the business case with recruitment and estates work commenced with a target date of opening in the first week of January.

Theatre Utilization
Ormskirk improved in month to 73% for October by 1% against the previous month. However Southport utilization recorded a decline in performance due to high numbers of cancellations (15.66% mainly attributed to patient flow issues (i.e. no beds available)

Key Risks	Mitigating Actions	RAG
Achieving Constitutional Standards The key issues being: • Workforce – gaps in acute medicine physicians, radiologists, anaesthetics and geriatricians are clearly impacting on current performance and being able to sustain a consistent level of performance (across 4 hour standard, diagnostic and cancer in particular) • The Southport & Ormskirk system being able to implement winter schemes and deliver against the assumptions the CCG have signed off. The assumptions formed the basis in the system being able to mitigate the gap identified by Venn particularly within the *out of hospital* provision (40 beds).	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 has referenced previously the concerns that the schemes put forward by the system will not address the gap identified by Venn due to the assumptions being ambitious given timescales set within the implementation plans. The system has setup a weekly UEC System Leaders meeting which is chaired by the UEC Programme Director and this meeting now monitors progress of each winter schemes reporting through to the SMB.	R

2019/20 FINANCIAL PLAN (1)

RAG Rating

Key Achievements/Progress

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

Current performance

The month 7 YTD position before Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) is a deficit of £16.328 million which is £869,000 worse than plan.

The in-month position before PSF/FRF is a deficit of £2.372 million, £0.861 million worse than plan.

The Trust's forecast outturn, based on month 6 performance and shared with NHSI/E on 1 November 2019, is £3.6 million overspend against the deficit plan.
Month 7 expenditure is higher than the trajectory allowed to achieve this forecast outturn.
The 2019/20 CIP programme is £1,350,000 behind plan at month 7; the forecast outturn is £4.3 million against the £6.3 million plan leaving an unidentified gap of £2.0 million.
If material cash reducing CIP schemes cannot be transacted during the remainder of the year then any pressure on the expenditure run rate will not be mitigated.

Trust activity and income performance at month 7 YTD is as follows:

- Elective – activity is 3.9% below plan; £435,000 loss of income.
- A&E – activity 5.5% above plan; £353,000 of additional income.
- Non Elective – activity is 2.4% below plan; £2,567,000 additional income due to case mix
- Outpatients – activity is 3.94% above plan; £627,000 of additional income

Not all of the above activity performance is payable in 2019/20 due to:

- Only a proportion of the non-elective value is payable due to the application of the "blended tariff" adjustment.
- Sefton CCG's contract applies the "blended tariff" to all points of delivery.

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

Underlying expenditure levels in month 7 have risen mainly due to additional staff having been employed compared to previous months. The Trust spent above £2.0 million in October on bank and agency staff which equates to an annual spend of £24 million on premium rate staff.

Month 7 YTD agency spend is £6.978 million (8.45% of the pay bill); Medical staff £3.717 million; Nursing £2.619 million. The Trust breached the NHSI agency target cap of £4.891 million in September. Monthly agency spend has increased again in October to £1,109,000 (9.3% of the pay bill); Medical staff £511,000; Nursing £458,000.

Total Bank spend is consistent with previous months; October is £944,000 (7.9% of the total pay bill) bringing YTD spend to £6.533 million (7.9% of the total pay bill).

Key actions

Weekly meetings now established with the Executive team for CIP and the wider financial recovery plan with a focus on the operational detail behind both of these areas (delivery of £1.5 million recovery plan schemes required wef November 2019 but this would still result in the Trust £3.6 million away from the year end plan).
Elements of the financial recovery plan include; Reduction in high cost temporary spend (this will cover bank, agency, interim staff and waiting list initiatives);
Plan of action on how the work on fragile services will be delivered along with unfunded/under funded services; Make best use of NHSI support on offer such as the Model Hospital.

Cost Improvement Programme

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

Progress re plan

At month 7, the Trust had transacted £2.863 million of CIPs. The Trust is forecasting delivery of £4.3 million, gap of £2.0 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 and donated assets 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 £2.098 million (planned spend year to date of £4.027 million) with a further £1.137 million committed expenditure. Comparing this against the annual plan, £5,103,000 excluding donated and GE radiology assets, then the Trust has spent/committed 63.4% of the plan at the end of October 2019.

The Southport ward upgrade project has started and the first 5 wards will be completed before Christmas. The 6th ward is planned for completion before the end of the financial year. Work is progressing well within the Spinal Unit on the Isolation works and the work required as a result of the Klebsiella outbreak with completion expected in the very near future.

IM&T contingency scheme at £450,000 was originally intended for the data centre, however, this looked unlikely to be implemented in 2019/20 and a re-utilisation of these monies to other IT projects is reflected in the revised plan.

On a positive note the Trust has been successful in bidding for ePMA (Electronic Prescribing and Medicines Administration) and has been awarded £700,000 in 2019/20.

The Board approved a revised capital plan on 6th November 2019 and authorisation was given to proceed with the winter plan at £350,000. However, costs are now clearer and an a request to increase the scheme value to £495,000 will be discussed at Finance, Performance & Investment Committee on 25th November 2019.

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.*	*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.* *October 2019 - performance is below plan and forecast to be £2 million away at year-end. Schemes identified above will not mitigate the shortfall on other schemes.*	A
New CIP target for expenditure reduction of £6.3 million		R

WORKFORCE — AMBER

Key Achievements/Progress (1)

WORKFORCE EFFICIENCY

- *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.*
- *Supporting Attendance Policy (sickness absence) launched from 28th January 2018 with guidance, training and support to ensure a sustained reduction in sickness absence rates. The Policy is undergoing a 6 month review with the first and second review sessions completed. YTD Sickness absence rates have consistently decreased since December 2018 and continue to do so in September 2019. The YTD rolling sickness absence rate has reduced by 0.53% since December 2018 to 5.35% in September 2019. Monthly sickness absence rate for September 2019 was a reduction to 4.32% the lowest monthly sickness absence rate since 2014. 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 69.58% for September 2019. All CBU's have presented their revised PDR improvement at Performance Review Boards. Further support meetings planned to look at team objectives.*
- *Engagement with alternative medical bank provider commenced – October 2019*
- *Establishment of Employee Relations report to be presented at Workforce Committee on a monthly basis.*
- *Scoping exercise underway to implement an Employee Relations electronic system this will provide an artificial intelligence element to the process and also support the recommendations following the Baroness Dido Harding Report*
- *Workforce Efficiencies Improvement programme scoped and governance arrangements proposed via PMO.*
- *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.*

CLINICAL WORKFORCE PLAN

- *The Clinical Workforce Plan – to be reviewed following current cycle of business planning.*

RECRUITMENT AND RETENTION

- *Reduction in Time to Hire programme reporting to Model Hospital and Workforce Improvement Group*
- *QI priority for Trust*
- *Focussed pieces of recruitment being undertaken to fill medical vacancies. Especially hard to fill areas such as Radiology and Obstetrics and Gynaecology.*
- *Scoping of international recruitment options for nurses.*
- *Continued recruitment to fully establish the Trust recruitment team.*
- *Working to support CBUs recruitment, alongside corporate nurse leaders.*

WORKFORCE — AMBER

Key Achievements/Progress (2)

LEARNING AND DEVELOPMENT

- *CBU's continue to work with HR to set trajectories to increase mandatory training rates to stretch target of 95%. Issue highlighted in relation to resuscitation compliance which is being treated as a priority by the organisation to address the issue and increase compliance.*
- *CBU's continue to work with HR to set trajectories to increase appraisal rates to 85%. PDR compliance continues to be challenge for the organisation and is currently on a downward trajectory. Issue due to be addressed in Workforce Improvement Group to discuss with key stakeholders how to move forward with increasing compliance. In addition to compliance being challenged, quality of appraisals is an issue for the organisation and the OD team is currently carrying out a myth buster in order to try to increase compliance and address the issue around quality.*
- *Leadership Strategy approved at Board Sept 2019*
    - *Shadow Board Programme commenced in Sept 2019. the programme has been well attended, received and is continuing*
    - *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' – co-design with Aspire for launch in Feb 2020 – to establish the 'Southport & Ormskirk Way' of leadership for all staff (2020)*
    - *New Consultants/SAS Doctors programme (2020) - scoping exercise completed, specification document with Medical Director*
- *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 Q4*
- *Customer Service training under consideration for roll out starting Q4*

