NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC

To be held at 10.30 – 13.30 on Wednesday 5 February 2020
Seminar Room, Clinical Education Centre, Southport

V = Verbal D = Document P = Presentation

Ref N^{o.}	Agenda Item	Lead	Purpose	Time
PRELIMINARY BUSINESS				**10:30**
TB001/20 (V)	**Chair's welcome & note of apologies**	**Chair**	***To Note***	10 mins
TB002/20 (D)	**Declaration of Directors' Interests concerning agenda items**	**Chair**	***To Approve***	
TB003/20 (D)	**Minutes of the previous meetings held on 4 December 2019**	**Chair**	***To Approve***	
TB004/20 (D)	**Matters Arising Action Logs - Outstanding & Completed Actions**	**Chair**	***To Discuss***	
TB005/20 **(D/V)** **(V/P)**	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:** ○ **NEDs:** (verbal) ○ **Executives:** (document/verbal) • **Patient Story:** Cancer Services to present on: Risk Stratified Follow Up	**NEDs and EDs** **Michelle Kitson**	***To Discuss***	30 mins
STRATEGIC CONTEXT				**11:10**
TB006/20 (D)	**Chief Executive's Report**	**CEO**	***To Receive***	10 mins
Quality and Safety				
TB007/20 (D)	**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) CQC Update Report f) 7 Day Service - Self-Assessment Board	**DoN / MD**	***To Discuss***	**30** mins

	Assurance Return			
PERFORMANCE & GOVERNANCE				**11:50**
TB008/20 (D)	**Winter plan**	**COO**	***To Receive***	10 mins
TB009/20 (P/D)	**Integrated Performance Report (IPR)**	**COO**	***To Receive***	15 mins
TB010/20 (D)	**Financial Position, 2019/20**	**DoF**	***To Receive***	10 mins
TB011/20 (D)	**Risk Management: Corporate Risk Register (CRR)**	**DoN**	***To Receive***	10 mins
ITEMS FOR APPROVAL				**1235**
TB012/20 (D)	**Single Improvement Plan Update (SIP)**	**DCEO &DOS**	***To Approve***	5 mins
TB013/20 (D)	**Equality, Diversity and Inclusion Annual Report**	**DoHR**	***To Approve***	5 mins
TB014/20 (D)	**Annual Report, Accounts and Quality Accounts Timelines**	**ADCG**	***To Approve***	5 mins
CONCLUDING BUSINESS				**12:50**
TB015/20 (V)	**Questions from Members of the Public**	**Public**	***To Receive***	10 mins
TB016/20 (V)	**Any Other Business** To **receive/discuss** any urgent business not on the agenda, including items for forward agenda – 4 March 2020	**Chair**	***To Receive***	5 mins
TB017/20 (D)	**Meeting Evaluation** To give members the opportunity to evaluate the performance of the Board meeting.	**Chair**	***To Assure***	5 mins
TB018/20 (V)	**Message from the Board** • To **agree** the key messages to be cascaded throughout the organisation from the Board.	**Chair**	***To Approve***	5 mins
TB019/20 (V)	**Date and time of next meeting:** **10:30, Wednesday 4 March 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

NHS
Southport and Ormskirk Hospital
NHS Trust

Register of Interests Declared by the Board of Directors 2019/20 AS AT 03 January 2020

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
Armstrong-Child Mrs Trish	Chief Executive Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**16 December 2019**
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 Mrs Juliette	Director of Nursing, Midwifery and Therapies	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Appointed Chief Nurse for NHS Professionals**	**Governor – Southport College**	**04 October 2019**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
			coaching services to Directorate and senior NHS Management personnel							
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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KATEMA Mrs Sharon	Interim Associate Director of Corporate Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**02 December 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	Deputy 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**	**Nil**	**Nil**	**Trustee – Age Concern**	**4 October 2019**

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						the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust.				
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health** **Trustee of the Medical Education Charity at Southport & Ormskirk Hospital NHS Trust**	**Nil**	**Nil**	**Nil**	**9 April 2018** **04 December 2019**

Southport and Ormskirk Hospital NHS Trust

Minutes of the Board of Directors' Meeting held in public
Wednesday, 4 December 2019

Ruffwood Suite, Clinical Education Centre, Ormskirk District General Hospital, L39 2AZ
(*Subject to the approval of the Board on 8 February 2020*)

Members Present

Mr Neil Masom	Trust Chair
Mrs Trish Armstrong-Child	Chief Executive
Dr David Bricknell	Non-Executive Director
Mr Jim Birrell	Non-Executive Director
Mrs Juliette Cosgrove	Director of Nursing, Midwifery & Therapies
Mrs Julie Gorry	Non-Executive Director
Dr Terry Hankin	Medical Director
Mrs Therese Patten	Deputy Chief Executive/ Executive Director of Strategy
Mr Steve Shanahan	Director of Finance
Mr Gurpreet Singh	Non-Executive Director

In Attendance

Mrs P Gibson	Non-Executive Director Designate
Mr S Christian	Chief Operating Officer
Mrs C Griffiths	NHSE/I Improvement Director
Mrs S Katema	Interim Associate Director of Corporate Governance
Mrs J Royds	Director of Human Resources & Organisational Development

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB197/19	**Chairman's Welcome and Note of Apologies** Mr Masom welcomed all in attendance and in particular welcomed the new Chief Executive, Mrs Armstrong-Child to her first meeting. He thanked Mrs Patten for providing support during the interim period and for being instrumental in securing £2.4m worth of non-recurring funding into the Trust. Mr Masom also welcomed the new Interim Associate Director of Corporate Governance to the meeting and thanked Mrs Davenport for providing support Mrs Armstrong-Child thanked the Chair and all colleagues across the Trust for the warm welcome she had received. There were no apologies for absence.	
TB198/19	**Declaration of Directors' Interests** There were no declarations in relation to the agenda items. Mr Singh clarified that he had been asked to become a trustee and not a member of the Medical Education Charity at Southport & Ormskirk Hospital NHS Trust. The Register of Interests and minutes would be updated to reflect the amendment.	
TB199/19	**Minutes of the previous meeting**	

The Board reviewed and approved the minutes from the meeting held on 6 November 2019 subject to the amendment in relation to Mr Singh's interest.

RESOLVED:
The Board **approved** the minutes as an accurate record of proceedings subject to the noted amendments.

TB200/19 Matters Arising Action Log

The Board considered the matters arising in turn and **approved** the closure of the below actions:

TB028/19 Monthly Mortality Report
TB149/19 Quality Improvement Plan. Item included on agenda.
TB174/19 Items for Approval or Ratification:

- Learning lessons to improve our People Practices Report
- Workforce Disability Equality Standard Information Report
- Workforce Race Equality Standard Information Report

TB 186/19 Quality and Safety Reports

- Complaints and Compliments
- Safe Staffing

TB201/19 Patient and Engagement Issues

a) NEDs and Executive Visits/Walkabouts:

Mr Singh and Mrs Royds had visited Ward 11a, Ward 14a, Medical Equipment and Devices, and Catering. They shared a good news story in relation to the dishwasher that had been sourced for the kitchen staff. Overall, the Catering team felt appreciated and supported by a leader that listened and engaged with them and was highly respected. The Board noted this example as a demonstration of the value of walkabouts and the benefits of a having dialogue with staff.

Other conversations on the wards related to workload as staff were increasingly busy and some had raised the issue of more which was not in the board members' gift. Whilst there was positive feedback from the visits and people showed a willingness to stay with the Trust, other areas had raised concerns in relation to minimal involvement from managers and frustration at not seeing perceived improvements.

Mr Bricknell shared his interaction with a colleague in Outpatients when he had conducted a secret shopper visit. The colleague had highlighted that she had been partly through her degree when she got pregnant. The flexible system of working had provided a stability as it fit in with her childcare commitments. The colleague had highlighted that intended to complete her degree and continue working with the Trust. Mr Bricknell highlighted that it was reassuring to learn of that focus on personal development and retention applied across all levels.

Mrs Gorry and Mr Shanahan provided details of the responses received from their visit to Ward 11a. The engagement had centred on "What are you" style questions:

- Proud of **-** staff resilience also during challenging and works and refurbishment

- Challenged by –
  - recruitment process
  - Ongoing and delayed refurbishment.
  - Red to Green created misunderstanding.
  - Volume of emails within core working hours.
- Concerns – Early patient discharge and subsequent readmissions.

The Matron for Patient Experience highlighted the importance of asking similar questions adding that key questions to ask patients included:

- Do you know the nurse in charge of your care
- Do you know what is happening
- Are you involved in decisions about your care

In response to Mrs Gorry observation on the ability to provide feedback after presentation at Board, Mrs Patten highlighted that the ward reconfiguration was progressing in spite of the significant delays. Four wards were scheduled for completion by the end of December. Whilst no work would be carried out during winter, it was expected that work would resume in March 2020.

Mr Christian responded that the continual challenges within Urgent Care were being replicated and impacting other areas. He noted the ongoing support and visibility during periods of overwhelming demand and highlighted that senior leaders would continue supporting Red to Green and optimising patient flow.

RESOLVED:
The Board **received** and **noted** the updates.

b) Patient Story
The patient story focussed on the provision of pastoral, spiritual and religious support by the Chaplaincy and Spiritual Care Service. Rev Adams provided a brief overview of the composition of the Chaplaincy which included himself as a full-time ecumenical chaplain; a 0.4wte Roman Catholic priest as well as ministers and volunteers. He outlined that the Chaplaincy and Spiritual Care was broader than the church in that in addition to religious ministry, it offered spiritual support.

The Chaplaincy has good relationships with all major faiths including the Islamic and the Jewish community. This has resulted in patients having access to an ablution room which is an essential element of the Muslim faith. The Chaplaincy was also strengthening relationships with the Jewish community and had been able to work with arrange burials and arranging Jewish burials in as short an interval after death as possible.

The presentation showcased the work undertaken by the service which included:

- 650 follow up visits
- 110 new referrals in October 2019.
- The opening of the Baby Garden in September
- Attending Neonatal Natter which actively brings parents of premature babies together to share their experiences and knowledge. The Group is also supported by a representative from Bliss Charity who attends once a week.
- Working closely with the Palliative Care team and the Registrar's Office, enabled the Chaplaincy to facilitate two weddings for patients approaching End

of Life.

The Board took assurance from the work of the Chaplaincy and Spiritual Care Services and noted the positive impact it had on patient experience.

RESOLVED:
The Board took assurance from the work of the Chaplaincy and Spiritual Care Services and **noted** the positive impact on patient experience.

STRATEGIC CONTEXT

TB202/19 Chief Executive's report

Mrs Patten presented the Chief Executive's Report. The following key points were noted:

- The Trust had received the Care Quality Commission (CQC) report that reflected significant progress and outlined improvements in care and leadership.
- Electronic prescribing would be phased in over 18 months following a £1.4m investment.
- Further improvement in mortality performance
- CQC Children's and young people's survey
- Dr May Ng was awarded an Honorary Professorship by the University of Liverpool.

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

QUALITY AND SAFETY REPORTS

TB203/19 Quality and Safety Reports

Key issues from the comprehensive reports provided in relation to this agenda item were highlighted in a joint presentation by the Director of Nursing, Midwifery & Therapies and the Medical Director, as follows:

a) Quality Improvement Plan update

i. Care of the Deteriorating Patient

Dr Hankin advised that mortality screening rates met the 90% target. However, the challenge now was using this information to identify and propose improvement work which would include fractured Neck of Femur as one of the first areas.

ii. Infection Prevention and Control

Dr Hankin highlighted that C.Diff was above trajectory.

- C.Diff incidents were above trajectory. However, the C.Diff target was more challenging this year due to a change in how cases are attributed to the Trust
- Klebsiella outbreak on the Spinal Injuries Unit had been controlled and contained effectively. Six beds that had been closed were expected to open on 10 December 2019.

iii. Medicines Management

A Serious Incident RCA in relation to the CQC concern was completed with recommendations incorporated into the Medicine Management Development Plan.

There was a continued focus on improving 7 Day working, staffing and Electronic prescribing further to NHSE/I approving the funding application of £700k for EPMA.

b) Complaints and Compliments

The report provided a breakdown of the compliments, complaints, and concerns received in October. It was noted that whilst the numbers were decreasing, similar themes remained the subject of improvement work. Overall, areas of improvement had been identified with relevant actions being implemented.

c) Learning from deaths

Dr Hankin presented the monthly report which detailed measures for mortality alongside activity supporting the improvement of quality of care and performance. He outlined that the Summary Hospital Level Mortality Indicator (SHMI) was within the expected range and steadily declining.

d) Safe Staffing

Mrs Cosgrove presented the report which set out the safe staffing position for October 2019. It was noted that the Trust reported s92.3% against the national average (90%) at 92.3%. The Board took assurance from the report as no harm events occurred to patients due to staffing levels.

Progress had been made on the following work streams aimed at improving staffing levels:

- A local recruitment event had resulted in three conditional offers
- Nursing Associate recruitment events in collaboration with Edge Hill and UCLAN were taking place in December
- Recruitment to additional posts to deliver the winter ward
- Continued reduction to off framework agency utilisation
- Block booking Registered Nurses to deliver 20wte nurses into ward teams over the winter months.

e) Medical Vacancy rates

Dr Hankin provided an update on Medical Vacancy rates across the Trust which included analysis across specialty areas. He highlighted that the report indicated that the Trust was significantly under represented. Radiology was currently at 50% of consultant staffing levels leaving the service being supported by third party providers and locums.

Mr Birrell highlighted that there was a need for a more positive measure in relation to the deteriorating patient key indicator. Dr Hankin advised that he was developing a dashboard across all quality priorities.

f) Summary of CQC Report Ratings

Mrs Cosgrove provided a brief overview of the CQC Report Findings as follows:

- Overall, the inspectors saw good areas of practices
- The Well Led improvements in both Urgent and Emergency Services and Surgery meant the overall rating for the Trust in this domain improved to Requires Improvement
- Whilst the Children's and Young People services at Ormskirk improved to Good overall, but deteriorated from Good to Requires Improvement in Safe domain but has improved to Good in both Effective and Responsive domains.
- There was no change from Requires Improvement for either Maternity or

Surgery as they were not inspected.
- Sexual Health and End of Life Care achieved a Good rating

RESOLVED:
The Board **received** the Quality and Safety Reports and was **assured** by the Quality Improvement Report.

PERFORMANCE AND GOVERNANCE

TB204/19 Integrated Performance Report (IPR)

The Chief Operating Officer presented the Integrated Performance Report which detailed operational performance in October 2019. This included:
- In response to the increase in hospital deaths, the Medical Director and Mortality Operational Group were analysing the data to identify themes.
- Loss of activity within specialist teams due to a reduction in GP referrals.
- Achievement in Diagnostic and Stroke indicators against a backdrop of challenges with Flow.
- The Trust achieved 84.6% against the constitutional standard of 95% for the 4hour standard. This was due to an 11% increase in demand across all urgent and emergency care services over a 6week period, which was exacerbated by worsening performance against Medically Optimised Discharges. However, despite the significant challenges, the Trust was within the Top 5 best performing trusts in the North West a stark contrast to the same reporting period from two years ago when the Trust was in the bottom three.

Mr Christian highlighted that it was important to recognise the progress made due to interventions introduced. This included;
- Improvements to Same Day emergency care and Length of stay of which the Trust was now performing above national median albeit with further improvements yet to be made.
- Negotiated with regulators and secured £1.6m to drive service improvements during winter.
- Identified key priority areas to address unwarranted variations to support patient Flow and improve discharge rates during weekend services.
- Enhanced bed base

The Trust was continuing to work with partners on the system winter plan. Concerns around deliverability of the plan due to resource constraints and a lack of therapies provision within community services had been raised at SOIB. Furthermore, to support patient flow internally, the Executive Team was considering temporary enhanced capacity and an escalation plan in response to current operational pressures.