HEALTH AND WELLBEING

- *Health & Wellbeing Strategy approved at Workforce Committee September.*
- *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. The Trust reached the 80% target on the week commencing 11/11/2019 ahead of the campaign schedule*
- *Provide 'mental health first aid' to staff, 'Mental Health First Aid Training' consideration given on how to promote the role in line with the Health & Wellbeing agenda.*
- *Trust Attendance at NHSi Health and Wellbeing Summit – 7th November 2019 – share learning and experiences with other providers on Health & Wellbeing improvement programme*

WORKFORCE — AMBER

Key Achievements/Progress (3)

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*
- *Staff Engagement Strategy approved at Board Sept 2019*
- *In-house coaching service launched Oct 2019. Purchase of online coaching modules for all staff to access for a 12 month period (2020)*
- *Staff FFT – increase in completions from 2.1% (Q1) to 13.7% (Q2) - CBU infographics circulated early Nov 2019*
- *Staff Survey launched Oct 2019 – increase in communications via e-comms and social media. Current response rate 31%. Closing Date 29th November*
- *Talent Management Self-Diagnostic Tool – currently out for consultation – online report expected Dec 2019*
- *Continued bespoke OD Interventions to support the roll out of SONAAS & team developments for specific hot spot areas*
- *Corporate Induction review taken place, report to be tabled at HMB in November 2019.*
- *Board Visibility initiatives ongoing – will be reviewed when new Chief Executive commences in post.*
- *Monthly Valuing Our People Group meetings to deliver Workforce & OD Plan*
- *SOProud Conversations – focussed conversations on the behaviours to underpin our SCOPE Values – Nov & Dec 2019*
- *Relocation of HR consultation has concluded. Further cabling, networking and infrastructure work has began to be undertaken in order to support the additional workstations, contractors have been sourced and have began to undertake this piece of work.*
- *Workforce Efficiencies Improvement programme scoped and governance arrangements proposed via PMO.*
- *Agreement obtained to implement revisions to salary sacrifice vehicles schemes to address issues and gain improvements and efficiencies*
- *Rostering policy development – attained final sign off at policy ratification group.*
- *Review of format and behavioural contract of the Workforce Committee*

HR IMPROVEMENT PRIORITIES

- *Workforce Improvement Group - held monthly – driver diagrams & action plans in place – reports into Hospital Improvement Board*
- *Core mandatory training remains above the Trust target at 88.34% (31/10/19)*
- *Continued reduction of YTD sickness absence rate – 0.53% reduction since December 2018*
- *Supporting Attendance Policy Review*
- *Employee Relations Policy review*
- *Increase PDR compliance*
- *Increase staff survey response rate*
- *Reduce Time to Hire*
- *Increase flu vaccination rate for clinical staff*
- *Appointment of key enabler roles for HR Transformational Change as per the Business Case*
- *Re-establishment Staff Network Meetings*
- *Priority recruitment to roles that support the winter plan*

WORKFORCE (4)	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 discussions took place with all key stakeholders on 06/09/19 and 01/11/19. Healthy debate and discussion took place with those who attended on the 01/11/19 therefore moving the review forward. Final further date to conclude the review is to be arranged.	A
Development of admin and clerical staff bank	Engagement with NHSP to provide support to development of admin and clerical bank. Project ongoing.	A
CBU's failing to meet trajectories of improvement for appraisals	PDR compliance continues to be challenge for the organisation and is currently on a downward trajectory. Issue due to be addressed in WIG to discuss with key stakeholders how to move forward with increasing compliance. In addition to compliance being challenge, quality of appraisals is an issue for the organisation and the OD team is currently carrying out a myth buster in order to try to increase compliance and address the issue around quality. Team objectives also being considered.	A
Lack of recruiting manager ownership in key responsibilities to improve Time to Hire	Recruitment website to be developed. Escalation process and deep dive into breaches of KPI targets required. Meetings being set up with CBU's to understand roles and responsibilities within the process. Training sessions for Recruiting Managers set up in November / December to roll out and to outline responsible and accountability throughout the recruitment journey.	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 – paper presented to HMB no further action agreed	R

ACUTE SUSTAINABILITY	RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

The draft outline PCBC was delivered on the 31st October 2019 setting out the foundation of a full business case describing where we are, where we want to be and how we will get there. The new models of care have been presented in the draft outline PCBC alongside 5 emerging delivery scenarios ranging from a brand new hospital build through to optimising the existing two sites with as little capital as possible. Although the draft outline PCBC describes the standards of clinical care our populations should expect tor receive through the care models, the delivery scenarios do not yet identify a financial or workforce sustainable solution. Following review with the Trust Board, Joint Committee, Sefton Transformation Board and a review group consisting of NHSEI and CMHCP colleagues the acute sustainability programme is being refreshed aligning new priorities to a delivery plan.

CLINICAL SCENARIOS

All 5 clinically led models of care have undergone the final stage of the check and challenge process - these models of care of still draft and will undergo further development in the next stage as part of a wider engagement approach with patients and the public post purdah and Christmas (expected to start in January 2020)

ESTATES SOLUTIONS

Schedules of accommodation and indicative capital costs for the initial emerging scenarios have been produced. Further work is required to validate the findings and align with new scenarios to be developed

FINANCE SOLUTIONS

The Sefton Transformation Finance Directors Group continue to have oversight of the activity and financial modelling and have set the scope for the next phase of work

Key Achievements/Progress in Month

CMHCP Mid Year review was successful with the full £497k requested in May being released to the programme (previously they had released in principle the first £400k)
Draft Outline PCBC delivered on 31st October
Joint Committee held their inaugural meeting on the 7th November to review the draft outline PCBC
A review group made up of CCG, NHSE, CMHCP and Trust colleagues met on the 8th November

Key Risks/Issues	Mitigating Actions	RAG
The lack of available capital to enable delivery of any of the emerging scenarios will impact on the systems ability to consult with the public The lack of current and projected clinical workforce to enable delivery of any of the clinical models to be realised	Exploring alternative delivery scenarios and ongoing discussions with NHSEI and CMHCP Exploring alternative workforce models to enable delivery including opportunities around single service models and ongoing discussions with NHSEI and CMHCP	R

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Single Improvement Plan

Board Update

December 2019

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

Single Improvement Plan - Background

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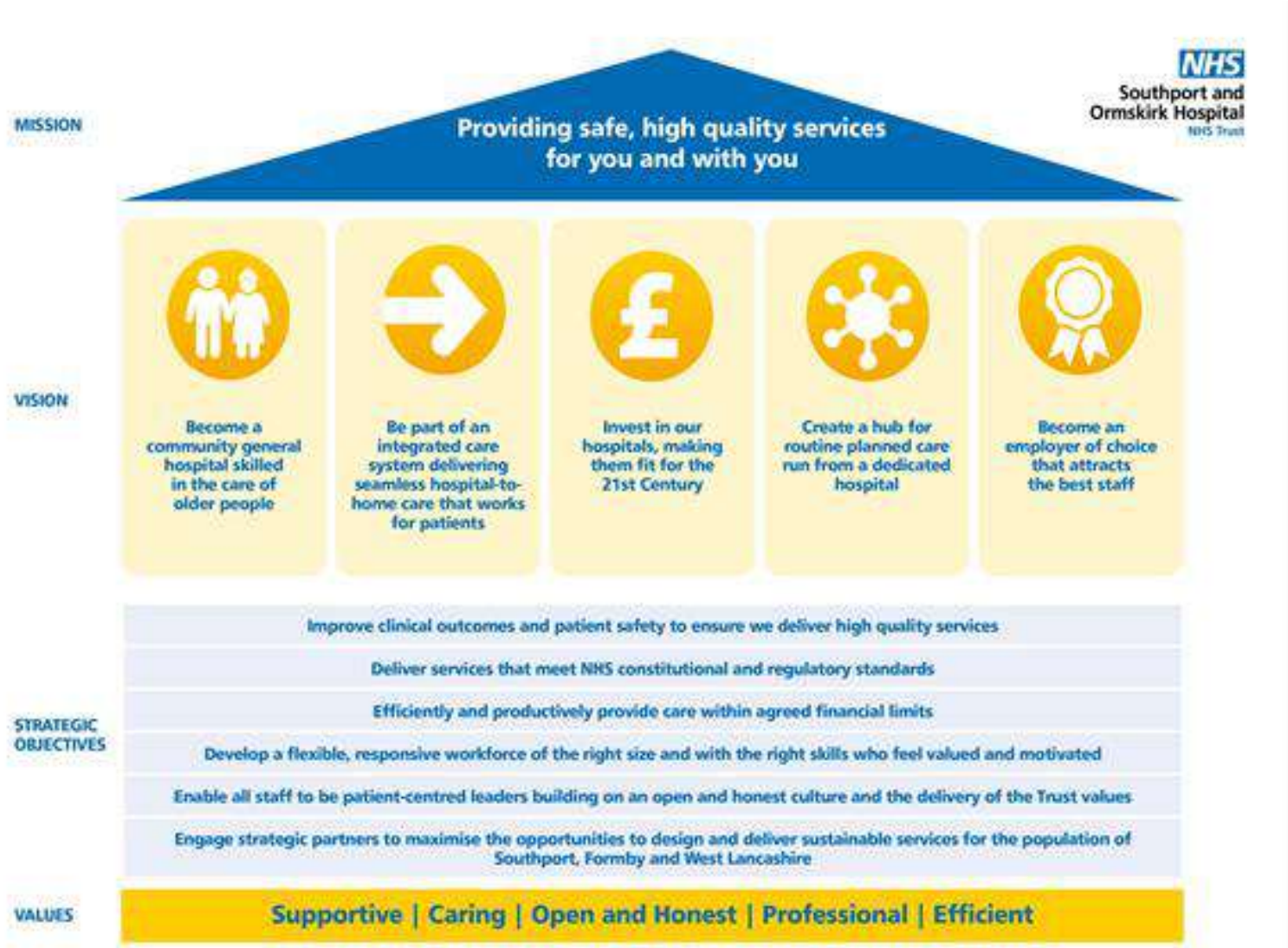

Single Improvement Plan – Priorities & Trajectories

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 – November 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**
Workforce Priority 1 - Culture – organisational development, staff engagement and Freedom to Speak Up **Workforce Priority 2** - Clinical workforce strategy to ensure the right numbers of skilled staff	**Amber**
Strategy Priority 1 - Engage with partners to develop opportunities for joint working **Strategy Priority 2** - Develop an affordable, sustainable acute services model	**Amber**

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

Progress to date – Risks November 2019

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Priorities	Risks (after mitigation)			
	Amber	Red	Narrative	Mitigation
Quality Priorities	1	1	Winter pressures	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 1.1.20
Finance Priorities	1	2	Underlying expenditure levels will not reduce to pre Q4 2018/19 level New CIP target for expenditure reduction of £6.3 million	Development of Trust Financial Recovery plan (part of overall System Recovery Plan).
Workforce Priorities	4	2	Capacity of the HR business services team QI Training Programme – to develop a training action plan following the end of the NHSi 'Introduction to QI'	Temporary funding through E&F team to support volume of work in this area NHSI discussed with Head of PMO – paper presented to HMB no further action agreed
Strategic Priorities	0	2	The lack of available capital to enable delivery of any of the emerging scenarios will impact on the systems ability to consult with the public The lack of current and projected clinical workforce to enable delivery of any of the clinical models to be realised	Exploring alternative delivery scenarios and ongoing discussions with NHSEI and CMHCP Exploring alternative workforce models to enable delivery including opportunities around single service models and ongoing discussions with NHSEI and CMHCP

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY STANDARDS

Draft CQC Inspection Report received, factual accuracy complete and submitted to CQC on time within office hours. Expected publication date November / December 2019. A review is currently being undertaken to incorporate any incomplete actions and key themes from the draft inspection report into the quality improvement plan.

The Medicines Development Plan continues to be monitored and updated on a weekly basis. Two new additions to the improvement plan include a 6 month plan and assurance tracker. Ward checklists now in place, weekly audits commenced 21 October and outcomes are to be fed into the tracker to provide assurance against compliance and identify any gaps.

The funding application of £700,000 for EPMA has been approved by NHSE/I (Meds and Pharmacy Improvement).

SONAAS - The assessment programme continues to be rolled out across the Trust. 5 wards have been assessed, 2 rated bronze and 3 silver in the first assessment. The first reassessment of the bronze wards took place w/c 28 October and one ward improved their overall rating from Bronze to Silver. A review of the SONAAS process is taking place w/c 5 November to ensure the process is delivering measurable improvements for patients. This will assist in informing the final version of the SOP, currently in draft form.

Spinal Centre refurbishments and deep cleaning
- Patient room and bathroom refurbishment nearing completion
- Domestic hours increased to correspond with national guidelines
- PHE Assurance visit of national experts scheduled for 12 November 2019 to provide advice and verify adequacy of processes undertaken.

Older People's Programme
- The training programme for Care of Older People has continued to be delivered with excellent feedback. 170 people are booked to undertake the programme by the end of 2019.
-The first member of the Dementia and Delirium Team in post 04.11.19 and the Admiral Nurse due in post 16.12.19

SAFE STAFFING

Overall fill rate for September 2019 was 91.83% (against the national average of 90%), an increase on previous month. 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.

QUALITY & SAFETY GOVERNANCE

Complaints process mapping review and incident process mapping exercise completed with subsequent actions developed, a further complaints review incorporating patient experience led by the Deputy Director of Nursing has commenced in November 2019, 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 35.76% April 2019 - October 2019 compared to 23.08% in April 2018 - October 2018

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Key Achievements/Progress in Month – Quality & Safety

CQC Inspection completed, awaiting final report

Work relating to the 4 quality priorities continues to move forward

Key Risks/Issues	Mitigating Actions	RAG
Inability to release clinical staff to participate in Mouth Care Matters projects	Secured 3 additional places for Mouth Care Matters programme in London 15th November 2019	A
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

Cancer 62 Day
Performance for September 2019 was 82% an increase on the August position of 75.3% and the best performance since October 2018.
There are just five trusts nationally that are delivering an improvement in cancer performance, within the region we are the only service showing improvements in performance.

18 Week RTT Performance
September 18-week RTT performance was 93.4%
Predictions for October show performance will remain around 93% and continue to be above the 92% threshold.
There are currently 7 patients waiting over 40 weeks, a slight increase , however the number of 30+ week waiters has dropped from 99 to 88 over the past 4 weeks, these long waiters are largely due to the continuing challenges in Community Paediatrics and Gynaecology.
The Gynaecology position is predicted to recover from January 2020 as the Trust ahs recently appointed 4 consultants
The Community Paediatrics performance will continue to be compromised until we can appoint into the vacant community Paediatrician post

Diagnostics
Performance for October against the 6 week wait target was 2.16% an improvement of 0.5% over the September position and in line with trajectory set with NHS I / CCG
Non-obstetric Ultrasound and Cystoscopy remain the areas of most concern, with 34 and 13 waiters over 6 weeks, all other modalities have single figure waiters.
Endoscopy recorded the most number of scopes in a month (on record) in October at 653 with zero sessions cancelled due to no nurses.