With regards to reduction in GP referrals, Mr Singh queried if this was the case with other providers. Mr Christian responded that the Finance, Performance and Investment (FP&I) Committee would consider whether there was a need for a detailed analysis once the initial scoping had concluded. He added that a strategic

review of the services could enable the Trust to be a provider of choice and maximise opportunity by recruiting into those pathways.

RESOLVED:
The Board **received** the Integrated Performance Report.

TB205/19 Financial Position at Month 7, 2019/20

The Director of Finance presented the Financial Position at Month 7. The following key points were noted:

Forecast
The Trust is forecasting a year end overspend of £3.6 million against the deficit plan of £26.6 million. Whilst the £3.6m overspend was the best case for the organisation, discussions with regulators and efforts to improve the position, were ongoing.

Financial Plan
This was not achieved due to higher expenditure on a temporary workforce despite recruiting to substantive posts. It was expected that the increase in agency spend would increase due to additional pressure.

CIP
The forecast outturn position was £4.3 million against £6.3 million plan leaving an unidentified gap of £2.0 million. Discussions with regulators were ongoing as the Trust was £1,35m behind plan at month 7.

Capital
The Capital Plan would be revised as the capital loan of £935,000 could be received in the current financial year. It was expected that the IT infrastructure and MRI scanner would be part of the projects to be brought on track within the current financial year.

RESOLVED:
The Trust **received** the Financial Report.

TB206/19 Risk Management: Corporate Risk Register

The Director of Nursing, Midwifery and Therapies presented the Corporate Risk Register update advising that one new risk had been added to the risk register following concerns raised by the CQC.

RESOLVED:
The Board received the Corporate Risk Register.

TB207/19 Single Improvement Plan (SIP)Update

The Director of Strategy presented the Single Improvement Plan Update.

Mr Masom queried if the Board could consider ways to reduce duplication as the SIP update was communicated elsewhere a view also shared at Shadow Board.

RESOLVED:
The Board **received** the SIP Board update

TB208/19 Workforce Directorate Presentation

The Director of HR and OD delivered a presentation that showcased the workstreams being undertaken by the Trust. Mrs Royds reminded the Board that the Human Resources directorate was brought back in the Trust in April 2019 and was undergoing a two year programme of transformation which was aligned to the strategic intentions of the Trust and address concerns relating to the workforce challenges. Plans to develop a Business Case to enhance funding and capacity within the Workforce Directorate were progressing.

The presentation detailed the national developments regarding the Interim People Plan and listed achievements and plans for the future across the following areas:

- Education and Training
- Health and Wellbeing
- Recruitment
- Resourcing services and workforce systems
- HR Business services
- Equality, Diversity and Inclusion

RESOLVED:
The Board **received** the Workforce Directorate Presentation.

TB209/19 Charity Update

a) Charity Name

The Director of Finance presented the paper which sought a change of name from “Southport and Ormskirk Hospital NHS Trust Charitable Fund” to “Southport and Ormskirk Hospitals Charity.”

Noting Mr Birrell’s discomfort at the request, the Board resolved to change the Charity’s name to Southport and Ormskirk Hospitals Charity which would enable progression with a formal application to the Charity Commission to change the name.

RESOLVED:
The Board **approved** the change of name for the charity

b) Charity Investment Policy

The Director of Finance presented the Charity Investment policy which provides a framework for investment together with ethical constraints.

RESOLVED:
The Board **approved** the Charity Investment Policy

TB210/19 ITEMS FOR APPROVAL/RATIFICATION

The following items were presented for approval by the Board**:**

- Learning Lessons to Improve our People Practices Report
- Workforce Disability Equality Standard Information Report April 2019 – March 2020
- Workforce Race Equality Standard Information Report April 2018 – March 2019
- Request for approval

RESOLVED:
The Board **noted** and **approved** the request

TB211/19 Questions from Members of the Public

The Chair posed the question on the morale across the hospital going into winter season.

Simon highlighted that the general feeling from colleagues in Pharmacy was that of optimism particularly in light of the news relating to the EPMA investment. He added that whilst there was a tendency to overlook the support services who are very close to the patients, the team was confident they could help to drive the organisation in line with strategy. Studying masters and feel the conversations at board are in line

Janette highlighted that there had been an overwhelming sense of achievement following the CQC briefing sessions. She highlighted that her team acknowledged there was still more to be done but they had felt enthused by the positive results.

Mrs Armstrong-Child observed that overall the staff were apprehensive but positively optimistic and were proud of what they have achieved. She highlighted that the corporate induction had provided her with an insight into the organisation as two returnees to the Trust had described their teams as a family.

Mr Johnson queried if further thought had been given to his previous question from October regarding to liaising with the twin city and hospital in Lindesberg, Sweden. Dr Hankin highlighted that he had tried to find anyone within the organisation that had a memory of this.

Mr Johnson asked if the Board could consider streaming meetings on the internet as this would help reach a wider audience.

RESOLVED:
The Board **received** the comments.

TB212/19 Message from the Board

The messages from the board were agreed and included:

- Workforce
- Attendance
- Expanding on Winter interventions
- Extra capital

- Ward refurbishment
- Monthly report to visually describe performance improvement happening in the Trust.

CONCLUDING BUSINESS

PB214/19 Any Other Business

Mr Christian highlighted that the Trust Charity had received a donation of £5,498 from the captains of Men's and Ladies teams at Southport and Ainsdale Golf Club.

Mr Masom welcomed the donation and highlighted that the re-launch of the Charity had provided a good opportunity for fundraising. He added that donations had been received from Bramall Golf Club worth £20k as well as an individual donation of £10k in recognition of the excellent treatment received at the Trust.

Mrs Gorry queried what the Trust's intention was with regards to signing up to the NHS Single Plastic Reduction Pledge. She highlighted that the deadline was 20 December and the Trust needed to submit data to demonstrate how it would address the reduction. Mrs Gorry to discuss with Mrs Patten offline.

TB215/19 DATE, TIME AND VENUE OF THE NEXT MEETING

Wednesday 5 February 2020, 10:30
Seminar Room, Clinical Education Centre
Southport District General Hospital
PR8 6PN

Board Attendance 2019/20

Members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Neil Masom (Chair)	✓	✓	✓	✓		✓	✓	A	✓			
Trish Armstrong-Child									✓			
Jim Birrell	✓	✓	✓	✓		✓	✓	✓	✓			
David Bricknell	✓	✓	✓	✓		✓	✓	✓	✓			
Ged Clarke	✓											
Juliette Cosgrove	✓	✓	✓	✓		✓	✓	✓	✓			
Julie Gorry	✓	✓	✓	✓		✓	✓	✓	✓			
Terry Hankin	✓	✓	✓	✓		✓	✓	A	✓			
Joanne Morgan		✓	✓	✓		**A**						
Silas Nicholls	✓	✓	✓	✓		✓	✓					
Therese Patten	✓	✓	✓	✓		✓	✓	✓	✓			
Steve Shanahan	✓	✓	✓	✓		✓	✓	✓	✓			
Gurpreet Singh	**A**	✓	✓	**A**		✓	✓	✓	✓			

In Attendance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pauline Gibson	✓	✓	✓	✓		✓	A	✓	✓			
Audley Charles	✓	✓	✓	✓								
Steve Christian	✓	✓	✓	✓		✓	✓	✓	✓			
Jane Royds	✓	✓	✓	✓		✓	A	✓	✓			
Anita Davenport						✓	✓	✓				
Sharon Katema									✓			
Jenny Pennifold							✓					
A = Apologies ✓ = In attendance												

Public Board Matters Arising Action Log
5 February 2020

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

COMPLETED 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**
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**
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		**BLUE**
		Workforce Disability Equality Standard Information Report April 2019 – March 2020 (DoHR)		**DoHR**	Oct 2019	Dec 2019		**BLUE**

Public Board Matters Arising Action Log
5 February 2020

Southport and Ormskirk Hospital NHS Trust

		Workforce Race Equality Standard Information Report April 2018 – March 2019 (DoHR)		**DoHR**	Oct 2019	Dec 2019		**BLUE**
			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. All actions wre complete and actions learnt were disseminated. Overseen by Mortality Group.**	**BLUE**
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: December Update: Item included on agenda. Action completed**	**BLUE**
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	**December Update:** Item included on agenda. Action completed	**BLUE**

Southport and Ormskirk Hospital NHS Trust

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:** Item included on agenda. Action completed.	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
5 FEBRUARY 2020

Agenda Item	**TB005/20**	**Report Title**	**Board Engagement**
Executive Lead	Deputy Chief Executive/Director of Strategy		
Lead Officer	Michelle Kitson, Matron for Patient Experience		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓ To Note ☐ To Receive	

Executive Summary

The report outlines a summary of Board members' planned engagement with staff and patients

- Leadership Walk Round
- Back to the Floor

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

Leadership Walkrounds

Visible leadership is essential to ensure connection with an organisation. It is especially important for Board members and demonstrates to staff that they are engaged and interested in the work that they undertake. It also allows staff to showcase the areas they are proud of and to highlight some of the challenges they face.

During 2019 members of Trust Board participated in Leadership Walkrounds to engage executive and non-execuitve directors in the work of teams and departments within the Trust. In response to feedback we are suggesting for 2020 a revised template that is simplified and inlcudes the opportunity to get feedback from patients. The Communications Department and the Matron for Patient Experience have agreed to review returned proformas on a monthly basis to support action planning and Board reporting.

Appendix 2 is an updated visit schedule. The methodology behind this has been updated slightly to take account of feedback that it would be of value if leaders could develop stronger relationships with a smaller number of departments. The schedule and frequency of visiting will be agreed by NED/ED teams.

It is likely that Leadership Walkrounds will be just one part of a comprehensive Board Visibility progarmme. It is suggested that, if approved, we implement this approach an review after three months.

DRAFT

Appendix 1 Revised Template

Leadership Walk Rounds

Ward/Area Visited	
Date	
Non-Executive Director	
Executive Director	

Staff Questions

What are you proud of?	
What frustrates you?	
What can you do to change some of the frustrations into positives?	

DRAFT

Patient Questions (where questions are appropriate please ask a minimum of x5 patients)

Does the patient know which nurse/midwife is in charge of your care?	
Do they know what is happening today to support their care and treatment?	
Do they feel involved as much as they want in the decisions about their care and treatment?	
Any other patient comments to note.	

Record of Actions Taken in Response to Staff/Patient Feedback

DRAFT

Appendix 2 Board Teams and Areas

Cluster	Area to Visit	Who
1	Maternity Ward ODGH	Juliette Cosgrove Jim Birrell
	Maternity Assessment Unit ODGH	
	Accident and Emergency SDGH (inc Obs and CDU)	
	Ward 15a	
	Radiology SDGH	
	Medical Day Unit	
2	Neonatal ODGH	Pauline Gibson Therese Patten
	Delivery Suite ODGH	
	G/H ward	
	Ward 11a	
	Sterile Services SDGH	
	Critical Care (HDU/ITU/ CCU)	
	Ward 9b (FESS)	
3	Ward 15b	Julie Gorry Steve Shanahan
	Ward 7a	
	Audiology SDGH	
	Ward 14a	
	Estates and Facilities	
	Radiology ODGH	
	Pharmacy ODGH	
4	Ward 10b	Neil Mason Terry Hankin
	Outpatients (inc orthopaedic and plaster room) SDGH	
	Catering Dept SDGH (inc. observation of mealtimes)	
	Catering Dept ODGH (inc. observation of mealtimes)	
	Ward 7a	
	E/F Ward ODGH	
5	Spinal Injuries	Gupreet Singh Jane Royds
	ENT and Opthamology SDGH	
	Theatres ODGH	
	Treatment Centre	
	EBME/ Equipment Library	
	Ward 7b (rehab)	
6	Ward 11a	Trish Armstrong Childs NED
	Ward 9a	
	Theatres Southport	
	Paediatrics ODGH (inc. Ward/A+E/ Outpatients)	
	Maxillo Facial unit ODGH	
	Sexual Health Services (Community)	
7	Pharmacy SDGH	David Bricknell Steve Christian
	Ward 14b	
	Ward 11b	
	Estates and Facilities ODGH	
	Outpatients ODGH	
	Ward 10A	
	Discharge Lounge	

DRAFT

Board members' engagement with staff and patients

The Trust recognises the importance and benefits of regular engagement with both patients, carers and Trust staff to develop and maintain a positive culture within the organisation.

The following report gives oversight of the outcomes from recent Leadership Walk Rounds and 'Back to the Floor' visits that continue to improve the visibility of Board members across the organisation.

1. Leadership Walk Round

Therese Patten, Deputy Chief Executive and Director of Strategy, and Pauline Gibson, Non-executive Director (designate), conducted leadership walk rounds on 27 January 2020 at Ormskirk hospital and visited four departments.

Radiology

What staff said …

- The team said they worked well together and with colleagues across the Trust
- Managers, although visible, did not seem recognise the pressures staff faced

What patients said …

- Patients were positive about the service

Neonatal

What staff said …

- The team supported each other, including cover for sickness
- They were proud of the quality of care they gave parents, building their confidence for baby's discharge
- Rotation from Paediatrics allowed staff to develop
- Working between paediatric unit and paediatric ward a challenge for staff because different skills required
- Transitional care unit would enable mums and babies to be kept together
- Would like to set up continuity support services

What patients said …

- Patients were very happy with the care they and their baby was receiving
- They were given clear information, progress checks and helped building confidence caring for their baby

F Ward

What staff said …

- Balance between elective list sometimes very busy, sometimes very quiet
- When lists cancelled, not always told why
- Concerns over timing of moving staff between areas
- Not yet got day care policy right

What patients said …

- Patients said they were kept full informed, including why a previous appointment had been cancelled
- Staff were supportive of patients

Outpatients

What staff said …

- Praised team approach of Ormskirk workforce
- Local leadership style – approachable, bring Southport and Ormskirk team together
- Concerns over timing of moving staff between areas
- Layout of department confusing for patients
- Would like a water fountain for patients and way of playing music in waiting area
- TV screen information, including waiting times, needs improvement

What patients said …

- Patients were happy but confused by the misleading time on the TV screen

No actions were made in response to staff/patients feedback were recorded.

2. Back to the Floor

Juliette Cosgrove, Director of Nursing, Midwifery and Therapies, spent half-a-day as domestic on 14B at Southport hospital.

The following comments were published on the The Meeting Place, the staff Facebook page:

Like Comment

Christopher Efc Sean Doing a grand job there xx
Like · Reply · Message · 1w

Cheryl Lambert Nice to see well done Juliette
Like · Reply · Message · 1w

Jackie Bailey Well done xx
Like · Reply · Message · 1w

Kaleigh Ward
Like · Reply · Message · 1w

Paula Mccallum Tierney Shes a fab role model
Like · Reply · Message · 1w

Carol Fowler Great pic - all spit spot!
Like · Reply · Message · 1w

Marivic Mallari Camacho Horsley A grand model for all xx well done!
Like · Reply · Message · 1w

Juliette Cosgrove Thanks guys, worked hard scrubbing those toilets and sinks
Like · Reply · Message · 1w

Comment as Southport And Formby District Gene...

MK/TE 290120

CHIEF EXECUTIVE'S REPORT TO BOARD – FEBRUARY 2020

1. Awards and recognition

1.1 National Awards.

Congratulations to orthopaedic surgeons Mr Krushroo Suraliwala and Mr Imran Ullah who were winners in the National Institute for Health Research Network Awards.

They were named Best Musculoskeletal Trauma Principal Investigator and Best Musculoskeletal Trauma Trainee Principal Investigator, respectively, and received their awards at a ceremony in Newcastle last month. It was a multi-centre research project with the potential to alter clinical guidelines.

Prof Matthew Costa, national specialty lead for trauma and emergency care, described their application as "outstanding" in what was "a very strong field of applicants".

Mr Suraliwala commended Anna Morris, musculo-skeletal research practitioner, and her research team for the invaluable input to the Orthopaedic department during the study.

1.2 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 presented to:

- All the staff at Ormskirk hospital involved in the ward changes during December and January, enabling the creation of additional beds for patients at Southport
- Nurse Tony Sutherland, Trauma and Orthopaedics team
- Colette Morris, receptionist, Treatment Centre, Ormskirk hospital

2. News and Developments

2.1 System Pressures.

As anticipated, it has been a busy to start to the year with winter presenting its own challenges, along with additional demands on the service and the hospital at capacity on a number of occasions.

The launch of our staff-focused Safer Start campaign in January, meant we were better prepared than ever to keep patients moving through hospital and getting patients back home to family and friends. This included reopening E Ward at Ormskirk hospital for orthopaedic trauma patients needing rehabilitation and freeing up 14 beds at Southport hospital.

The outpatient physiotherapy team also temporarily started working out of an empty ward at Ormskirk, whilst the vacant space at Southport become a ward for patients waiting, or shortly ready, to go home from hospital. Outpatient physiotherapy appointments are continuing to be provided at Southport as necessary.

We could only have made these important changes with the support and hard work of our staff.

2.2 Appointment of a new Director of Nursing, Midwifery and Therapies.
Following the resignation of the Director of Nursing, Midwifery and Therapies, the Trust held interviews on 28 January 2020 and a new appointment will be announced shortly. Juliette Cosgrove will leave us shortly to commence her new role as Chief Nurse of NHS Professionals. We wish her every success in her new post.

2.3 NHSI/E Meetings

The Trust met with the NHSI/E finance team on 22 January 2020 for the systems finance recovery meeting. The system provided a progress update on the work to date of the 2020/21 organisation and system efficiency schemes. Whilst progress has been made, this now has to develop into detailed schemes at operational provider level with clear lines of accountability for delivery, to enable implementation by April 2020. The financial challenges within this system are significant, and so progress in implementation of efficiency schemes needs to occur at pace.

3. Reportable Issues Log

Issues occurring between 29/12/19 and 29/1/20

3.1 Serious Incidents and Never events

We have reported no serious incidents this month.

3.2 Level Four and Five Complaints

There have been no recorded level four and five complaints reported this month.

3.3 Regulation 28 Reports

No concerns were detailed in HM Coroner reports.

3.4 Whistleblowing

None to report

4. Media Coverage

Thanks to the kindness of local residents and businesses, our children's department at Ormskirk hospital was inundated at Christmas with donations of toys, chocolates and even two computer consoles.

Thank you to the Co-Op, Iceland, Asda, Morrisons and Southport Football Club.

5. Board Assurance Framework

The full Board Assurance Framework (BAF) is currently under review in preparation for the new financial year. The BAF will be used to record and report the risks to the achievement of the Trust's strategic objectives, the controls to reduce or mitigate these risks, and identifying any gaps in these controls ensuring that the assurance and controls are effective.

The revised BAF will reviewed in detail at the March Board.

Trish Armstrong-Child
Chief Executive
5 February 2020

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
5 FEBRUARY 2020

Agenda Item	**TB007/20a**	**Report Title**	**Quality Improvement Programme**
Executive Lead	Juliette Cosgrove, Director of Nursing		
Lead Officer	Jo Simpson, Assistant Director of Quality Amanda Locke, Programme Manager, PMO		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	X To Note ☐ To Receive	

Executive Summary

The purpose of this report is to provide the Trust Board with assurance on the progress of delivery of Southport and Ormskirk Hospital NHS Trust's (the Trust's) Quality Priorities and an overview of the Quality Improvement Plan (QIP) for 2020/21 and the governance process that has been refined to oversee and facilitate delivery.

The report provides the Board with an overview of the work the Trust has undertaken to review progress to date, and the work currently underway to agree detailed delivery plans, critical milestones and quality improvement metrics for its four quality priorities. This work will be complete and reported to Board at its meeting in April 2020.

The Trust Board is asked to note the refresh that took place during December, and to further note the ongoing work that is scheduled throughout January and February to refine the detailed delivery plans for each of the priorities and agree appropriate progress and performance reporting for 2020/21.

The Board is asked receive the summary highlight report for each of the four quality priorities, which will be used for assurance to meet 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
X	**SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	*If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.*
X	**SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*

☐ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*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**
X Caring	☐ Statutory Requirement
X Effective	☐ Annual Business Plan Priority
X Responsive	X Best Practice
X Safe	X Service Change
☐ Well Led	
Impact *(is there an impact arising from the report on any of the following?)*	
☐ Compliance	☐ Legal
☐ Engagement and Communication	X 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)*	
Not applicable. Progress against the plans agreed for the Quality Improvement Programme will be presented to Trust Board on a monthly basis.	
Previously Presented at:	
☐ Audit Committee	X Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee

☐	Finance, Performance & Investment Committee	☐	Workforce Committee

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Quality Improvement Programme Update January 2020

1. Purpose of Report

The purpose of this report is to provide the Trust Board with assurance on the progress of delivery of Southport and Ormskirk Hospital NHS Trust's (the Trust's) Quality Priorities and an overview of the Quality Improvement Plan (QIP) for 2020/21 and the governance process that has been refined to oversee and facilitate delivery.

2. Quality Improvement

The QIP is an integral part of the Trust's Vision 2020 Programme. The QIP identifies four quality priorities. An overview of the quality priorities is tabled below.

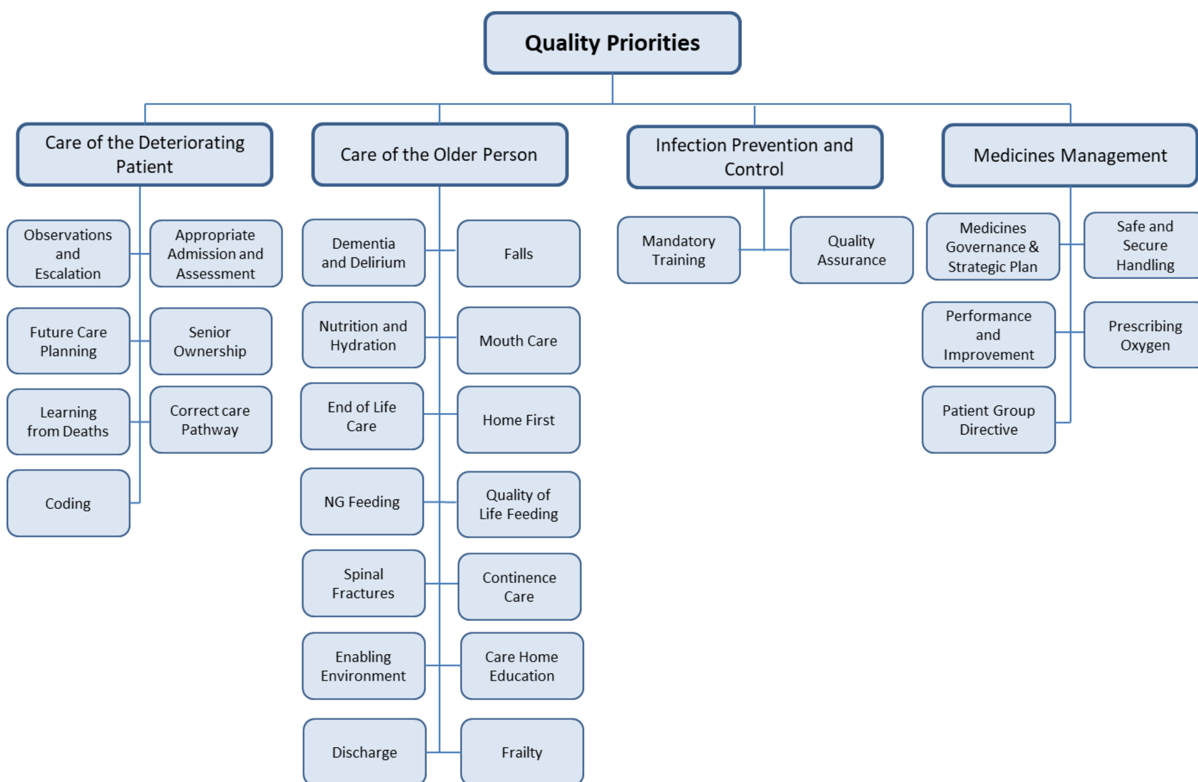
Quality Improvement Programme: Four Quality Priorities

Quality Priority	Overarching Aim	Headline Outcomes
Medicines Management Executive Lead: Dr T Hankin Programme Lead: J Williams	Deliver a safe and optimum acute medicines management system from admission to discharge	Patients receive the right medication at the right time
Care of the Deterioration Patient Executive Lead: Dr T Hankin Programme Lead: Dr C Goddard	Reduce the average time for the recognition, review and treatment of the deteriorating patient by April 2021	Deteriorating patients receive the right care, in the right place and at the right time More people are supported to die in their preferred place
Care of Older People Executive Lead: J Cosgrove Programme Lead: M Langley	Reduce length of stay, re-admission rates and incidence of harm from care of older people	More people are supported to die in their preferred place Overall length of stay for older people is reduced Patients' experience of care, and their outcomes, are improved
Infection Prevention and Control	Prevent and reduce healthcare associated	Reduction in the number of

Quality Priority	Overarching Aim	Headline Outcomes
Executive Lead: Dr T Hankin Programme Lead: A Chalmers	infections and to ensure that outbreaks are effectively and appropriately managed in line with Trust policy	hospital acquired infections 85% compliance with statutory and mandatory training

The structure of the QIP, including the individual work streams that make up each of the priorities is illustrated below.

Quality Improvement Plan – Programme Structure



Throughout quarter four of 2019/20 the Quality Improvement Plan will be reviewed and the detailed delivery plans for the financial year 2020/21 for each of the quality priorities will be agreed. In parallel, the current governance arrangements for the programme will also be refreshed and restated across the Trust to ensure that a robust, executive led framework is in place to oversee the progress against plans and the delivery of outcomes for each of the four quality priorities.

During December, in advance of the refresh of the QIP, the project documentation for each of the quality priorities has been reviewed and updated in light of both the progress made during 2019/20 to date, and the recommendations made in the Care Quality Commission Inspection report published in November 2019. The review has confirmed that the four priorities will remain as the focussed areas of the Quality Improvement Plan into 2020/21.

A Programme level Gantt chart that sets out the high level timeframes for the delivery f each of the individual work streams within the quality priorities for 2020/21 is tabled overleaf.

Quality Improvement Programme Headline Gantt Chart

Programmes and Work streams		Project Lead	Start Date	End Date	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
QP 1 - Care of the Deteriorating Patient																			
QP100	1. Appropriate Admission and Assessment	C Goddard	02.01.20	31.03.2021															
	2. Senior Ownership		01.06.19	31.03.2021															
	3. Correct Care Pathways		01.03.19	31.03.2021															
	4. Observations and Escalation		01.08.19	30.06.2020															
	5. Future Care Planning		02.01.20	31.03.2021															
	6. Learning from Deaths		01.03.19	31.03.2021															
	7. Coding		14.01.20	31.10.2020															
QP 2 - Care of the Older Person																			
QP201	1. Nutrition and Hydration	M Langley	01.08.19	31.08.20															
QP202	2. Frailty		01.08.19	Ongoing															
QP203	3. Falls		01.08.19	2 year project															
QP204	4. Enabling Environment		01.08.19	31.08.20															
QP205	5. Dementia and Delirium		01.08.19	2 year project															
QP206	6. Discharge Pathways and Flow		01.02.20	TBC															
QP207	7. Continence		16.04.19	31.07.19															
QP208	8. Spinal Fractures		01.08.19	30.04.20															
QP209	9. Mouth Care		01.08.19	30.04.20															
QP210	10. Home First		01.08.19	31.09.20															
QP211	11. NG Feeding		01.08.19	30.07.20															
QP212	12. Quality of Life Feeding		01.08.19	30.07.20															
QP213	13. Care Home Education		01.08.19	Ongoing															
QP214	14. End of Life Care		01.08.19	2 year project															
QP 3 - Infection Prevention & Control			01.03.19	Ongoing															
QP300	1. Mandatory Training	A Chalmers	01.01.20	Ongoing															
	2. Compliance/ Quality Assurance		01.01.20	Ongoing															
QP 4 - Medicines Management			24.07.2019	30.06.2021															
QP400	1. Safe & Secure Handling of Medicines	J Williams	24.07.19	31.12.2020															
	2. Controlled Drugs		01.09.19	31.07.2020															
	3. Governance, Reporting and Assurance		01.12.19	31.10.2020															
	4. Workforce and Leadership		01.12.19	31.08.2020															
	5. EPMA (IT Project)		31.03.20	30.06.2021															
	6. Automated Ward Drugs Storage Systems		(IT Projects dependent upon successful business cases submitted as part of Business Planning 20/21)																
	7. Pharmacy Automation - Falsification of Medicines Directive (FMD)																		
	8. Centralised Temperature Monitoring																		

Project initiation documents, which provide the strategic rationale and detailed description of the each of the quality priorities were revised in December and presented for challenge at the Quality and Safety Group on 6 January. In response to feedback received each of the priorities is being developed further and detailed delivery plans, including critical milestones, key performance indicators and quality improvement metrics will be presented to Quality and Safety Group in March 20.

Summary highlight reports for each of the priorities are detailed in section 4 of this paper.

3. Governance

The governance arrangements to oversee the delivery of the programme overall and each of work streams 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.

4. Quality Priorities Summary Highlight Reports

Medicines Management

<table>
<tr><th colspan="8">Medicines Management</th></tr>
<tr><td colspan="8">An updated Programme Initiation document (PID) was reviewed by the Quality and Safety (Q&S) Group in January. Project delivery plans to be reviewed during January and presented to Q&S Group for confirm and challenge in February.

Business case for the recruitment of additional front line Pharmacy staff has been approved. The recruitment process has commenced and is expected to take between 3 to 6 months to complete. Proposals for enhanced weekend working have been developed. A detailed paper has been presented at JNC and engagement sessions with staff have been scheduled throughout February in collaboration with Trust HR and the unions. Extended opening hours have been put in place to commence in January.