Length of Stay
Length of stay for full emergency admissions, which does not include patients being admitted to assessment wards, was recorded at 6.3 days in October an improvement from the September position, with patients on assessment wards staying an average of 8 hours, which is the same as September.
There were 185 stranded patients in October 2019, an increase from the previous month.
Super Stranded patients also increased to 70
The key in-month progress is the reintroduction of the senior lead supporting R2G and the introduction of a Board Round SOP

A&E 4 Hour Performance
The Trusts reported 4 hour A&E performance in October was 84.6% a 4% decrease from the September position of 88.6%
This is due to a significant decrease in Southport performance which has dropped from 77.6% in September to 70% in September 2019.
The Southport it site is experiencing significant demand pressures with attendances and admissions up by 17% against the same time period of last year.

Winter planning
The Trust has introduced a weekly Winter Operational Group to support implementation of the hospital winter schemes. The schemes include the opening of a 16 bedded post operative Orthopaedic ward to support appropriate transfer of patients still under acute care that can receive their rehabilitation at Ormskirk. This in effect will release 16beds at Southport as this current cohort of patients remain on the Southport site until fit for discharge. The Trust Board has signed off the business case with recruitment and estates work commenced with a target date of opening in the first week of January.

Theatre Utilization
Ormskirk improved in month to 73% for October by 1% against the previous month. However Southport utilization recorded a decline in performance due to high numbers of cancellations (15.66% mainly attributed to patient flow issues (i.e. no beds available)

Key Risks	Mitigating Actions	RAG
Achieving Constitutional Standards The key issues being: • Workforce – gaps in acute medicine physicians, radiologists, anaesthetics and geriatricians are clearly impacting on current performance and being able to sustain a consistent level of performance (across 4 hour standard, diagnostic and cancer in particular) • The Southport & Ormskirk system being able to implement winter schemes and deliver against the assumptions the CCG have signed off. The assumptions formed the basis in the system being able to mitigate the gap identified by Venn particularly within the *out of hospital* provision (40 beds).	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 has referenced previously the concerns that the schemes put forward by the system will not address the gap identified by Venn due to the assumptions being ambitious given timescales set within the implementation plans. The system has setup a weekly UEC System Leaders meeting which is chaired by the UEC Programme Director and this meeting now monitors progress of each winter schemes reporting through to the SMB.	R

2019/20 FINANCIAL PLAN (1)

RAG Rating

Key Achievements/Progress

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

Current performance

The month 7 YTD position before Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) is a deficit of £16.328 million which is £869,000 worse than plan.

The in-month position before PSF/FRF is a deficit of £2.372 million, £0.861 million worse than plan.

The Trust's forecast outturn, based on month 6 performance and shared with NHSI/E on 1 November 2019, is £3.6 million overspend against the deficit plan.
Month 7 expenditure is higher than the trajectory allowed to achieve this forecast outturn.
The 2019/20 CIP programme is £1,350,000 behind plan at month 7; the forecast outturn is £4.3 million against the £6.3 million plan leaving an unidentified gap of £2.0 million.
If material cash reducing CIP schemes cannot be transacted during the remainder of the year then any pressure on the expenditure run rate will not be mitigated.

Trust activity and income performance at month 7 YTD is as follows:

- Elective – activity is 3.9% below plan; £435,000 loss of income.
- A&E – activity 5.5% above plan; £353,000 of additional income.
- Non Elective – activity is 2.4% below plan; £2,567,000 additional income due to case mix
- Outpatients – activity is 3.94% above plan; £627,000 of additional income

Not all of the above activity performance is payable in 2019/20 due to:

- Only a proportion of the non-elective value is payable due to the application of the "blended tariff" adjustment.
- Sefton CCG's contract applies the "blended tariff" to all points of delivery.

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

Underlying expenditure levels in month 7 have risen mainly due to additional staff having been employed compared to previous months. The Trust spent above £2.0 million in October on bank and agency staff which equates to an annual spend of £24 million on premium rate staff.

Month 7 YTD agency spend is £6.978 million (8.45% of the pay bill); Medical staff £3.717 million; Nursing £2.619 million. The Trust breached the NHSI agency target cap of £4.891 million in September. Monthly agency spend has increased again in October to £1,109,000 (9.3% of the pay bill); Medical staff £511,000; Nursing £458,000.

Total Bank spend is consistent with previous months; October is £944,000 (7.9% of the total pay bill) bringing YTD spend to £6.533 million (7.9% of the total pay bill).

Key actions

Weekly meetings now established with the Executive team for CIP and the wider financial recovery plan with a focus on the operational detail behind both of these areas (delivery of £1.5 million recovery plan schemes required wef November 2019 but this would still result in the Trust £3.6 million away from the year end plan).
Elements of the financial recovery plan include; Reduction in high cost temporary spend (this will cover bank, agency, interim staff and waiting list initiatives);
Plan of action on how the work on fragile services will be delivered along with unfunded/under funded services; Make best use of NHSI support on offer such as the Model Hospital.

Cost Improvement Programme

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

Progress re plan

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 and donated assets 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 £2.098 million (planned spend year to date of £4.027 million) with a further £1.137 million committed expenditure. Comparing this against the annual plan, £5,103,000 excluding donated and GE radiology assets, then the Trust has spent/committed 63.4% of the plan at the end of October 2019.

The Southport ward upgrade project has started and the first 5 wards will be completed before Christmas. The 6th ward is planned for completion before the end of the financial year. Work is progressing well within the Spinal Unit on the Isolation works and the work required as a result of the Klebsiella outbreak with completion expected in the very near future.

IM&T contingency scheme at £450,000 was originally intended for the data centre, however, this looked unlikely to be implemented in 2019/20 and a re-utilisation of these monies to other IT projects is reflected in the revised plan.

On a positive note the Trust has been successful in bidding for ePMA (Electronic Prescribing and Medicines Administration) and has been awarded £700,000 in 2019/20.

The Board approved a revised capital plan on 6th November 2019 and authorisation was given to proceed with the winter plan at £350,000. However, costs are now clearer and an a request to increase the scheme value to £495,000 will be discussed at Finance, Performance & Investment Committee on 25th November 2019.

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.*	*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.* *October 2019 - performance is below plan and forecast to be £2 million away at year-end. Schemes identified above will not mitigate the shortfall on other schemes.*	A
New CIP target for expenditure reduction of £6.3 million		R

WORKFORCE

AMBER

Key Achievements/Progress (1)

WORKFORCE EFFICIENCY

- *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.*
- *Supporting Attendance Policy (sickness absence) launched from 28th January 2018 with guidance, training and support to ensure a sustained reduction in sickness absence rates. The Policy is undergoing a 6 month review with the first and second review sessions completed. YTD Sickness absence rates have consistently decreased since December 2018 and continue to do so in September 2019. The YTD rolling sickness absence rate has reduced by 0.53% since December 2018 to 5.35% in September 2019. Monthly sickness absence rate for September 2019 was a reduction to 4.32% the lowest monthly sickness absence rate since 2014. 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 69.58% for September 2019. All CBU's have presented their revised PDR improvement at Performance Review Boards. Further support meetings planned to look at team objectives.*
- *Engagement with alternative medical bank provider commenced – October 2019*
- *Establishment of Employee Relations report to be presented at Workforce Committee on a monthly basis.*
- *Scoping exercise underway to implement an Employee Relations electronic system this will provide an artificial intelligence element to the process and also support the recommendations following the Baroness Dido Harding Report*
- *Workforce Efficiencies Improvement programme scoped and governance arrangements proposed via PMO.*
- *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.*

CLINICAL WORKFORCE PLAN

- *The Clinical Workforce Plan – to be reviewed following current cycle of business planning.*