EPMA MOU has been signed. IT project manager has been agreed. EPMA Pharmacist and IT spend to be approved in January.</td></tr>
<tr><th>Quality Strategy KPI's:</th><th>Target</th><th>Actual</th><th>YTD Actual</th><th>RAG</th><th>Trend</th><th>Trajectory RAG</th><th>Comments</th></tr>
<tr><td>Medication Errors (Moderate and above Harm)</td><td>0</td><td>0</td><td>0.8</td><td>●</td><td>v</td><td>○</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><th>Milestone</th><th>Start Date</th><th>End Date</th><th>Lead</th><th>Completion %</th><th>BRAG</th><th colspan="2">Progress</th></tr>
<tr><td>3, 6 & 9 Month Improvement Plan included within the Safe and Secure handling of medicines plan</td><td>Dec-19</td><td>Jan-20</td><td>J Williams</td><td>100%</td><td>Green</td><td colspan="2">Plan to be presented at Q&S Group in February</td></tr>
<tr><td>Weekly Meetings established</td><td>Dec-19</td><td>Jan-20</td><td>J Williams</td><td>85%</td><td>Green</td><td colspan="2">Matrons' checklists/ SONAAS/Pharmacy Safe & Secure Medicines Audits submitted to Medicines Safety Committee</td></tr>
<tr><th>Risk</th><th>RAG</th><th colspan="3">Mitigating Actions</th><th>RAG</th><th colspan="2">Comments</th></tr>
<tr><td>EPMA - there is risk that the implementation of the EPMA system will be further delayed</td><td>Red</td><td colspan="3">Dedicated resource to oversee and deliver the implementation has been requested.</td><td>Green</td><td colspan="2">IT project management resource confirmed</td></tr>
<tr><td>Workforce and Leadership - There is a risk that there is insufficient resource to deliver change programme</td><td>Red</td><td colspan="3">External support to deliver change has been secured. Scope of the delivery plan has been agreed. Detailed plan and timeline to be confirmed</td><td>Amber</td><td colspan="2">Names, roles and responsibilities of those to be involved in recruitment plan to be confirmed.</td></tr>
</table>

<u>Recognition and Care of the Deteriorating Patient</u>

Recognition and Care of the Deteriorating Patient							
An updated Programme Initiation document (PID) was reviewed by the Quality and Safety Group in January. In response to feedback, National Early Warning Signs (NEWS) data will be included in the project performance reporting to ensure the Trust maintains a quality improvement focus on the recognition and subsequent proactive management of deteriorating patients. The Assessment and Admission and Future Care Planning work streams that were previously part of the programme will now be delivered through the Older Peoples Care Programme. A project to develop a Cross Setting Anticipatory Care Management Plan has been included which will feed into the Older Peoples Care work. Milestones and a detailed project plan for the 2020/21 work programme is being developed and progress will be reported in February. Initial review of ward level data indicates that the quality improvement cycle implemented on ward 9a has not been sustained. Meetings have been scheduled during January to both understand the factors that have prevented improvement from being sustained, and to learn from good practice on those wards that are demonstrating improved performance. An update, including actions to address the issues found will be reported in February.							
Integrated Performance Report Indicators:	**Target**	**Actual**	**YTD Actual**	**RAG**	**Trend**	**Trajectory RAG**	**Comments**
Percentage of deaths screened	100%	90.70%	65%	● (red)	▲	○	
Summary hospital-level mortality indicator (SHMI)	100	99.6	100.7	● (green)	▼	○	
Rolling 12 month hospital standardised mortality rate (HSMR)	100	91.0	91	● (green)	▼	○	
Milestone	**Start Date**	**End Date**	**Lead**	**Completion %**	**BRAG**	**Progress**	
Coding and Documentation - Undertake scoping session	Dec-19	Mar-20	R Kinney	15%	Amber	Initial scoping completed. Meeting in Jan to evaluate comorbidity alerting process SSU	
PDSA Cycle Review - Timely observations - Ward 9a	Dec-19	Feb-20	C Goddard	10%	Amber	Jan meeting to understand work undertaken and factors contributing towards improvement not being sustained.	
Risk	**RAG**	**Mitigating Actions**			**RAG**	**Comments**	
Nurse Training - Care of the Deteriorating Patient. There is a risk that without dedicated resources appropriate staff will not have the skills to recognise and care for deteriorating patients in line with Trust standards	Red	Meeting is scheduled for January to discuss the resource allocation and capacity to deliver, and release nursing and care staff for training			Red	Update provided in Feb following meeting to confirm resource allocation.	
Electronic Ward Boards - IT Development There is a risk that a lack of capacity in the IT department will cause further delays to the roll out of the Electronic Ward Boards	Red	Meeting in January with the IT Implementation Lead to identify additional resource			Red	IT support for Electronic Ward Board delayed due to a lack of capacity.	

Care of Older People

Care of Older People							
Roll out of Get up, Get dressed, Keep moving has paused due to refurbishment work on ward 9A. Roll out is being reviewed with a reschedule in Jan 20. The team continue to develop an activity planner and patient information leaflets. Nutrition policy and care plan being revised and will be shared with the NHMCG in Jan 20 before launch. Lead dietitian has been recruited to and has started in post. New roll-out plan will be shared following approval of the policy and care plan. Mouth Care Matters continued to be rolled out across the Trust throughout Dec 19. Roll out complete on 5 wards by end of Jan 20. Dementia and Delirium Team have commenced the roll out of the new risk assessment and care plan for cognitive impairment, identifying patients with a diagnosis of dementia or who are diagnosed with delirium and delivering training to Trust staff at Tier 2. New continence assessment, care plan and product bank being launched and trial planned on wards 7A and 7B from 6th January for 1 month before feedback and amendments are made, then the further roll-out planned. West Lancashire HomeFirst pathway regularly achieving target of 6 patients per week. Southport and Formby HomeFirst Pathway has been agreed and launched on 6th January 2020. Falls Improvement Plan approved and launched, trial of two new sets of alarms commences on 6th January on wards 9B and 14A. New risk assessment, care bundle rolled out across the organisation. Discharge Quality - First meeting to review the End of Life pathways has taken place, next meeting scheduled for Jan 20 to review other pathways and a third meeting to review the documentation and communication before then setting an action plan based on outcomes.							
Integrated Performance Report Indicators:	**Target**	**Actual**	**YTD Actual**	**RAG**	**Trend**	**Trajectory RAG**	**Comments**
Falls - Moderate / Severe / Death	1	1	12	●	⌄	○	
Fractured Neck of Femur	90%	83.30%	72.70%	●	⌄	○	
Milestone	**Start Date**	**End Date**	**Lead**	**Completion %**	**BRAG**	**Progress**	
Frailty Model	2019/20	2020/21	M Langley	60%	Green	Business case approved and recruitment commenced. S&F Care Home Forum established	
Dementia and Delirium	2019/20	2020/21	M Langley	60%	Green	Identification of cognitive impairment, risk assessment and care plan complete Draft pathway for 24 hour care in final draft Dementia E-learning available to all staff Ward resource pack developed, a charitable funds bid is required to purchase items. Dementia and Delirium Team are in post.	
Risk	**RAG**	**Mitigating Actions**			**RAG**	**Comments**	
Inability to discharge patients home due to lack of resource to support HomeFirst in S&F.	Red	Meetings continue with system partners to progress.			Amber	Confirmed launch S&F on 6th January	
Difficulty in recruiting to the Older Peoples Model.	Red	Recruitment strategy discussed as part of the agenda on the OPSG meetings.			Amber	Alternative attempts to recruit and model are underway incl. new pathway trial in Feb	

Infection Prevention and Control

Infection Prevention and Control							
An updated Programme Initiation document (PID) was reviewed by the Quality and Safety Group in January. In response to feedback the detailed work programme for 2020/21 will be revised during January to ensure a focus on targeted areas for improvement. The Trust has chosen infection prevention and control as one of it's 4 Quality Priorities, we've been able to identify 2 main work streams that focus around mandatory training and compliance/quality assurance. Within those two work streams there are number of smaller projects that are being undertaken to ensure overall as a Trust we improve our Infection Prevention and Control.							
Integrated Performance Report Indicators:	**Target**	**Actual**	**YTD Actual**	**RAG**	**Trend**	**Trajectory RAG**	**Comments**
MRSA	1	0	1	●	→	●	
C-Diff	1.33	2	21	●	↓	●	
Milestone	**Start Date**	**End Date**	**Lead**	**Completion %**	**BRAG**	**Progress**	
AQuA Project in 3 wards - Reducing catheter usage. This is aiming to reduce catheter days in the wards to	Nov-19	Feb-20	P McCallum		Green	Currently running on Ward 7B/15A/15B to reduce catheter bed days.	
ANTT Training within the Trust. Primary area to concentrate on is A&E Department.	Jan-20	Mar-20	A Chalmers		Red	Information to be collated on who requires training, who has had the training	
Risk	**RAG**	**Mitigating Actions**			**RAG**	**Comments**	
Need funding for Abx App	Amber	Dr Gray provided documentation the Trust and Jo Simpson is organising funding			Green		
Run out of isolation signs for Maternity side rooms on ODGH site	Red	Discussed with ODGH Maintenance manager - who will escalate to Interim Estates Manager			Green		

5. Recommendation

The Trust Board is asked to note the refresh that took place during December, and to further note the ongoing work that is scheduled throughout January and February to refine the detailed delivery plans for each of the priorities and agree appropriate progress and performance reporting for 2020/21.

The Board is asked receive the summary highlight report for each of the four quality priorities, which will be used for assurance to meet both internal and external requirements.

Complaints & Compliments

December 2019

1.0 Introduction

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

2.0 Compliments

The compliments received across the trust related to the quality of care received by patients, communications with relatives & patients, staff behaviour, attitude, staff availability & competence, also related to privacy & dignity.
Planned Care Business Unit received the most compliments with 51 in total and the Anaesthetics Pain Clinic receiving 14.

Urgent Care Business Unit received 23 Compliments, with the Short Stay Unit receiving the highest number (7), followed by the Cardiac Rehab (4).

Women & Children's Business Unit received 14 compliments, of which 7 related to Maternity and 5 to Neonatal.

The compliments are put onto the Datix system by the Business units and are shared within the area.

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 16 formal complaints were received in December.

Urgent Care received the highest number, with 10 received in month, with A&E receiving 4 in month. Specialist Services received 4 complaints, of which 2 related to Maternity Ward. Planned Care received 2 complaints in December.

The following themes were identified:

- Clinical Treatment – in particularly co-ordination of medical treatment and alleged wrong diagnosis
- Staff attitude/behaviour
- Verbal communication
- Basic care including help with washing/dressing/mobilising
- Patient not fit for discharge

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

The Trust has a target of 40 days for complaints to be investigated and closed; the current average number of days to close complaints across the Trust is 79 days.

Improvements identified

There have been 27 complaints closed during the month of November and December, there has been some key areas of improvement work been identified through the complaints process.

Within the Trust, there has been an increase in the number of complaints relating to the discharge process, a project group has been taken forward with external stakeholders to review issues and also an internal project group to review internal processes re discharge.

In order to support staff customer services training has been commissioned to be delivered to front line staff through the training and education department. The key aim is to improve communications and staff attitude and behaviour.

The following are areas where improvement has been highlighted

- Sharing of learning through lessons learned bulletin and personal reflection by the medical staff following a complaint about a diagnosis which the parents felt was not managed appropriately
- Review of safeguarding processes, including documentation following a complaint about poor communications
- Development of a task and finish group to focus on patient property. Following a request by the Trust, Mersey Internal Audit Authority are also currently auditing processes in relation to patient's property

The process of reviewing the complaints and identifying actions of improvement have been reviewed through the complaints review group and an action plan will be required for complaints going forward to demonstrate our improvements and changes in practice.

2.2 Concerns

There have been a total number of 53 concerns raised in December. The themes are shown below:

- Communication (12)
- Appointment dates (7)
- Clinical treatment (6)
- Requests for information (9)
- Staff attitude/behaviour (6)
- Patient lost property (4)

3.0 Conclusion

The numbers of complaints and concerns are decreasing; however, some of the same themes are being observed e.g. discharge, customer service/staff attitude. These themes are subject to key areas of improvement work within the Trust.

Southport and Ormskirk Hospital NHS Trust

Public Trust Board

5 February 2020

Agenda Item	TB007/20c	Report Title	Learning from Deaths Report (Formerly the Monthly Mortality Report)
Executive Lead	**Dr Terry Hankin,** Medical Director		
Lead Officer	**Dr Chris Goddard,** Associate Medical Director of Patient Safety		
Authors	**Mike Lightfoot,** Head of Information **Rachel Flood-Jones,** Project Delivery Manager		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

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.

This is the monthly Learning from Deaths Report which gives assurance to the Board on Learning from Deaths activity to reduce avoidable deaths. It reports on national mortality ratios and local Hospital Summary Mortality Rates by condition.

The report allows the Board to be sighted on the trajectory of mortality ratios and attributes contributing factors. It provides assurance on the implementation of the Structured Judgement Review across the Trust and the outcome of its findings. Assurance is also given on the delivery of the External Mortality Review Action Plan.

Compliance to the SJR process and associated improvement work is ongoing through the Recognition and Care of the Deteriorating Patient Programme. Mortality ratios and Advanced Quality performance measures will continue to be monitored through the Mortality Operational Group and reported to the Quality and Safety Committee and the Trust Board with assurance of ongoing quality improvement.

Recommendations
The Board is asked to **receive** the paper.

1.0 Executive Summary

System pressure is high, this impacts adversely on the causes of mortality such as impaired A&E flow, over populated hospitals, high agency usage and outlying patients. These aspects are being further evaluated.

2.0 Mortality Indicators

- Summary Hospital-level Mortality Indicator (SHMI): 12 month rolling published up to July 2019 was 99.1
- Hospital Standardised Mortality Ratio (HSMR): Rolling 12 month and in month for August 2019 was 88.3
- Disease-Specific Mortality Ratios are reported for August 2019

3.0 Mortality Improvement Activity

Highlights of the new Recognition and Care of the Deteriorating Patient Programme as at January 2020.

4.0 Learning from Deaths: Structured Judgement Reviews (SJRs)

Screening rates, first and second stage SJRs and thematic reviews from SJRs are summarised.

5.0 Conclusions

6.0 Recommendations

7.0 Appendices

Appendix 1: The External Mortality Review Board Assurance Action Plan: January 2020
Appendix 2: Recognition and Care of the Deteriorating Patient Project Highlight Report January 2020
Appendix 3: Mortality Dashboard.(Dr Foster Mortality Data) January 2020
Appendix 4: Distribution Performance Graph, May & June 2019
Appendix 5: Mortality Indicators for August 2019

Strategic Objective(s) and Principal Risks(s)
(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

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

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

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

Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance ☐ Engagement and Communication ☐ 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)*
The Quality and Safety Committee did not run in January 2020 which means that contrary to the usual governance process, this report has not been presented to the Quality and Safety Committee.

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

1. Executive Summary

- The current headline figures, whilst favourable, are subject to change. Numbers of deaths have increased in the past month, this may be seasonal change, and is being driven by sepsis, mainly respiratory.
- System pressure is high, this impacts adversely on the causes of mortality such as impaired A&E flow, over populated hospitals, high agency usage and outlying patients. These aspects are being further evaluated.
- 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?
- Screening of deaths has reduced as a percentage, but the actual number of screens is static. This is likely to represent increased clinical demand on medical staff and the holiday period.
- 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

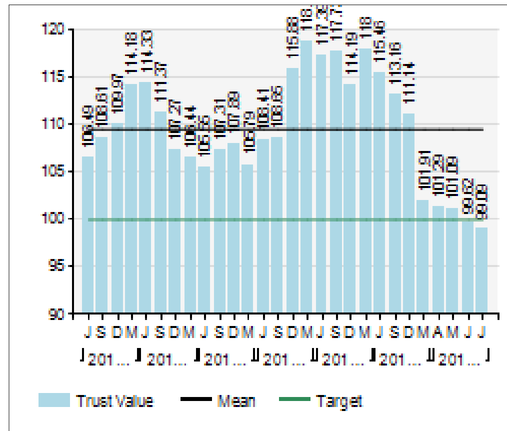
	2018/19				2019/20								Target
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	
Rolling 12 Month HSMR	112.0	102.9	98.7	94.8	96.3	98.3	95.6	91.2	88.3				*100.0*
Monthly HSMR	105.3	84.7	81.5	82.8	121.0	102.1	64.8	70.7	60.8				*100.0*
SHMI	111.1			101.9	101.3	101.1	99.6	99.1					*100.0*
Local HSMR Bronchitis	138.1	133.0	118.4	105.9	116.2	115.8	114.1	100.6	106.9				*100.0*
Local HSMR LRTI	138.9	134.1	119.5	106.8	120.8	116.8	115.1	101.5	107.8				*100.0*
Local HSMR Pneumonia	120.1	112.6	104.8	103.7	110.2	108.3	104.2	97.7	92.7				*100.0*
Local HSMR Septicemia	90.2	81.1	79.1	80.0	79.5	75.6	75.6	72.7	70.6				*100.0*
Local HSMR Stroke	112.0	100.3	100.2	103.5	105.5	98.0	95.6	100.6	98.2				*100.0*
Local HSMR UTI	120.0	106.2	109.0	80.0	84.2	91.7	85.5	76.0	73.0				*100.0*
Local HSMR Acute Renal Failure	128.8	126.8	115.0	101.3	112.8	113.9	118.1	106.7	115.4				*100.0*
Mortality Screens - %	50.62%	64.52%	61.67%	47.22%	35.16%	32.93%	58.33%	89.83%	84.62%	90.48%	90.67%	78.75%	*90.00%*
SJRs	6.0	4.0	5.0	9.0	5.0	2.0	6.0	4.0	8.0	22.0	13.0	8.0	*0.0*
2nd Review	0.0	0.0	0.0	0.0	0.0	3.0	0.0	2.0	1.0	1.0	1.0	0.0	*0.0*
In Hospital Deaths	81.0	94.0	60.0	72.0	91.0	82.0	48.0	60.0	52.0	63.0	75.0	80.0	*77.0*
In Hospital Deaths Crude Rate	24.5	27.5	19.2	21.6	30.2	25.6	16.0	17.8	15.4	19.4	21.4	22.8	*31.0*
LD Deaths	0.0	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	*1.0*
Sickness Absence Medics	1.04%	2.22%	2.80%	3.32%	2.82%	2.08%	1.75%	2.11%	0.57%	0.92%	0.91%	2.71%	*1.00%*

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

The actual numbers of deaths in November has risen, and daily data for December also shows a sustained rise on the previous year. The crude mortality rate for November however remains at 22.8%. Analysis of the underlying data shows the signs of a system under stress, deaths from ward outliers have risen and AED waiting times continue to rise. Patients with longer AED waits have a higher mortality rate. Further work will be undertaken to understand this interplay and will be reported subsequently.

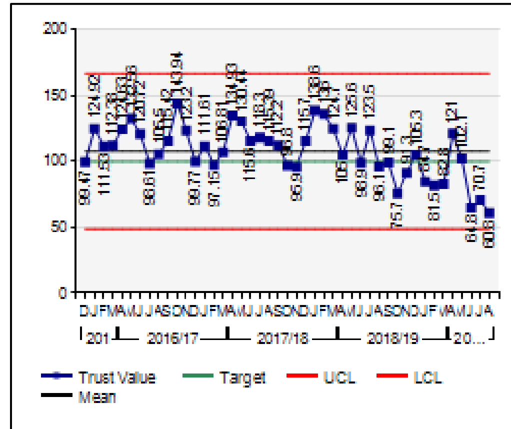
The impact of this on the headline mortality figures (HSMR and SHMI) is as yet unknown.

2.2 SHMI (*to May 19*)



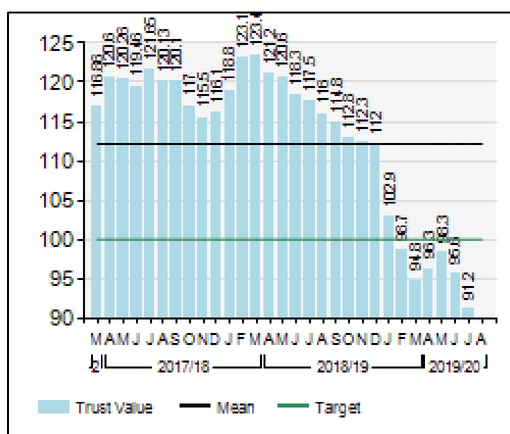
The SHMI is now presented monthly due to a change in process by NHSX. SHMI includes all diagnosis codes, deaths within 30 days of discharge and deaths of patients receiving palliative care. The currently reported figure is within the expected range.

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



The in-month HSMR is reported for August 19. This is 60.8 suggesting less deaths than would be expected on the HSMR model. This model excludes palliative patients and deaths after discharge. System performance in August with respect to deterioration response and mortality was good, but deaths in low acuity (low NEWS 2 scores) represented a high proportion. This will be investigated further.

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



Rolling HSMR to August 2019 is 88.3, and sits within the expected range.
Areas of analysis:

1. Deaths by diagnosis group (see below)
2. Deaths after elective procedures. This was discussed in the November MOG and an analysis has been completed. The deaths reported where overwhelmingly from patients with haematological malignancy receiving outpatient top-up transfusions (this is coded as a procedure). There was one death after discharge of a high risk patient having joint replacement surgery. More information will be obtained on this case from the community.
3. Waiting times to be seen in AED. Patients with long AED waits (>4hours) have a higher mortality rate than those with shorter one (<4hours). Further work is needed to understand this issue better.
4. Rising deaths in low acuity (low NEWS score) patients will be evaluated further.

2.5 Diagnosis Groups

Respiratory: LRTI and Acute bronchitis have a low risk of death as conditions, and thus any deaths from this cause a rise in HSMR. Reviews have shown that The LRTI / Bronchitis usually causes a decompensation of an underlying significant pathology (such as heart failure or pulmonary fibrosis for example). Improvement work is focused around identifying these co-morbidities so they can be actively managed.

Renal Failure: Understanding here remains limited. The AQ focus areas of appropriate use of urinalysis, critical care review of AKI3, stopping of nephrotoxic medication, rehydration, repeat blood testing and self-management advice on discharge remain the KPIs to improve. Investigation of the AKI process by MIAA is ongoing and internal review of a cohort of deaths coded as due to AKI (acute renal failure) is ongoing.

3. Mortality Improvement Activity

3.1 Update on Recognition and Care of the Deteriorating Patient Programme

The Programme Initiation Document for the Recognition and Care of the Deteriorating Patient Programme was reviewed at the Quality & Safety Group, 6th January 2020. In

response to feedback, the aims and work streams have been reviewed; the new structure is reported below.

Project within the RCDP Programme	Progress and achievements this month
1.Observations and Escalation	Best practice has been identified through PDSA cycles for observations compliance on the wards. Detailed process mapping is taking place 30th January with senior nursing staff from the Short Stay Unit, ITU and Medical Ward, 14B. VitalPac reporting is informing compliance levels and is being used to monitor progress against PDSA cycles and will inform Project KPIs going forward. Clarity of best practice processes, supported by defined roles and responsibilities will drive and embed best practice culture. IT Fixes are still awaited from System C to realign the reporting of compliance times for Early Warning Scores 7+ with the Trust's (Track and Trigger) Policy. Clarification is being sought on the long term plans for AIMS and Red Day Training for the care of deteriorating patients.
2. Correct Pathways of Care	The method of delivery for this project will be through following framework: • Access to Diagnostics • Access to / Training in Current Best Practice Guidance • Early Intervention • Ergonomic Process Design Pneumonia and AKI are current focus with the other key conditions phased over the life of the project. The project group will be represented on 23rd January at the quarterly AQUA Mortality Community Improvement Event to ensure continued learning and the adoption of best practice.
3. Documentation & Coding	The scope of the Documentation & Coding Project was confirmed at the meeting of 9th January. An evaluation of the Comorbidity Alerting Process on Ward 9A (Short Stay Unit) is being undertaken with a view to rolling onto a second medical ward before the end of February. One of the project's drivers is complete and correct documentation to ensure accurate and full coding. The remit of this work stream is to specifically address improved recognition of comorbidities, improved diagnoses and treatment plans. All activity will be undertaken coherently with the Trust's Documentation Programme, (which was relaunched with a

	new Programme Lead on 8th January.)
4. Senior Ownership	Work is being undertaken to secure resource to make the required IT fixes to complete the Electronic Ward Board PDSA. A meeting to confirm a timeline for the required support is set for 24th January. Resource is expected to be available from March 2020.
5.Learning from Deaths	All primary and secondary drivers have been confirmed for this work stream; the working group is meeting to finalise the detail and activity now required. The clarification of roles and responsibilities for the SJR process (including that of the Medical Examiner) are to be incorporated alongside the standardisation of Mortality and Morbidity Meetings within the Clinical Business Units. Work is already ongoing in these areas however the project will streamline and refocus attention to ensure progress and delivery within the calendar year.
6. Cross Setting Anticipatory Clinical Management Plan	This new project replaces two that were initially included at the end of the Reducing Avoidable Mortality Project, (Appropriate Assessment and Admission and Future Care Planning.) Both work streams are now picked up under the Older People's Care Programme. Talks between programme leads have now concluded and clearly delineated / mutually supportive scopes have been confirmed. The remit for this project is to engage and consult with the Trust and system partners to design a Cross Setting Anticipatory Clinical Management Plan. This will require a defined data set and processes for storage and alerts. Once confirmed, a plan to roll out and embed will be required in partnership with the Older People's Care Programme Team who will be delivering all associated training.

4. Learning from Deaths: Structured Judgement Reviews (SJR)

4.1 Screening

Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review	No reviewed	% reviewed	Excellent Care	Good Care	Adequate Care	Poor Care	Very Poor Care	N/A - Not Stated
Dec-18	81	41	50.6%	7	17%	7	100%	1	6				
Jan-19	94	60	63.8%	13	22%	10	77%	1	3	4	1	1	
Feb-19	60	38	63.3%	4	11%	4	100%	1	1	1	1		
Mar-19	72	32	44.4%	9	28%	9	100%		7	2			
Apr-19	91	33	36.3%	6	18%	5	83%	1	4				
May-19	82	27	32.9%	6	22%	6	100%		2	2	1	1	
Jun-19	48	26	54.2%	9	35%	7	78%	1	3	1	2		
Jul-19	59	53	89.8%	11	21%	9	82%	1	5	3			
Aug-19	52	44	84.6%	13	30%	9	69%		4	4	1		
Sep-19	63	57	90.5%	18	32%	7	39%	1	3	3			
Oct-19	75	68	90.7%	19	28%	1	5%		1				
Nov-19	80	66	82.5%	15	23%	0	0%						
Dec-19	102	65	63.7%	24	37%	0	0%						

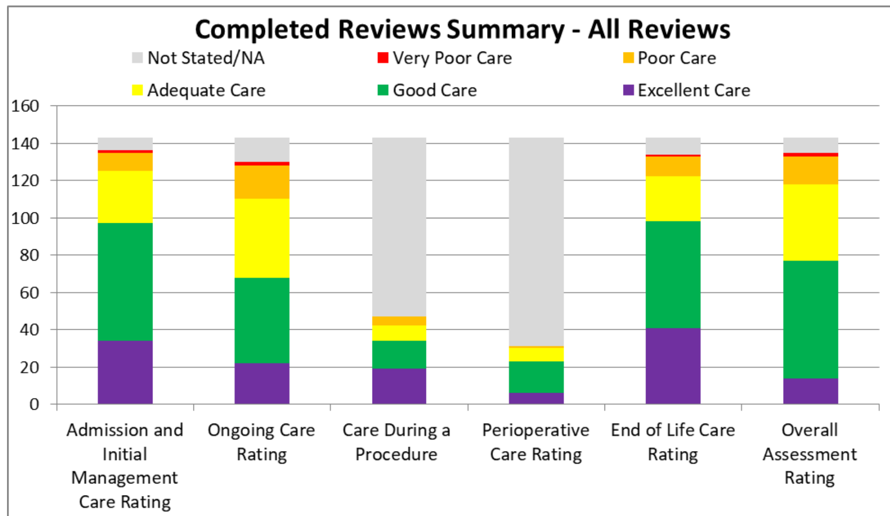
The screening rate for December 2019 has fallen to 63%, the number of deaths screened has remained static at 65. There has been a significant increase in the number of deaths to 102 in this month, reflecting the seasonal nature of mortality and the probable impact of this winters' severe Influenza. A process to remind and ensure completion of screening will be scoped, together with the implementation of the medical examiner system.

4.2 First Structured Judgement Review

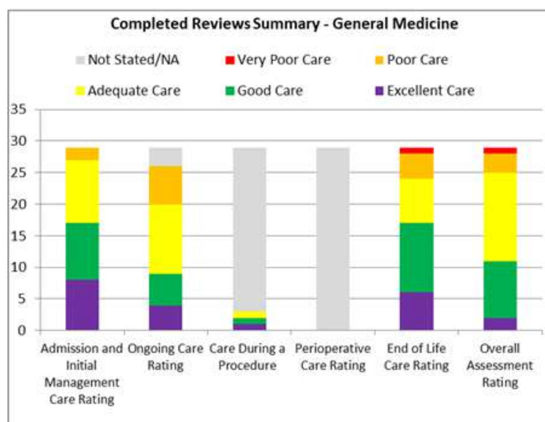
Completed First Structured Judgement Reviews

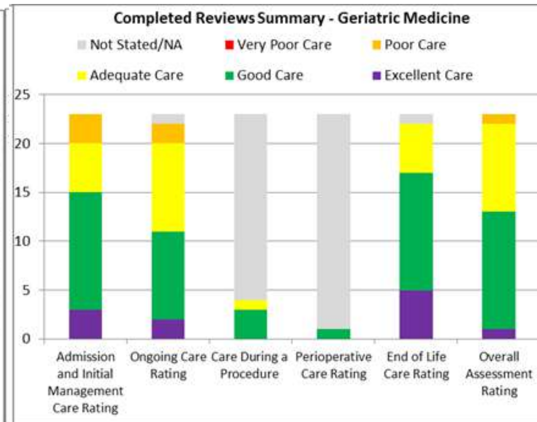
	Date of Review																		
	2018						2019												Grand Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
General Medicine				4	4	1	1	1	3	2				2	5	3	1	2	**29**
Geriatric Medicine			1	3	1	2	1	3	2		1		1	1	3	1	1	1	**22**
Intensive Care/Coronary Care/High Dependency	1	2	1	3	1	1	1		3		1	2	1		2	1			**20**
Respiratory Medicine/Thoracic Medicine				1	1				2	2		1		2	3	1	2		**15**
Trauma & Orthopaedics		1	1	1									1		6	5			**15**
Stroke						2						1		1	1		2	2	**9**
Cardiology				2	1							2	1	1	2			1	**10**
Gastroenterology							1			1						2		1	**5**
Urgent Care														1			3		**4**
Urology								1				1	1		1				**4**
A&E														1	1		2		**4**
Endocrinology														1			1		**2**
Grand Total	**1**	**3**	**3**	**14**	**8**	**6**	**4**	**5**	**10**	**5**	**2**	**7**	**5**	**10**	**24**	**13**	**12**	**7**	**139**

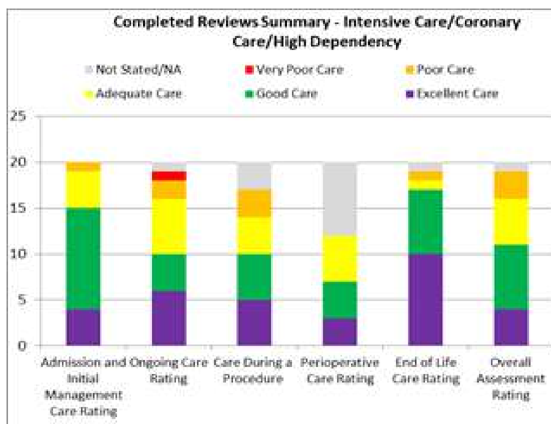
A substantial amount of reviews are occurring each month, as a proportion of deaths, this is staying in line with the annual target of reviewing 10-20% of in-hospital deaths.

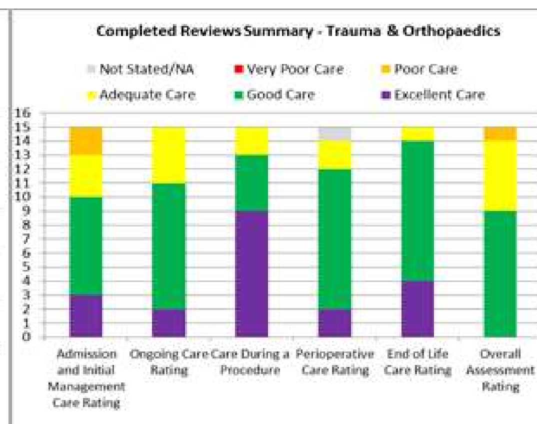


Graphical presentation of all reviews performed demonstrates that ongoing (or ward based) care, in the opinion of our reviewers, is where a patient is most likely to experience 'poor' or at best 'adequate' care. Improvement work on observation, intervention and escalation is ongoing, as is structural improvement in IT to enable this.









This is also highlighted when broken down by areas with 15 or more reviews. Planned analysis of this is:

1. Poor ongoing care cases in medicine
2. Poor / very poor ongoing care cases in Critical Care
3. Excellent end of life care cases in critical care.
4. Excellent procedure care cases in orthopaedics.
5. Poor initial assessment cases in Orthopaedics.