RECRUITMENT AND RETENTION

- *Reduction in Time to Hire programme reporting to Model Hospital and Workforce Improvement Group*
- *QI priority for Trust*
- *Focussed pieces of recruitment being undertaken to fill medical vacancies. Especially hard to fill areas such as Radiology and Obstetrics and Gynaecology.*
- *Scoping of international recruitment options for nurses.*
- *Continued recruitment to fully establish the Trust recruitment team.*
- *Working to support CBUs recruitment, alongside corporate nurse leaders.*

WORKFORCE — AMBER

Key Achievements/Progress (2)

LEARNING AND DEVELOPMENT

- *CBU's continue to work with HR to set trajectories to increase mandatory training rates to stretch target of 95%. Issue highlighted in relation to resuscitation compliance which is being treated as a priority by the organisation to address the issue and increase compliance.*
- *CBU's continue to work with HR to set trajectories to increase appraisal rates to 85%. PDR compliance continues to be challenge for the organisation and is currently on a downward trajectory. Issue due to be addressed in Workforce Improvement Group to discuss with key stakeholders how to move forward with increasing compliance. In addition to compliance being challenged, quality of appraisals is an issue for the organisation and the OD team is currently carrying out a myth buster in order to try to increase compliance and address the issue around quality.*
- *Leadership Strategy approved at Board Sept 2019*
    - *Shadow Board Programme commenced in Sept 2019. the programme has been well attended, received and is continuing*
    - *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' – co-design with Aspire for launch in Feb 2020 – to establish the 'Southport & Ormskirk Way' of leadership for all staff (2020)*
    - *New Consultants/SAS Doctors programme (2020) - scoping exercise completed, specification document with Medical Director*
- *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 Q4*
- *Customer Service training under consideration for roll out starting Q4*

HEALTH AND WELLBEING

- *Health & Wellbeing Strategy approved at Workforce Committee September.*
- *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. The Trust reached the 80% target on the week commencing 11/11/2019 ahead of the campaign schedule*
- *Provide 'mental health first aid' to staff, 'Mental Health First Aid Training' consideration given on how to promote the role in line with the Health & Wellbeing agenda.*
- *Trust Attendance at NHSi Health and Wellbeing Summit – 7th November 2019 – share learning and experiences with other providers on Health & Wellbeing improvement programme*

WORKFORCE

AMBER

Key Achievements/Progress (3)

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*
- *Staff Engagement Strategy approved at Board Sept 2019*
- *In-house coaching service launched Oct 2019. Purchase of online coaching modules for all staff to access for a 12 month period (2020)*
- *Staff FFT – increase in completions from 2.1% (Q1) to 13.7% (Q2) - CBU infographics circulated early Nov 2019*
- *Staff Survey launched Oct 2019 – increase in communications via e-comms and social media. Current response rate 31% . Closing Date 29th November*
- *Talent Management Self-Diagnostic Tool – currently out for consultation – online report expected Dec 2019*
- *Continued bespoke OD Interventions to support the roll out of SONAAS & team developments for specific hot spot areas*
- *Corporate Induction review taken place, report to be tabled at HMB in November 2019.*
- *Board Visibility initiatives ongoing – will be reviewed when new Chief Executive commences in post.*
- *Monthly Valuing Our People Group meetings to deliver Workforce & OD Plan*
- *SOProud Conversations – focussed conversations on the behaviours to underpin our SCOPE Values – Nov & Dec 2019*
- *Relocation of HR consultation has concluded. Further cabling, networking and infrastructure work has began to be undertaken in order to support the additional workstations, contractors have been sourced and have began to undertake this piece of work.*
- *Workforce Efficiencies Improvement programme scoped and governance arrangements proposed via PMO.*
- *Agreement obtained to implement revisions to salary sacrifice vehicles schemes to address issues and gain improvements and efficiencies*
- *Rostering policy development – attained final sign off at policy ratification group.*
- *Review of format and behavioural contract of the Workforce Committee*

HR IMPROVEMENT PRIORITIES

- *Workforce Improvement Group - held monthly – driver diagrams & action plans in place – reports into Hospital Improvement Board*
- *Core mandatory training remains above the Trust target at 88.34% (31/10/19)*
- *Continued reduction of YTD sickness absence rate – 0.53% reduction since December 2018*
- *Supporting Attendance Policy Review*
- *Employee Relations Policy review*
- *Increase PDR compliance*
- *Increase staff survey response rate*
- *Reduce Time to Hire*
- *Increase flu vaccination rate for clinical staff*
- *Appointment of key enabler roles for HR Transformational Change as per the Business Case*
- *Re-establishment Staff Network Meetings*
- *Priority recruitment to roles that support the winter plan*

WORKFORCE (4) — 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 discussions took place with all key stakeholders on 06/09/19 and 01/11/19. Healthy debate and discussion took place with those who attended on the 01/11/19 therefore moving the review forward. Final further date to conclude the review is to be arranged.	A
Development of admin and clerical staff bank	Engagement with NHSP to provide support to development of admin and clerical bank. Project ongoing.	A
CBU's failing to meet trajectories of improvement for appraisals	PDR compliance continues to be challenge for the organisation and is currently on a downward trajectory. Issue due to be addressed in WIG to discuss with key stakeholders how to move forward with increasing compliance. In addition to compliance being challenge, quality of appraisals is an issue for the organisation and the OD team is currently carrying out a myth buster in order to try to increase compliance and address the issue around quality. Team objectives also being considered.	A
Lack of recruiting manager ownership in key responsibilities to improve Time to Hire	Recruitment website to be developed. Escalation process and deep dive into breaches of KPI targets required. Meetings being set up with CBU's to understand roles and responsibilities within the process. Training sessions for Recruiting Managers set up in November / December to roll out and to outline responsible and accountability throughout the recruitment journey.	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 – paper presented to HMB no further action agreed	R

ACUTE SUSTAINABILITY

RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

The draft outline PCBC was delivered on the 31st October 2019 setting out the foundation of a full business case describing where we are, where we want to be and how we will get there. The new models of care have been presented in the draft outline PCBC alongside 5 emerging delivery scenarios ranging from a brand new hospital build through to optimising the existing two sites with as little capital as possible. Although the draft outline PCBC describes the standards of clinical care our populations should expect tor receive through the care models, the delivery scenarios do not yet identify a financial or workforce sustainable solution. Following review with the Trust Board, Joint Committee, Sefton Transformation Board and a review group consisting of NHSEI and CMHCP colleagues the acute sustainability programme is being refreshed aligning new priorities to a delivery plan.

CLINICAL SCENARIOS

All 5 clinically led models of care have undergone the final stage of the check and challenge process - these models of care of still draft and will undergo further development in the next stage as part of a wider engagement approach with patients and the public post purdah and Christmas (expected to start in January 2020)

ESTATES SOLUTIONS

Schedules of accommodation and indicative capital costs for the initial emerging scenarios have been produced. Further work is required to validate the findings and align with new scenarios to be developed

FINANCE SOLUTIONS

The Sefton Transformation Finance Directors Group continue to have oversight of the activity and financial modelling and have set the scope for the next phase of work

Key Achievements/Progress in Month

CMHCP Mid Year review was successful with the full £497k requested in May being released to the programme (previously they had released in principle the first £400k)
Draft Outline PCBC delivered on 31st October
Joint Committee held their inaugural meeting on the 7th November to review the draft outline PCBC
A review group made up of CCG, NHSE, CMHCP and Trust colleagues met on the 8th November

Key Risks/Issues	Mitigating Actions	RAG
The lack of available capital to enable delivery of any of the emerging scenarios will impact on the systems ability to consult with the public The lack of current and projected clinical workforce to enable delivery of any of the clinical models to be realised	Exploring alternative delivery scenarios and ongoing discussions with NHSEI and CMHCP Exploring alternative workforce models to enable delivery including opportunities around single service models and ongoing discussions with NHSEI and CMHCP	R

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB209/19**	**Report Title**	**Charity Name Change**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	☑ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper requests the renaming of the Charity from "Southport and Ormskirk Hospital NHS Trust Charitable Fund" to "Southport and Ormskirk Hospitals Charity".