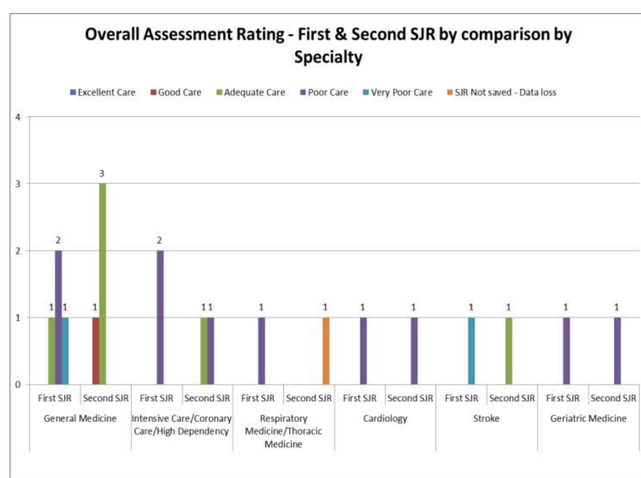
6. Poor initial assessment cases in Medicine.

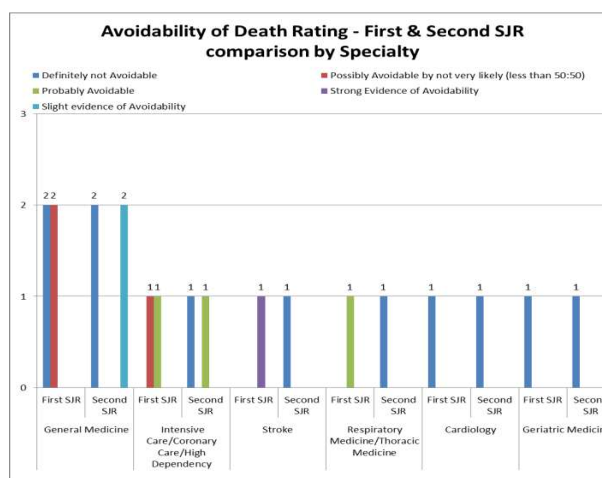
Analysis of individual cases in individual clinical areas is required for further insights.

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	29	6	4
Geriatric Medicine	23	1	1
Intensive Care/Coronary Care/High Dependency	20	3	2
Respiratory Medicine/Thoracic Medicine	17	1	1
Trauma & Orthopaedics	15	1	
Stroke	9	1	1
Cardiology	11	1	1
Gastroenterology	5		
Urgent Care	4		
Urology	4		
A&E	4		
Endocrinology	2		
Grand Total	**143**	**14**	**10**

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 14 second reviews have been completed. All second reviews are presented to the Mortality Operational Committee.





There remains one previously reported case of probably avoidable mortality. Three cases of overall poor care have been confirmed on SJR 2.

4.4 Lessons Learned: Process & Activity

The trust will hold three or more 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.

Currently the Lessons Learned Bulletin is created out of the Mortality Operational Group by Janette Mills, Head of Audit and Effectiveness. The dissemination of learning will be further expanded as part of the Deteriorating Patient work stream, Learning from Death, which as detailed above (3.1) is currently being scoped.

5. Conclusions

Similar to last month's report, this report warns of the consequences of supply demand mismatch. When this equation is unbalanced the system is either potentially wasteful or potentially less safe.

The rise in number of deaths correlates with the rise in system pressures and the clinical perception of sicker patients. The drop in recorded acuity, which is based on the Early Warning Score (EWS) calculated in VitalPac, requires further investigation as this may be due to the incorporation of elective endoscopy into the VitalPac system.

The learning aspects of mortality review processes are progressing and we should have more useful information from SJRs as the number of reviews builds.

From a mortality governance perspective, we have evaluated the increased mortality seen after elective procedures in Novembers report, and found this to be an anomaly caused by the coding of blood transfusions as procedures. These deaths were mainly in multi-morbid patients or those with advanced haematological malignancy. Two patients had operative procedures, but died post discharge with no further information available – these will be followed up with the community teams.

Other areas on analysis are: understanding increased death with prolonged AED waiting times, deaths from ward outliers and deaths from renal failure.

6. Recommendations

6.1 Standing Recommendations

The recommendation is to ensure that the 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. Include measures to increase clinical capacity and measure to reduce demand.

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.

6.2 In Month Recommendations

Evaluate the link between AED wait to be seen and increased mortality.

Review the deaths of ward outlying patients.

Continue to support efforts to understand mortality due to Acute Kidney Injury.

7.0 Appendices

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

EMBAR

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

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

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 21st January 2020
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 / Older People's Care Programme	**The aim of the Patient Flow Improvement Programme has been to deliver a 0.5 day reduction in average length of stay from 7.5 in April 2019 to 6.6 by March 2020. This target was hit between September and November 2019 but dropped below target in December 2019.A consistent and sustained roll out of SAFER (see below) including the Red to Green patient days process has been driven by the Urgent Care Team through the Length of Stay Work Stream 2.** **While activity has been thoroughly rolled out (see completion rate), ongoing work is required to embed and deliver improved performance (see BRAG status) to: improve the 4 Hour Target, decrease the number of stranded and superstranded patients and sustain a reduced average length of stay against target. High levels of outiers and corridor care are indicative of the pressure on patient flow over the winter pressures period, despite consistent and coordinated efforts to overcome.** *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	Patient Flow Improvement Programme / Older People's Care Programme	**Establishing alternative routes to admission has been taken out of the Recognition and Care of the Deteriorating Patient (RCDP) Programme and is now an objective of the Frailty Pathway Project (part of the Older Peoples Care Programme.)** **The development of Anticipatory Clinical Management Plans (RCDP Programme) will be supported by a targeted training programme (Future Care Planning Project, OPC Programme.) This three pronged approach will support the care and treatment in the place of residence in cases where it is appropriate thereby avoiding uneccessary admissions.** It is to be noted that in October 2019 it was reported that the Strata Healthcare had discussed an electronic solution that would support the delivery of a single Patient Anticipatory Clinical Management Plan (ACMP) across all local health care providers. Since this time it has become clear that they will not be able to deliver an end to end solution for this within the dates of their contract with the Trust.
		b. Criteria led discharge	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.	Patient Flow Improvement Programme / Older People's Care Programme	Improving Criteria Led Discharge to support flow and reduce length of stay is a key deliverable of the Length of Stay Work Stream 2 (of the Patient Flow Improvement Programme). 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).*

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 21st January 2020
Patient Flow	EMR Action 1	c. **Proactive escalation planning**	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.	Patient Flow Improvement Programme / Older People's Care Programme	The aim of the Observations and Escalations Project (RCDP Programme) is to ensure a proactive approach in the recognition of the deteriorating patient and the timely adherence to observations to meet the individual needs of every patient. (In line with the Trust's Track and Trigger Policy.) The Documentation and Coding Project (RCDP Programme) is piloting the Concise Comorbidities Patient Summary (available to clinicians on wards for patients who have been previously admitted to the Trust) to provide key patient information in a timely manner to support diagnosis and treatment. The pilot of the Electronic Board Round model (which documents a senior clincial review or remote review) has been very well received those involved in the trial. The Project group are awaiting IT resource to become available to complete the required fixes in order to sign off and go live across the Trust. 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.
		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 / Older People's Care Programme	A multi-disciplinary team (MDT) approach is the cornerstone of the daily **Red to Green Board Rounds** which are run on all wards each weekday morning. Compliance levels for logging the Red to Green status of patients for the month of January at the time of reporting is an average of 64% which is a decline on previous months and will be discussed at the Length of Stay Work Stream 2 Project Meetings in February. Embedding SAFER is a cornerstone of the Trust's Patient Flow Improvement Programme. **Long Stay Tuesdays** are a multi-disciplinary and multi-agency approach to review patients with a length of stay of 7 days or over to find solutions to delays and expedite discharge are ongoing. These reviews are undertaken in the hospital / on wards with partners from across the health economy.
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'	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. A dedlcated AKI Steering Group has been organised to meet once a month to drive targeted activity. Quality improvement measures have been put in place: automated alerts of new cases of AKI are sent by the Medway Team to both the Critical Care Outreach Team and the Pharmacy Team while the 24/7 Critical Care Outreach Team (when adequately staffed) reviews patients with AKI level 3.** **While it was expected that these improvements would start to show in the Advancing Quality Alliance (AQUA) data in autumn 2019 this is still to be seen. In line with the AQUA AQ data set; between January and August 2019, Trust performance (against recommended diagnostic and therapeutic steps) ranged between 41% and 61% (against a target of 58%.)** It is expected that improvements will be visible in October data; latest information from AQUA shows Trust compliance for September at 48%, ranking 7th out of 9 for the regional peer group. AKI remains a priority area for quality improvement for the duration of the RCDP Programme.

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 21st January 2020
Correct Pathways of Care	EMR Action 2	**Improve awareness of Sepsis**	Improve awareness of Sepsis 6 guidelines and monitor adherence.	Deteriorating Patient Project: 'Correct Pathways of Care'	In line with the AQUA AQ data set; between January and August 2019, Trust performance against the Sepsis 6 (three diagnostic and three therapeutic steps to be delivered within one hour of the initial diagnosis of sepsis) was reported between 71% and 85% (against a target of 75%). **The latest reported level for August 2019 was 77% which put the Trust 9th out of 13 regional peers.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. Sepsis remains a priority area for quality improvement for the duration of the RCDP Programme, with a particular focus on the recognition and care of inpatients.** 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			
	EMR Action 3	**Establish Pneumonia Pathway**	Review and/or establish a pneumonia pathway to ensure that it meets national guidelines.	Deteriorating Patient Project	The Pneumonia Pathway has been created, briefed and is on the wards. Levels of compliance (use of the pathways and evidence in patient notes as measured by Clinical Audit) is scant hence the 90% compliance level and amber BRAG status. **In line with the AQUA AQ data set; between January and August 2019, Trust performance against Pneumonia (diagnostic and therapeutic steps) ranged between 80% and 94% (against a target of 91%.) The latest data from August shows the Trust at 85% compliance, ranking 4th out of 9 members of the regional peer group. Pneumonia remains a priority area for quality improvement for the duration of the RCDP Programme.** The Pneumonia Care Pathway is readily available across the Trust and has been given additional focus by the Consultant in Acute
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')	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		**Work is being undertaken to secure resource to make the required IT fixes to complete the Electronic Ward Board PDSA. A meeting to confirm a timeline for the required support is set for 24th January. Resource is expected to be available from March 2020.** The Electronic Ward Board 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.)

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 21st January 2020
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')	**The Programme was relaunched on 7th January with a scoping session under new programme lead, C. Harrington, Deputy Director of Nursing. It has been confirmed through the Quality and Safety Group that the programme must include the long term requirements for documentation 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.*
Documentation & Observations	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.		The Trust participates in the regional benchmarking exercise with Advancing Quality Alliance (AQuA). Every month the Trust collects 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. Work is ongoing and will be linked into the Trust Documentation Programme.
Documentation & Observations	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		**To be incorporated into the scope of the Trust's Documentation Programme.** Quality improvement work to deliver optimum fluid balance is included within both the Older Peoples Care Programme and the Recognition and Care of the Deteriorating Patient Programme.
Documentation & Observations	EMR Action 7	**Ensure Prescribing is legible, clearly signed and in line with national existing guidelines**	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.		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. An audit is required to understand the extent of the problem and to devise solutions to remedy.
Documentation & Observations	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.		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')	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) were trained with the remit to cascade training; this has had limited success as a method of training however there is wide spread knowledge of the Track and Tigger Policy which has been well publicised. As part of the Observations and Escalation Project, a coordinated programme of Red Days and AIMS training (for the care of the deteriorating patient) is being scoped to ensure maximum competencies across all relevant roles.** An electronic training module is being investigated. Training models are being reviewed to ensure appropriate support of the link nurse programe.
Appropirate Escalation	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.		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.

Section	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 21st January 2020
Learning from Deaths	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.		**As noted under 'Alternative to Admission': The development of Anticipatory Clinical Management Plans is scoped (under the RCDP Programme) and will be supported by a targeted training programme (being developed as part of the Future Care Planning Project under the OPC Programme.)** **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.**
	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')	**The Screening of deaths increased from 32.9% in May to 90.5% in September but had dropped in December 2019 to 63.7% Increased compliance in the Autumn, was attributed to improved access to IT and effective communications. In response to the subsequent decline, a process to remind and ensure completion of screening will be scoped, together with the implementation of the medical examiner system.** In October we reported that 59% of patients (who had been recognised to be likely to be dying) had an 'individual plan for the care of those thought likely to be dying' which had been developed with them / with those who are important to them (2018/19). Documentation of individual plans for care of those thought likely to be dying improving, but still a long way to go - education is ongoing. 66% people who die in hospital have documented preferred place of care and for these 70% achieved it by dying in hospital (2018/19). 127 people who PPC was not hospital were transferred in the Rapid End of Life Transfer process when dying was recognised and acheived their PPC. (2018/19). Members of the Reducing Avoidable Mortality and the Older People's Care Project Groups are collaborating on Future Care Planning activity; in particular the cultural shift towards proactive Anticipatory Clinical Management Planning and a system wide approach to Care Management Plans.
	RCA Action 6	**Mortality & Morbidity Reviews must occur in departments with evidence produced of agreed actions and improvement projects**	Mortality and Morbidity review must occur in departments with evidence produced of agreed actions and improvement projects, as defined by the cases presented. These improvements, generated by clinical teams, must have evidence of review by CBU and senior management to demonstrate openly how change is supported.		**It is to be noted that there has been a shift of focus within the Trust Programme Portfolio from mortality ('Reduction in Avoidable Mortality' Project) to the deteriorating patient ('Recognition and Care of the Deteriorating Patient' Programme).** **In order to ensure that there is continued activity and assurance on the reduction of mortality, the monthly Learning from Deaths Report (formerly the Monthly Mortality Report) will continue to be submitted to the Quality and Safety Committee and Public Trust Board. The Learning from Deaths Project (RCDP Programme) will evaluate and standardise the Mortality and Morbidity Meetings (across Clinical Business Units) and agree consistent measures for quality. The Project will also develop the most effective methods for dissemination of lessons learned with assurance that learning has been embedded.** *A structure has been agreed in principle to identify a governance lead clinician in each CBU to drive to M&M processes and identify the key work streams for improvement which will in turn be reported to the Mortality Operational Group. A monthly lessons learned bulletin cascades the general lessons from Level 2 Structured Judgement Reviews that are escalated to MOG.* *The Associate Medical Director for Patient Care is working with the Clinical Lead for Education to incorporate lessons learned dissemination through the junior doctors training programme. The AMD for Patient Safety, Clinical Lead for Education and Head of Risk are to meet to discuss the development of best practice.*
Specialist Services	RCA Action 7	**Management of Diabetes**	Review and update the trusts policy and approach to the management of inpatient diabetes. Ensure available, clear guidance exists for the management of diabetic emergencies and that appropriate patients are identified and referred to the inpatient diabetic service. Resource and support this service to provide the necessary support	Independent Work	The Trust now has a dedicated Diabeties Nurse. Recruitment for Diabetes and Endocronology Consultant cover is now underway and will address the long term gap left when the community services were contracted out in 2017. The Medical Director is organising a review of diabetes service.
	RCA Action 8	**Acute Pain Services**	Review and update the trusts approach to the provision of acute pain services, to include the available guidance to non-specialist doctors on a basic pharmacologic strategy, and how the ongoing support of a pain specialist can be obtained.	Independent Work	The Acute and Chronic Pain team have developed new yellow pain management resource folder which have been distributed across wards at Ormskirk and will be delivered to the relevant wards and departments at Southport before the end of January, The folders will be kept up to date by the pain team, the folders are packed with useful information about acute and chronic pain and also about pain assessment, referral processes, team information and contact details. 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

Programme	Recognition and Care of the Deteriorating Patient
Programme Start Date	01 April 2019
Programme End Date	31 March 2021

BRAG - KPIs against target (in-month)	TBC
BRAG - project actions against target (in-month)	Red

Executive Sponsor	Dr Terry Hankin, Medical Director
Clinical Lead	Dr Chris Goddard, Assistant Medical Director for Patient Safety
Project Manager	Rachel Flood-Jones, Project Manager
Information Lead	Mike Lightfoot, Head of Information
Reporting To	Quality and Safety Group
Report Date	January 2020

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

Executive Summary

An updated Programme Initiation document (PID) was reviewed by the Quality and Safety Group in January. In response to feedback, National Early Warning Signs (NEWS) data will be included in the project performance reporting to ensure the Trust maintains a quality improvement focus on the recognition and subsequent proactive management of deteriorating patients. The Assessment and Admission and Future Care Planning work streams that were previously part of the programme will now be delivered through the Older Peoples Care Programme. A project to develop a Cross Setting Anticipatory Care Management Plan has been included which will feed into the Older Peoples Care work. Milestones and a detailed project plan for the 2020/21 work programme is being developed and progress will be reported in February. Initial review of ward level data indicates that the quality improvement cycle implemented on ward 9a has not been sustained. Meetings have been scheduled during January to both understand the factors that have prevented improvement from being sustained, and to learn from good practice on those wards that are demonstrating improved performance. An update, including actions to address the issues found will be reported in February.

Overall BRAG rating is red due to three main factors:
1) There is a lack of resource to deliver IT fixes internally which is delaying the implementation of the Electronic Ward Board
2) There is a lack of funding for Nursing/HCA training and clarity is required on the strategy for releasing staff from wards for training
3) Low levels of delivery by Strata Healthcare (ACMP shared record) against expectations.

Project Objectives (SMART)

Programme Aim: To reduce the average time for the recognition, review and treatment of the deteriorating patient by April 2021.

Objective 1: Observation and Escalation - Reduce unwarranted clinical variation and ensure standardised and consistent recognition and care of deteriorating patients

Objective 2: Correct Pathways of Care - Embed standard practice in line with AQUA and national clinical guidance for specific identified conditions

Objective 3: Documentation and Coding - Improve the quality of documentation relating to deteriorating patients in order to improve the efficiency and consistency of care and support continuous improvement

Objective 4: Senior Ownership - Ensure senior clinical decision makers are involved in leading patient care

Objective 5: Learning from Deaths - Ensure learning and continuous improvement from the timely and consistent review of deaths

Objective 6: Cross Setting Anticipatory Clinical Management Plan - Devise a cross setting anticipatory clinical management plan process

Key Performance Indicators (KIPs)

Quality Strategy KPI's:	Target	Actual	Year to Date Actual	RAG	Trend	Trajectory RAG	Comments
Percentage breached observations for patients with EWS 5-6		49.00%					*Latest available data December 2019. Indicative performance indicators introduced to reporting January 2020, trajectories aligned 20/21 detailed plans to be presented and agreed by Q&S Group February 2020.*
Number and percent of patients removed from EWS protocol							
Number of referrals to Critical Care Outreach Team (CCOT)		931					
Time from CCOT referral to acceptance		2:46:03					
Time from CCOT acceptance to review		1:06:06					
Compliance with AQ standards for Sepsis, Pneumonia, AKI and Diabetes							
Percentage fractured NOF operated on within 36 hours of admission		85%					
Venus thromboembolism (VTE) risk assessment all inpatients		96.80%					
Proportion of stroke patients who have 90% of hospital stay on stroke ward		45.80%					
Percentage deaths screened per month							
Percentage of SJR 1 within 30 days		38.89%					
Percentage of SJR 2 within 60 days		14.29%					
Integrated Performance Report KPI's:							
Percentage of deaths screened	100%	90.70%	65%	● (red)	▲	○	Integrated Performance Report (November 19 data)
Summary hospital-level mortality indicator (SHMI)	100	99.6	100.7	● (green)	▼	○	Integrated Performance Report (November 19 data)
Rolling 12 month hospital standardised mortality rate (HSMR)	100	91.0	91	● (green)	▼	○	Integrated Performance Report (November 19 data)

Milestones

Milestone	Start Date	End Date	Lead	Completion %	BRAG	Progress
Data and Reporting - Agree programme and work stream KPIs for 2020/21	14.11.19	31.01.20	C Goddard	90%	Green	KPIs set out in the Trust Quality Strategy have been aligned and included within this report alongside metrics from the Integrated Performance Report (10/01/2020). Work stream KPIs are being updated to reflect Q&S Group recommendations.
Coding and Documentation - Undertake scoping session	01.12.19	31.03.20	R Kinney	15%	Amber	Initial scoping exercise has been completed. Meeting scheduled in January to evaluate comorbidity alerting process on the Short-stay Unit.
PDSA Cycle Review - Timely observations - Ward 9a	01.12.19	29.02.20	C Goddard	10%	Amber	Meeting scheduled in January to understand the work that has been undertaken to date and the factors that have contributed towards improvement made not being sustained.

Risks

Risk	RAG	Mitigating Actions	RAG	Comments
Nurse Training - Care of the Deteriorating Patient. There is a risk that without dedicated resources appropriate staff will not have the skills to recognise and care for deteriorating patients in line with Trust standards	Red	Meeting is scheduled for January to discuss the resource allocation and capacity to deliver, and release nursing and care staff for training	Red	Update to be provided in February following the meeting to confirm resource allocation. If resources are confirmed risk score can be de-escalated
Electronic Ward Boards - IT Development There is a risk that a lack of capacity in the IT department will cause further delays to the roll out of the Electronic Ward Boards	Red	Meeting in January with the IT Implementation Lead to identify additional resource	Red	IT support for the Electronic Ward Board has been delayed due to a lack of capacity. If resources are confirmed risk score can be de-escalated

Issues

Issue	Actions	RAG	Comments
Consultant Review (Documentation) - An issue was raised at Deteriorating Patient Operational Group regarding identification of Consultant review in medical notes	Consultants are being advised to carry and use name stamps.	Amber	Integral part of the emerging Trust-wide Documentation Quality Improvement Programme. Initial scoping session held in January, recommendations for next steps to be presented to Q&S Group in February.

Appendix 3: Mortality Monthly Data Report

Southport & Ormskirk NHS Trust Deteriorating Patient Dashboard January 2020

Southport & Ormskirk Hospital NHS Trust

Dr Foster National Mortality Statistics

Rolling 12 Month HSMR

Local HSMR August 2019/20

SHMI

Trust Mortality Statistics

In Hospital Deaths

YTD Deaths of Patients with Learning Difficulties: 3

0.54% ▲

YTD Deaths of Patients with GSF Alert: 88

16% ▼

Deaths Post Discharge - 30 Days

Avg Spell LOS whilst admitted:	Avg Days to death post discharge:	YTD Deaths of Patients with GSF Alert: 102
15.3	**11.4**	**31.2%** ▼

Palliative Care Coding %

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

Primary Diagnosis Name	This Month	
Sepsis, unspecified	16	▲
Lobar pneumonia, unspecified	10	▲
Pneumonitis due to food and vomit	10	▲
Congestive heart failure	4	▼
Alcoholic hepatic failure	2	▲

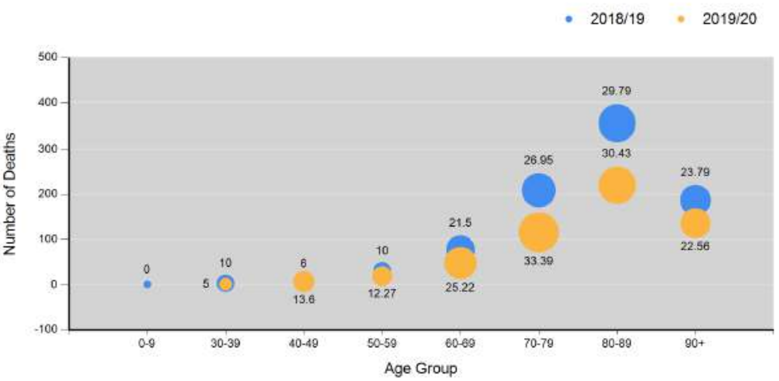
Mortality Reviews

	2018/19				2019/20							
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Screens Completed	41	60	37	34	32	27	28	53	44	57	68	63
Screens %	50.6%	63.8%	61.7%	47.2%	35.2%	32.9%	58.3%	88.3%	84.6%	90.5%	90.7%	78.8%

Overall Assessment Rating Outcomes - Last 12 Months

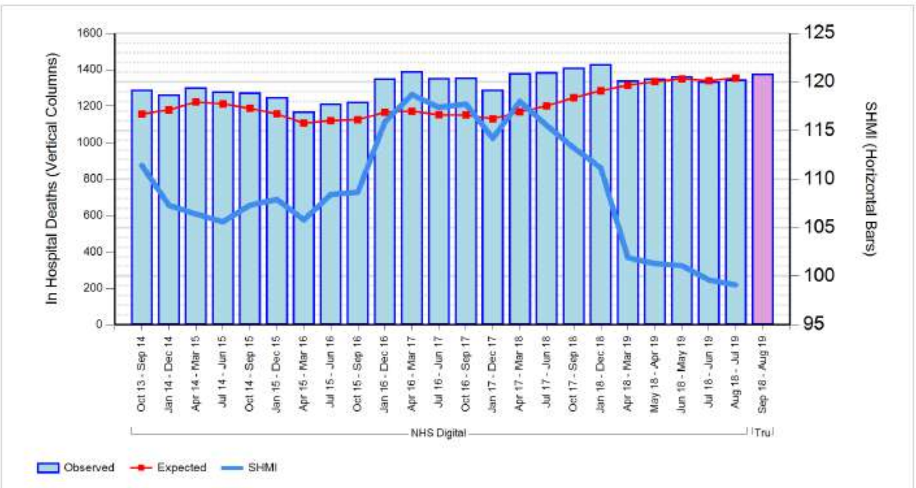
SHMI Breakdown

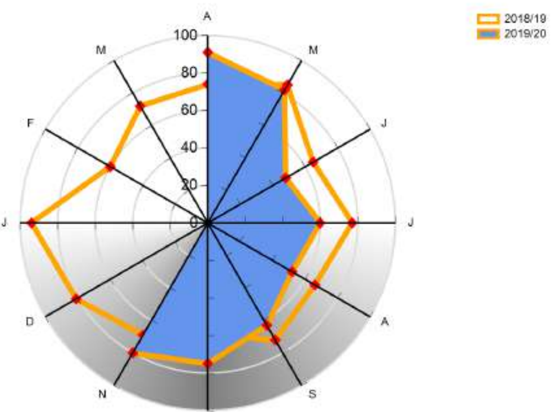
Southport & Ormskirk Hospital NHS Trust



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

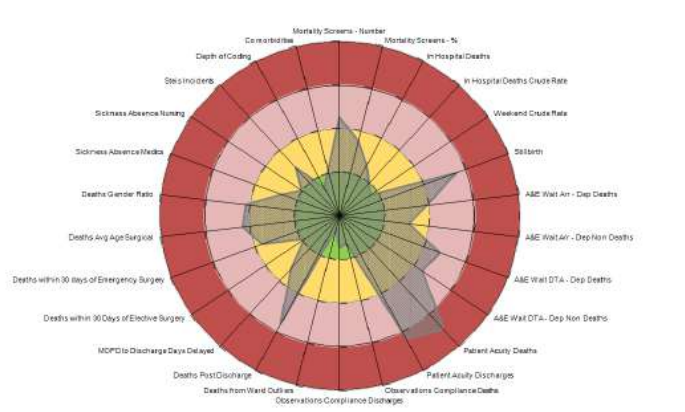
This should give an indication of the SHMI although the number of expected deaths for the recent periods is unknown.





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

Appendix 4: Peformance Distribution for May & June 2019



The in month HSMR in July 2019 was 70, there were 60 deaths which is a 25% increase on the previous month.

The notable changes in key indicators this month are for patient acuity of both those patients who died in hospital and those patients who did not die in hospital which are significantly higher than last month.

There was also a shift in stillbirths this month—there were 2 reported which is the most in a single month since December 2017.

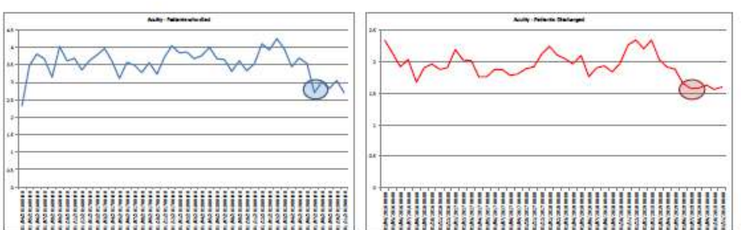
A&E timings improved marginally in this month—with patients having to wait slightly less time from arrival to departure and Decision to Admit (DTA) to departure.

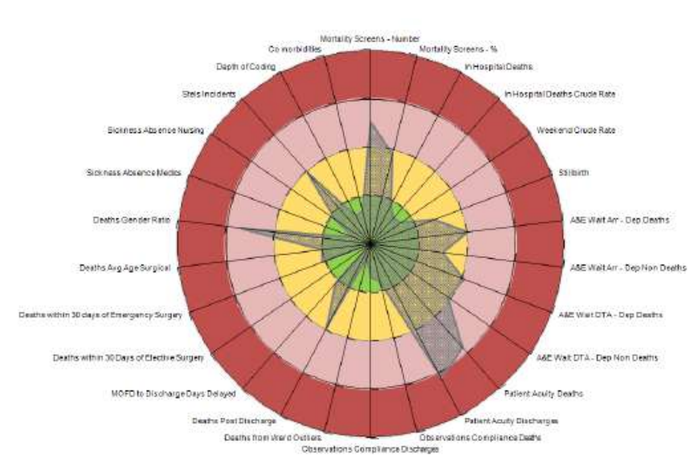
Performance Measuring

For each indicator the mean, upper and lower control limit are calculated in accordance with statistical process control methodology (Mean +/- 3 Sigma). The gauge represents the performance of the trust value being displayed within these parameters (green = lower control limit, red = upper control limit).
If the indicator is nearer to the green this means that performance is **better** compared to usual. If the indicator is nearer to the red it means performance is **worse** compared to usual.

The in month HSMR in August 2019 was 60.8, there were 52 deaths.

The lowest performing indicators this month were those relating to patient acuity, the indicative score for both those patients who were regular discharges and those who died was comparably low compared to historic trend. This will be raised at Mortality Group to be investigated.





APPENDIX 5 – CONDITION SPECIFIC MORTALITY RATIOS - August 2019

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

Trust Board
January 2020

Agenda Item	WFC	Report Title	**Monthly** Safe Nurse & Midwifery Staffing Report – January 2020
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery Therapies and Governance		
Lead Officer	Claire Harrington -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 January 2020 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 November 2019 and December 2019.

Alert

- For the month of December 2019 the Trust reports safe staffing against the national average (90%) at 88.51%.

Advise

- Care Hours per Patient Day (CHpPD) reporting remains under review to support accuracy of data reporting. Trust CHpPD reports at 8.0 for December 2019.
- UNIFY and CHpPD reporting has been refreshed following application to UNIFY.
- The Board is advised the trust healthcare assistant (HCA) vacancy position is 48.18 wte.
- The Board is advised the trust band 5 registered nurse (RN) vacancy position is133.29 wte.

Assure

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

Recommendation

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

Strategic Objective(s) and Principal Risks(s)

	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 November and December 2019.