A Board resolution is required so that a formal application to the Charity Commission can be made to change the name.

Recommendations:

The Board is asked to approve the change of name for the charity.

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)*

An on line submission to the Charity Commission will be made and the Board resolution attached.

Previously Presented at:

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

Charity name change

1 Introduction

1.1 As part of the charity re-launch strategy a minor amendment is required to the charity name.

1.2 To formalise this, the Charity Commission require a Board resolution authorising the name change.

2 Name change

2.1 The name change is from “Southport & Ormskirk Hospital NHS Trust Charitable Fund” to “Southport and Ormskirk Hospitals Charity”.

2.2 The Board should note that the marketing materials have already been prepared under the new proposed name.

2.3 Logo is shown below:

Southport AND Ormskirk Hospitals Charity

3 Recommendation

3.1 It is recommended that the Board approve the change of name of the charity.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB209/19**	**Report Title**	**Charity Investment Policy**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	☑ To Approve ☐ To Note ☐ To Assure ☐ To Receive ☐ For Information		

Executive Summary

The majority of the charity's monies are invested in a portfolio of shares and gilts. The Investment policy provides a framework for this investment together with ethical constraints.

A number of changes to the existing policy are contained in this report and the final policy for approval is shown in appendix 1.

Recommendations:

It is recommended that the Trust Board acting as the Corporate Trustee approve the charity's investment policy.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

☐	Compliance	☑	Legal
☐	Engagement and Communication	☐	Quality & Safety
☐	Equality	☐	Risk
☑	Finance	☐	Workforce
Equality Impact Assessment 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)*

Policy to be sent to Investment advisors.

Previously Presented at:

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

Charity Investment Policy

1 Introduction

1.1 The purpose of the investment policy is to ensure that the charitable fund portfolio is effectively managed by providing a framework to the Investment advisors that sets out the allocation to each asset class within the constraints set by the charity.

1.2 This policy covers the framework allocation and the ethical constraints.

2 Policy changes

2.1 UK and overseas equity should be combined rather than listed separately with a limited risk of 75%.

2.2 Upper limit on alternatives (now that it encompasses a wider range of assets) should be lifted to 15%.

2.3 Include a comment on capacity for loss in our investment policy statements – see below.

2.4 'The Charity has a moderate ability to bear investment losses which means that in extreme circumstances falls in the value of the portfolio of up to 35% would not have a material impact on the overall financial ability to carry out its function. Under the current structure and based on historic data, the investment manager estimates this strategy has the potential to fall up to 23% peak to trough in an investment cycle.'

2.5 On ethical investments include the point that the charity will not invest in no win no fee medical claims companies.

3 Charitable Fund Committee

3.1 The above changes have been agreed by the Charity Committee and appendix 1 sets out the final investment policy.

3.2 The Investment advisors also provided a comparison with other charities in terms of risk appetite which has been shared with the Committee members.

4 Risk appetite

4.1 Based on other charities, this investment policy in general is slightly on the cautious side of the 'average' charity, with a marginally lower equity content.

4.2 The reason for this is due to the ongoing potential that the portfolio may need to help meet short term requirements when there are cash flow issues and investments need to be liquidated.

4.3 With the charity relaunch and the prospect of a significant increase in donations, then a further review in 6 months may be required to re-assess risk appetite.

5 Conclusion

5.1 The final investment policy satisfies the charity's objectives and has been through the appropriate review and governance.

6 Recommendation

6.1 It is recommended that the Trust Board acting as the Corporate Trustee approve the charity's investment policy.

Appendix 1 – Charity Investment policy

Southport AND Ormskirk Hospitals Charity

Introduction

The purpose of the investment policy is to ensure that the charitable fund portfolio is effectively managed by providing a framework to the Investment advisors that sets out the allocation to each asset class within the constraints set by the charity.

Allocation

Asset Class	Allocation	Tactical Variance	Total range
UK Sovereign Debt	30%	+/-10%	20% to 40%
Cash	0%	+15%	0% to 15%
Equity Investments	65%	+/-10%	55% to 75%
Alternative Assets (hedge, commercial property, commodities)	5%	+/- 10%	0% to 15%

In terms of the risk profile and time horizon a medium risk strategy should be adopted with an indefinite time horizon.

Ethical constraints

The following ethical investment constraints have been set by the Trustees, which means that investments in those companies involved wholly or substantially in the following are excluded:

1. Tobacco.
2. Armaments.
3. Alcohol.
4. Betting/gaming.
5. Payday loans.
6. No win no fee medical claims companies.

Wholly or substantially is defined as more than two thirds of the business.

Equity constraint

No individual direct equity holding should account for more than 10% of the equity exposure of the fund.

Portfolio transfers

Transfers of cash into and out of the portfolio should be managed between the Charity and the Investment advisors to ensure there is sufficient notice period to make informed decisions.

Where the Trust foresees that it will require funds to be liquidated from the portfolio, the Charity should inform the Investment advisors with details of the value to be liquidated and the required liquidation date.

Surplus funds in the charity's bank account over and above the current requirements should be transferred to the Investment advisors.

The Assistant Director of Finance has delegated authority to transfer monies into the portfolio and to request transfers out.

Reserves

The value of the portfolio must always be greater than the charity's reserve target. The reserve is made up of the unrestricted funds (general).

Targets

Income generation from the portfolio is from dividends on equity shares and UK sovereign debt. The target income generation is reviewed annually and currently stands at 3.5% of the average annual portfolio value.

Capacity for loss

The Charity has a moderate ability to bear investment losses which means that in extreme circumstances falls in the value of the portfolio of up to 35% would not have a material impact on the overall financial ability to carry out its function. Under the current structure and based on historic data, the investment manager estimates this strategy has the potential to fall up to 23% peak to trough in an investment cycle.

Monitoring

The Investment advisors will report each quarter to the Charitable Fund Committee. The report will include the following:

1. Full details of the portfolio.
2. Comparison of returns against an appropriate industry benchmark.
3. Income generation for the quarter.
4. A table showing the actual allocation percentages by asset class.

Review

An annual performance review will take place at the end of each financial year. This in turn will feed into the investment policy review where the allocation of the portfolio can be considered together with the income generation target.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 December 2019

Agenda Item	**TB210/19a**	**Report Title**	**Learning lessons to improve Our People Practices**
Executive Lead	Jane Royds, Director of HR and OD		
Lead Officer	Laura Hilton, Head of HR		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

Alert
N/A

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

Further timescales were requested following presentation of this paper, at board in October 2019 in relation to the implementation of the Employee Relations Tracker system (Empactis). The timescales have been set out in the revised paper.

Full implementation of the Employee Relations Tracker system (Empactis) is expected by May 2020.

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

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

Strategic Objective(s) and Principal Risks(s)

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

	Strategic Objective	Principal Risk
☐	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
✓	**SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
☐	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest 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)*

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

Previously Presented at:

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

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

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

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

Learning lessons to improve our people practices

1. Introduction

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

2. Background

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

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

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

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

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

3.1. Adhering to best practice

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

The recommendation of Baroness Harding suggests that procedures should also follow the principles of the NMCs best practice guidance on local investigations (when published). The Business HR team in partnership with staff side will ensure review of this once published and make any amendments to our process if required.

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

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

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

3.2. Applying rigorous decision making

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

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

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

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

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

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

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

3.4. Assigning sufficient resources

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

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

The Business HR team have scoped out and requested as part of the HR Business Case Investment in an Employee Relations Tracker system (Empactis) which is recommended by NHSI and will automate some of the processes associated with ER cases and ensure timely responses/reminders in line with the policy timescales.

The system will enable timescales in relation to cases to be reported on easily and the identification of any hotspots areas in order to ensure effective and timely interventions. A HR Business Partner – Project Lead has been appointed to lead on the roll out of the implementation of this system and will commence in post on 9th December 2019.

Timescales in relation to this policy are as follows:

- Detailed Project Initial Document and Project Plan to be drafted December 2019
- ESR Data cleanse to commence December 2019 – January 2020
- Procurement and Information Governance process to commence December 2019
- Contract and Information Governance sign off by mid-January 2020
- Project to initiate February 2020
- Phase 1 will focus on Case Management and include Disciplinary, Grievance, MHPS, Dignity at Work case types.
    - This phase will include ESR interfacing.
    - The 1st Case Type to go-live as a full workflow for manager use will be Disciplinary.
    - Other case types will initially be tracked using the platform i.e. not as a workflow and so will continue to be managed by HR; workflow for the remaining case types will introduced in a staged way during 2020.
- The Trust would like to be live by 31st May 2020 with Case Management.

3.5. Decisions relating to the implementation of suspensions / exclusions

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

3.6. Safeguarding people health and wellbeing

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

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

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

3.7. Board level oversight

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

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

4. Recommendations

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

Actions to be taken:

- Review the contents of the NMCs 'best practice guidance on local investigations' when published, making any necessary amendments to process where needed.
- The team will develop a suspension pro-forma in order to record the process of escalation and informed decisions when the need to suspend arises. Whilst this can be evidenced at present this will ensure consistency and a central record of this information. Once developed a recommendation for this suspension pro-forma to be added as an appendices within the disciplinary policy to encourage its usage.
- The Business HR team to ensure evidence that a preliminary investigation has been undertaken prior to commencement of a formal process. Currently this can be difficult to evidence the separation of a preliminary and formal process.
- The Business HR team to will refresh a local training programme for investigations of employee relation cases.
- Continue to develop and review toolkits and guides to ensure they are fit for purpose.
- Add to terms of reference templates that the requirement for the commissioning manager to ensure wellbeing support is offered at regular intervals and a communication plan is established on the outset of an employee relations process.
- Develop and establish a governance framework in relation to the reporting of cases.
- Business Case funding will implement an employee relations case management system to ensure timeliness of case management. This system has shown much improvement when implemented in other Trusts.
- Investment in Employee Relations Tracker system – to automate some of the process and ensure timely responses in line with the policy timescales.

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

NHS Improvement

A just culture guide

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

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

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

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

Please note:

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

Start here - **Q1. deliberate harm test**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

if **No**

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

improvement.nhs.uk

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

Supported by:

Academy of Medical Royal Colleges · avma · BMA · Care Quality Commission · National Guardian Freedom to Speak Up · General Medical Council · NHS England · NMC Nursing & Midwifery Council · Royal College of Nursing · Royal Pharmaceutical Society · UNISON Health Care · unite

collaboration trust respect innovation courage compassion

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 November 2019

Agenda Item	**TB210/19b**	**Report Title**	**Workforce Disability Equality Standard Report**
Executive Lead	Jane Royds: Director of Human Resources and OD		
Lead Officer	Bob Davies: Equality Lead		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

Alert

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

Advise

- The WDES report highlights that staff with a disability have poorer experiences in areas such as bullying and harassment and attending work when ill.
- Paper has been reformatted as per action following October's Board meeting. New formatted report was accepted at Workforce Committee in November 2019.

Assure

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

Recommendation

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

	Strategic Objective	Principal Risk
✓	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
☐	**SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
☐	**SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in*

	question.
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right 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)*

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

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust Workforce Disability Equality Standard Information Report April 2019 – March 2020

1. Executive Summary

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

2. Introduction

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

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

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

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

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

3. WDES Highlights

The information below provides highlights from the WDES report for 2018-19, the information also provides the Trust figures compared to the average for combined acute and community hospital.

Please note this is the first year the WDES report have been compiled so there are no comparisons available.

Q/ Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more? (NHS staff survey 2018)

Southport Ormskirk Hospital NHS Trust response is 19.8% other Trusts average is 17.1%, therefore SOHT is 2.7% above the national average response.

The 2018-19 Trust ESR figures for staff highlighting they have a disability is 2.55% although19.8% of staff highlighted they have a disability in the NHS staff survey 2018.

The Trust are in the process of promoting to staff the process they should follow to register having a disability on ESR, staff are also informed in a letter after supporting attendance meetings that they can record their disability on ESR or there manager can support them with updating ESR.

The Trust is also looking at introducing a Reasonable Adjustment / Disability Passport for staff with a disability.

The Trust is aiming to set up a Disability staff network group which will look at why 30.48% of Trust staff have not disclosed if they do or don't have a disability.

Metric 2/ Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting
432 disabled staff were shortlisted and 16 were hired this is a success rate of 3.70% compared to 2515 non-disabled staff shortlisted and 150 who were successful which is a 5.96% success rate.

Metric 3/ Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process
For the purposes of Year 1 WDES report, capability is defined as capability on the grounds of performance, not ill health.

The figures highlight that no disabled or non-disabled staff entered the formal capability process on the grounds of performance in 2018-19.

Metric 4/ Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

i/ Patients/service users, their relatives or other members of the public in the last 12 months
Disabled staff = 37.3% Non-disabled 26.7% Difference = 10.6%

ii/ Managers
Disabled staff = 24.4% Non-disabled 11.5% Difference = 12.9%

iii/ Other colleagues
Disabled staff = 30.8% Non-disabled 15.9% Difference = 14.9%

Metric 5,6,7/ Staff with a disability highlighted in metric 5, 6, 7 of the report a score / response that is worse than staff without a disability, the responses highlight that appropriate actions need to be complied to address the issues raised.

Metric 8/ Has your employer made adequate adjustment(s) to enable you to carry out your work?(NHS staff survey)
The Trust response rate is 77% other Trusts average is 72%, SOHT is 5% above the national average response.

4. Staff Profile

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

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

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

5. Workforce Metrics

Three workforce Metrics, compares the data for both Disabled and non-disabled staff.

Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

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

Workforce Metrics

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

Metric:

1

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

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

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

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

Data for reporting year

Non – Clinical

2018-19

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

Clinical

2018-19

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

Cluster 5: Med & Dental Consultant

2018-19

Disabled	Non-Disabled
0%	58%

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

2018-19

Disabled	Non-Disabled
2%	64%

Cluster 7: Medical & Dental Trainee Grades

2018-19
2017-18

Disabled	Non-Disabled
1%	94%

Metric 2:

2

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

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

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

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

2018-19

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

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

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

Metric 3:

3

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

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

ii) This Metric is voluntary in year one.

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

2018-19

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

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

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

Metric 4:

4	**a/** Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: **i/** Patients/service users, their relatives or other members of the public in the last 12 months	**i/** Patients/service users, their relatives or other members of the public: **Disabled** : 37.3 % **Non-Disabled** 26.7%

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

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

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

5. Trust Actions taken to be compliant with the WDES

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

6. Recommendations

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

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

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

Appendix 1:

Workforce Disability Equality Standard (WDES) Action Plan

WDES ACTION PLAN 2019-20 Final.doc

Appendix 2:

WDES Technical guidance

wdes-technical-guidance-v1.pdf

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 November 2019

Agenda Item	**TB210/19c**	**Report Title**	**Workforce Race Equality Standard Report**
Executive Lead	Jane Royds: Director of Human Resources and OD		
Lead Officer	Bob Davies: Equality Lead		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

Alert

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

Advise

- Ensure that the Trust data for the WRES has been uploaded onto NHS England site and will be published on the Trust website and sent to the CCG as part of the equality section of the quality contract.
- Paper has been reformatted as per action following October's Board meeting. New formatted report was accepted at Workforce Committee in November 2019.

Assure

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

Recommendation

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

	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)*

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

Previously Presented at:

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

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

1. Executive Summary

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

2. Introduction

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

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

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

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

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

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

3. Drivers for WRES implementation

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

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

blowers.

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

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

5. WRES Highlights:
The information below provides a comparison for the WRES reports for 2017-18 and 2018-19, the information also provides the Trust figures compared to the average for combined acute and community hospital.

BME staff in clinical and non–clinical bands 8a-9
Non Clinical: The 2018-19 WRES report highlights that there has been no increase in non-clinical BME staff in bands 8b to 9 and there are no BME staff in band 8b 8c 9 these figures are the same in the 2017-18 WRES report.

Clinical: The WRES report highlights that there has been no increase in clinical BME staff in bands 8b – 8d and there are no BME staff in band 8b, 8c. 8d these figures are the same in the 2017-18 WRES report.

Relative likelihood of BME and white staff being appointed from shortlisting across all posts
3.70% of BME staff were hired from those shortlisted compared to 5.96% of white applicants hired from shortlisting in 2018-19.

The 2018-19 WRES data highlights that there has been an increase in BME staff being successful at interview and being hired by the Trust. 2018-19 = 3.70% compared to 1.78% in 2017-18 this is an increase of 1.78%

Relative likelihood of BME and white staff entering the formal disciplinary process
The number of BME staff (1) entering the disciplinary process in 2018-19 is the same as the 2017 - 18 WRES figures, the figure for white staff has decreased to 23 in 2018-19 compared to 38 in 2017-18.

NHS staff survey responses that are specific to WRES questions:

Q1/ The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
In the last 12 months Trust figures for white staff has seen a decrease of 0.1% and a 9.2% increase for BME staff.

The Trust figures compared to the average combined acute and community Trusts is 0.2% higher for white staff and 0.4% lower for BME staff.

Q2/ Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
Experiences of Trust staff experiencing harassment; bullying or abuse from staff in last 12 months has seen a 1.8% increase for white staff and a decrease of 6.5% for BME staff.

The Trust figures compared to the average combined acute and community Trusts is 0.7% lower for white staff and 2.1%% lower for BME staff.

Q3/ Percentage of Trust staff believing that Trust provides equal opportunities for career progression or promotion.
Experiences of white staff have seen an increase of 1.2% and an increase of 5.4% for BME staff.

The Trust figures compared to the average combined acute and community Trusts is 6% lower for white staff and 8.2% higher for BME staff.

Q4/ In the last 12 months have you personally experienced discrimination at work from any of the following manager/team leader or other colleagues?
Experience of white staff has seen a 0.3% increase from 2017 and there has been an increase of 3.5% from 2017 for BME staff

The Trust figures compared to the average combined acute and community Trusts is 0.4% higher for white staff and 1% lower for BME staff.

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

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

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

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

Note: This refers to both external and internal posts

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

2018-19

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

2017-18

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

3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year. For consistency, organisations should use the same methodology as they have always used.

Disciplinary Process: Overall breakdown of cases by ethnic origin categorised in line with WRES requirements as at 31.3.2019

2018-19

WRES Category	Head Count
BME	1
White	23
Not Stated	1
Total	25

2017-18

WRES Category	Head Count
BME	1
White	38
Not Stated	4

<table>
<tr><td></td><td></td><td><table><tr><td>Total</td><td>43</td></tr></table></td></tr>
<tr><td>4</td><td>Relative likelihood of staff accessing non-mandatory training and CPD</td><td>Training: The information below highlights the ratio of BME and White staff accessing training in 2018-19 and 2017-18

2018-19<table><tr><th>WRES Category</th><th>Head Count</th><th>Enrolment Headcount</th><th>Ratio</th></tr><tr><td>BME</td><td>244</td><td>226</td><td>0.93</td></tr><tr><td>White</td><td>2551</td><td>2219</td><td>0.87</td></tr><tr><td>NULL</td><td>12</td><td>8</td><td>0.67</td></tr><tr><td>Not Stated / Not Given</td><td>178</td><td>160</td><td>0.89</td></tr></table>2017-18<table><tr><th>WRES Category</th><th>Head Count</th><th>Enrolment Headcount</th><th>Ratio</th></tr><tr><td>BME</td><td>242</td><td>223</td><td>0.92</td></tr><tr><td>White</td><td>2603</td><td>2447</td><td>0.94</td></tr><tr><td>NULL</td><td>12</td><td>10</td><td>0.83</td></tr><tr><td>Not Stated / Not Given</td><td>206</td><td>191</td><td>0.93</td></tr></table></td></tr>
</table>

6.2 NHS Staff Survey:
The 2018 NHS Staff Survey was completed by 1,147 staff this is a response rate of 40% which is average for combined acute and community trusts in England (43%) and compares with a response rate in the Trust in 2017 of (45%) ,
For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff.

Key Findings KF25, KF26, and KF21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.
Note that for question Q17, the percentage featured is that of "Yes" responses to the question.

Key Finding and question numbers are the same in 2018 as 2017.
Figures in bold highlight BME figures

	Indicator	**Data for reporting year 2018**	**Data for previous year 2017**
5	**15a:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Experiences of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has seen the figures for white staff decrease by 0.1% and a **9.2% increase for BME staff**.	White staff 28.4 % BME staff : 29.4% Average (median) for combined Acute and Community Trusts White staff– 28.2% BME staff- 29.8%	White staff: 28.5% BME staff: 20.2%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months Experiences of experiencing harassment, bullying or abuse from staff in last 12 months has seen a 1.8% increase for white staff and a **decrease of 6.5% for BME staff**.	White staff: 25.7% BME staff: 26.5% Average (median) for combined Acute and Community Trusts White staff– 26.4% BME staff- 28.6%	White staff: 23.9% BME staff: 33%

7	Percentage believing that trust provides equal opportunities for career progression or promotion Experience of white staff has seen an increase of 1.2% for white staff and an **increase of 5.4% for BME staff.**	White staff: 80.5% BME staff: 80.4% Average (median) for combined Acute and Community Trusts White staff: 86.5% BME staff: 72.3%	White staff:79.3% BME staff: 75%
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues Experience of white staff has seen a 0.3% increase from 2017 and there has been a **increase of 3.5% from 2017 for BME staff.**	White staff: 7% BME staff: 13.6% Average (median) for combined MH/LD and Community Trusts White staff: 6.6% BME staff: 14.6%	White staff: 6.7% BME staff: 10.1%

6.3 Board Representation Indicator:
For this indicator, compare the difference for white and BME staff

	Indicator	**Data for reporting year**
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board Note: This is an amended version of the previous definition of Indicator 9	The information below provides information on the headcount and percentage difference between the organisations board membership and its overall workforce for BME and White Staff By executive and non-executive board membership = BME: 14.29% White:78.57% Not Stated: 7.14%

2018-19

WRES Category	Head Count	Head count %	Board Head Count	Board Headcount %
BME	258	8.18%	2	14.29%
White	2679	84.97%	11	78.57%
Null	23	0.73%	0	0.00
Not Stated /Not Given	193	6.12%	1	7.14%

2017-18

WRES Category	Head Count	Head count %	Board Head Count	Board Headcount %
BME	242	7.9%	3	30%
White	2603	85.01%	6	60%
Null	12	0.39%	0	0.00
Not Stated /Not Given	206	6.7%	1	10%

7. Trust Actions taken to be compliant with the WRES

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

8. Recommendations

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

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

- Note that the NHS Workforce Race Equality Standard came into effect on the 1st April 2015 and is completed by the Trust on a annual basis.
- Note that the Trust has put in place WRES action plan and agree that the performance against the plan will be reported through the various Trustwide Valuing Our Peoples Assurance Group and Workforce Committee meeting
- An annual report will be compiled for submission to the NHS England Co-ordinator, Commissioner outlining progress on the Workforce Race Equality Standards.
- Workforce Race Equality Standard report will be published on the Trust website
- A copy of the WRES Indicators has been sent to NHS England

Appendix 1:

Workforce Race Equality Standard (WRES) Action Plan

WRES ACTION PLAN 2019-20 Final.doc

Appendix 2:

wres-technical-guidance-2017 (1).pdf

Appendix 3:

wres-nhs-board-bulletin.pdf