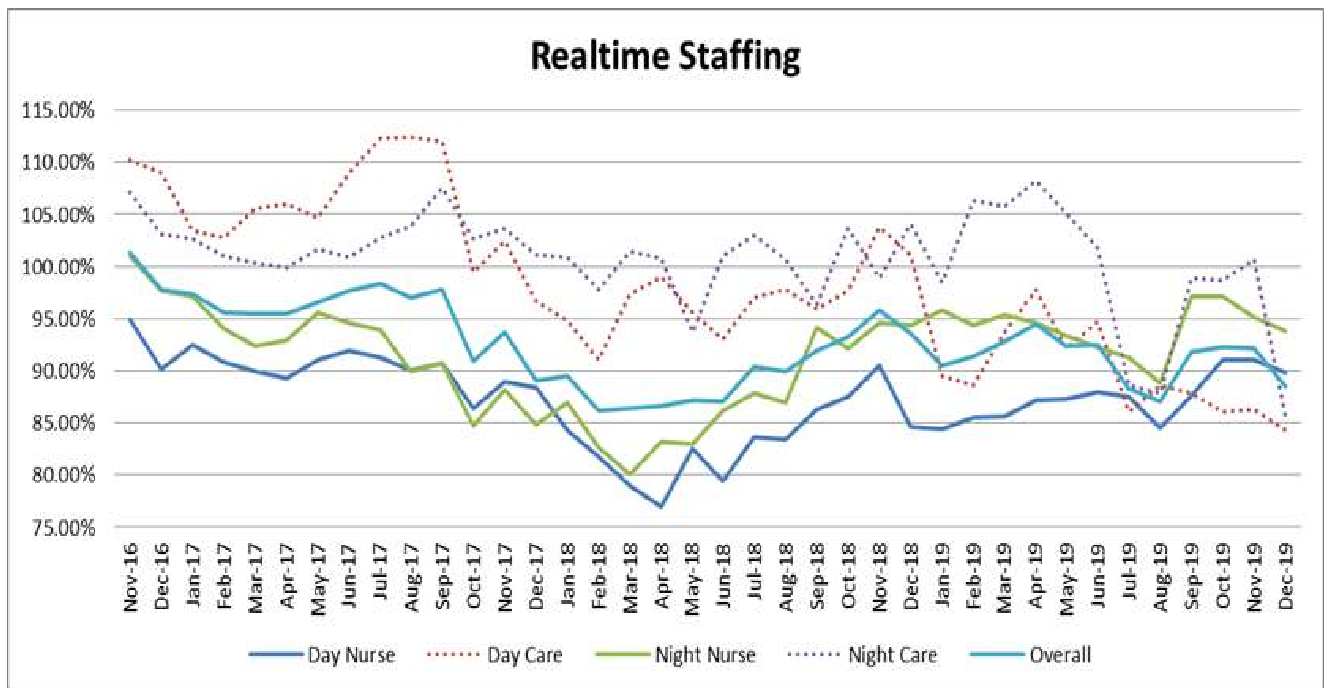
Overall fill rate for November 2019 is 90.36% (appendix 1).

- 89.89% Registered Nurses on days
- 91.8% Registered Nurses on nights
- 85.86% Care staff on days
- 97.33% Care staff on nights

Overall fill rate for December 2019 is 88.51% (appendix 2).

- 89.82% Registered Nurses on days
- 93.77% Registered Nurses on nights
- 84.26% Care staff on days
- 85.60% Care staff on nights

Table 1-Real Time staffing



The committee has previously been advised of the review against reporting to UNIFY to assure the Safe Staffing reporting includes the staff allocated on arrival of shifts to clinical areas from the flexible workforce pool. Retrospective review has identified slight uplift to the trust overall safe staffing % reporting and this is reported below in table 2:

Table 2-UNIFY reporting update:

	Previous UNIFY report	Refreshed UNIFY report
Apr	94.45%	95.17%
May	92.38%	93.98%
Jun	92.53%	93.81%
Jul	88.25%	89.67%

Table 3 -CHpPD Reporting updated post UNIFY.

	CHPPD Overall	CHPPD Overall
Apr	8.6	8.7
May	8.3	8.3
Jun	8.3	8.4
Jul	8.7	8.9
Aug	n/a	8.8
Sep	n/a	8.1

Table 4 below reports the Trusts CHpPD for November and December 2019 remaining slightly above the national average of 7.0. Further individual ward/department CHpPD reporting can be viewed for November 2019 in appendix 1 and for December 2019 in appendix 2.

The Trust current reporting for CHpPD includes Registered Nurses/Registered Midwives.

Table 4	Trust overall	Planned Care	Urgent Care	Women's & Children's
CHpPD Nov 2019	8.3	10.4	6.7	12.3
CHpPD Dec 2019	8.0	9.6	6.5	12.3

2. Quarter 3 Safe Staffing

Table 5 below reports the Trusts whole time equivalent (wte) funded establishment versus contracted for Quarter 3. –the committee is advised of 2 additional HCA funded posts in Dec 19 to support winter plans which are not included in the below figures. The committee is further advised the figures reported below reflect for HCA roles excluding band 4 roles which had previously been reported in the figures. Through this change to reporting the committee can be assured of a current 48.18 wte HCA vacancy. Recruitment to HCA posts is planned throughout January and February 2020.

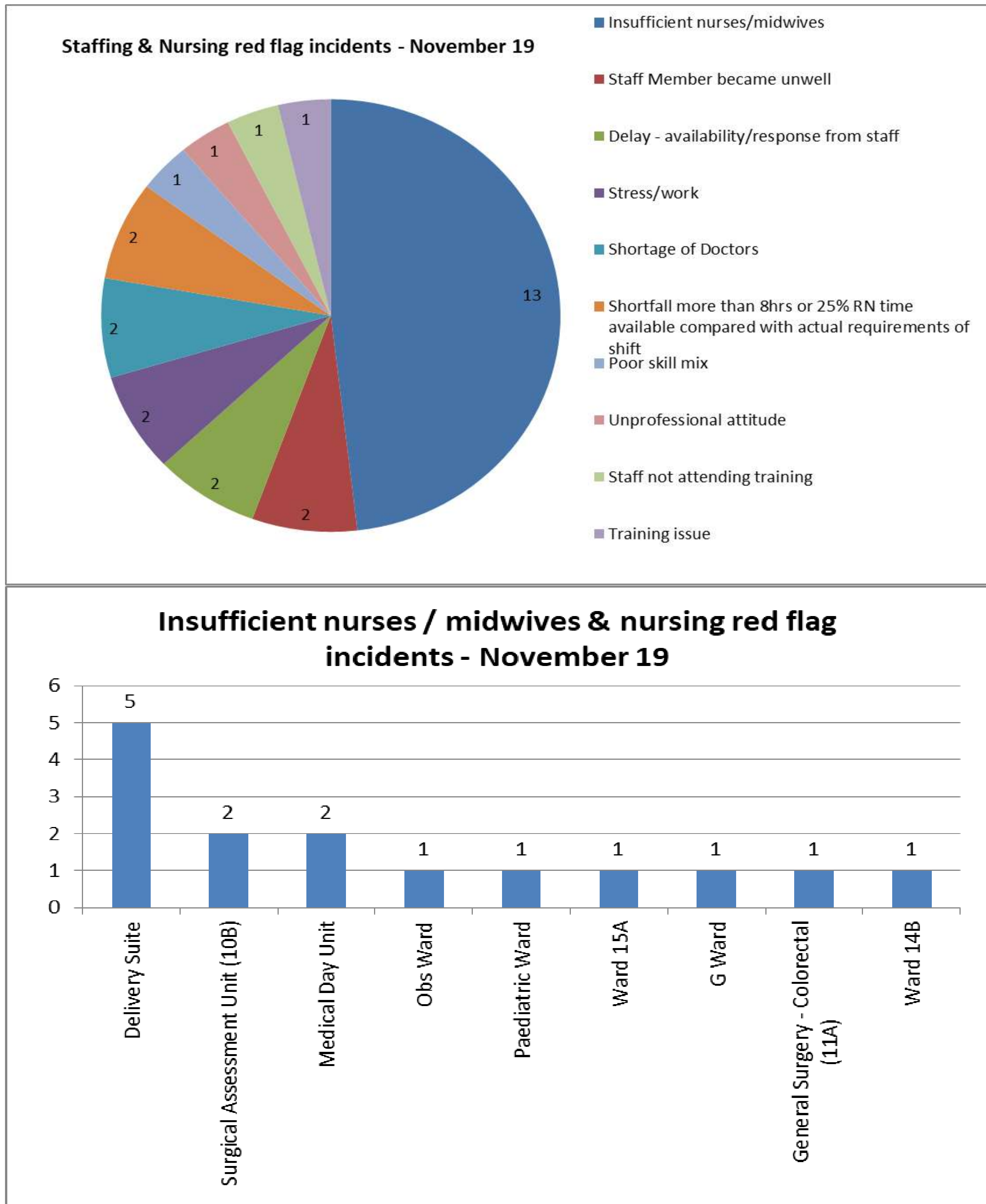
Table 5

	Funded wte Oct 19	Contracted Wte Oct 19	Vacancy Oct 19	Funded wte Nov 19	Contracted Wte Nov 19	Vacancy Nov 19	Funded wte Dec 19	Contracted Wte Dec 19	Vacancy Dec 19
RN Band 5	508.85	380.53	128.32	509.09	380.53	128.56	509.09	375.80	133.29
HCA Band 2/3	390.37	337.66	52.71	388.79	343.93	44.86	389.09	340.91	48.18

3a. Staffing Related Reported Incidents November 2019

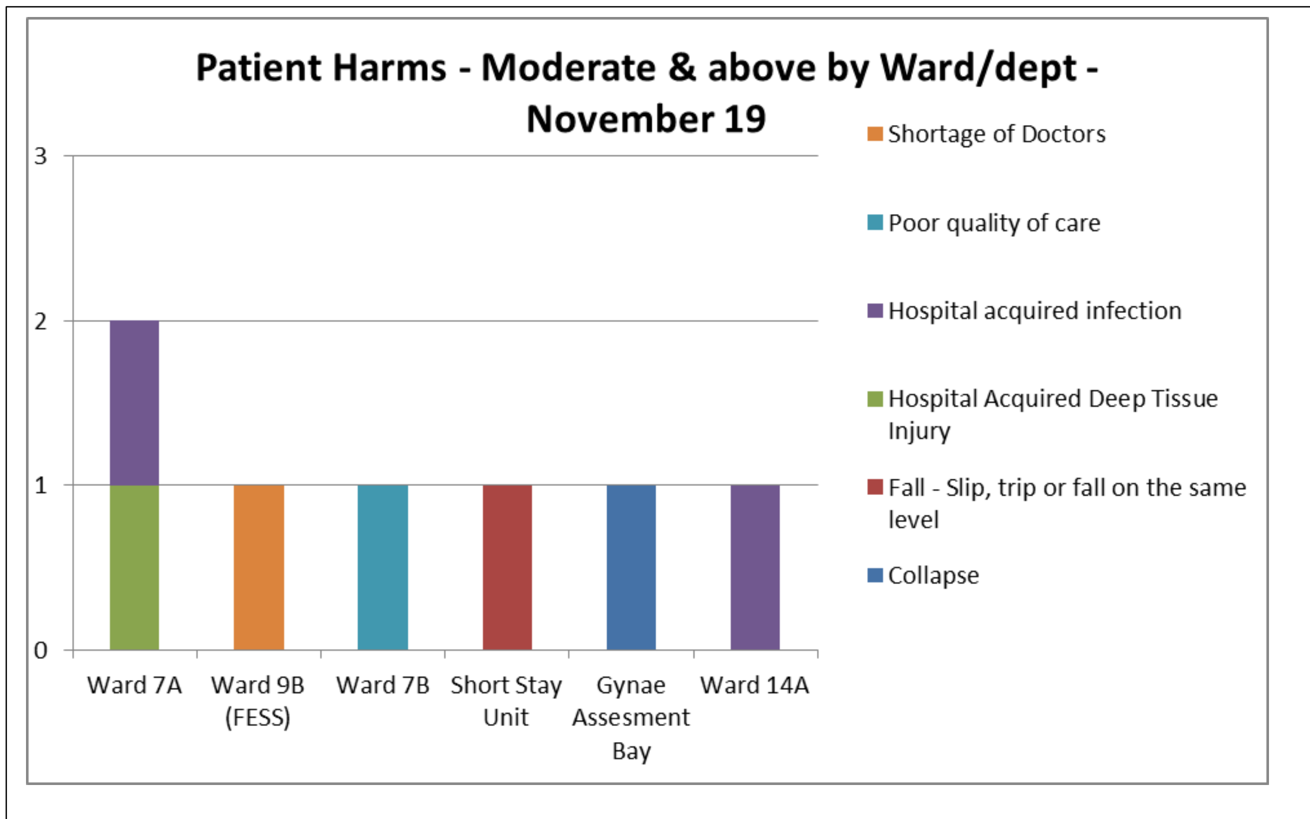
Graph 1 below reports 25 staffing incidents and 2 nursing red flags reported in November 2019. 13 of the staffing incidents highlight insufficient nurses. Five of these incidents related to Maternity/neonates as a result of increased acuity/activity which resulted in BAPM standards not being met. Appropriate escalation was carried out and there was no harm to patients.

Graph 1



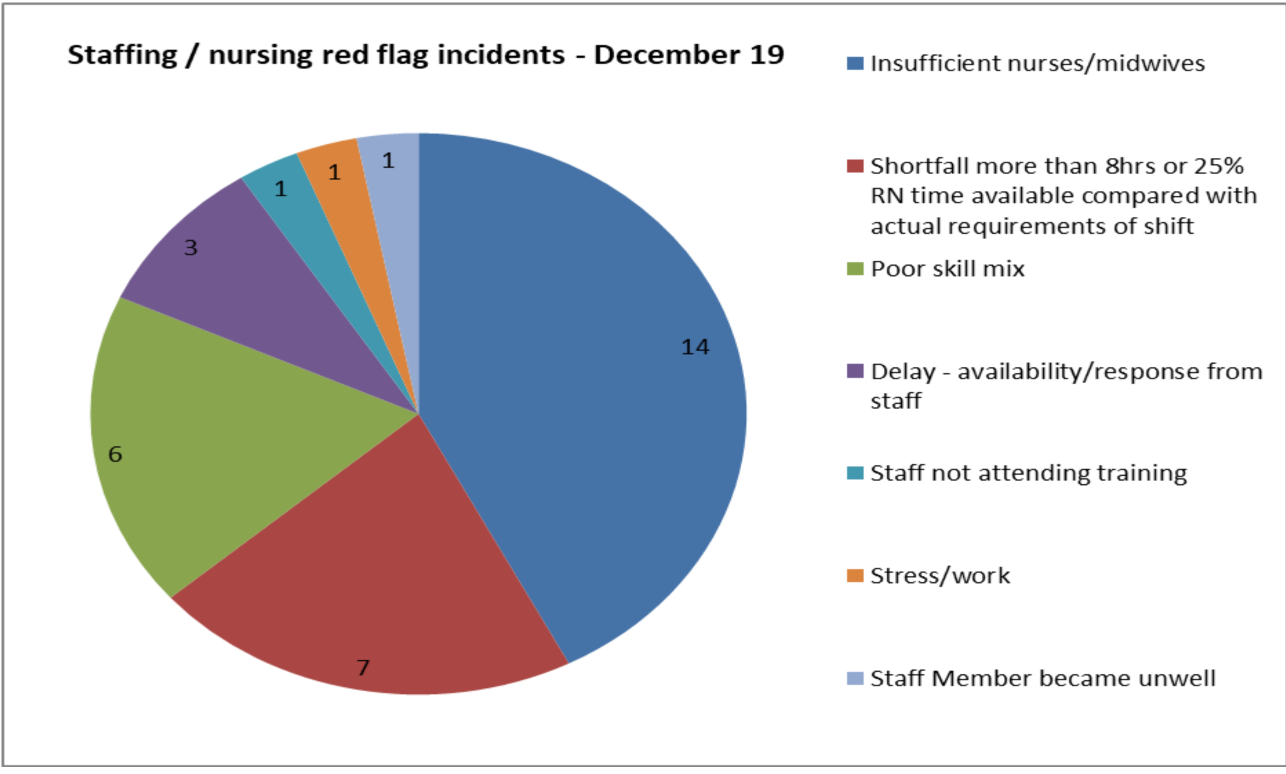
Graph 2 below reports 7 moderate or above incidents were reported in November 2019, 17 less than October 2019.

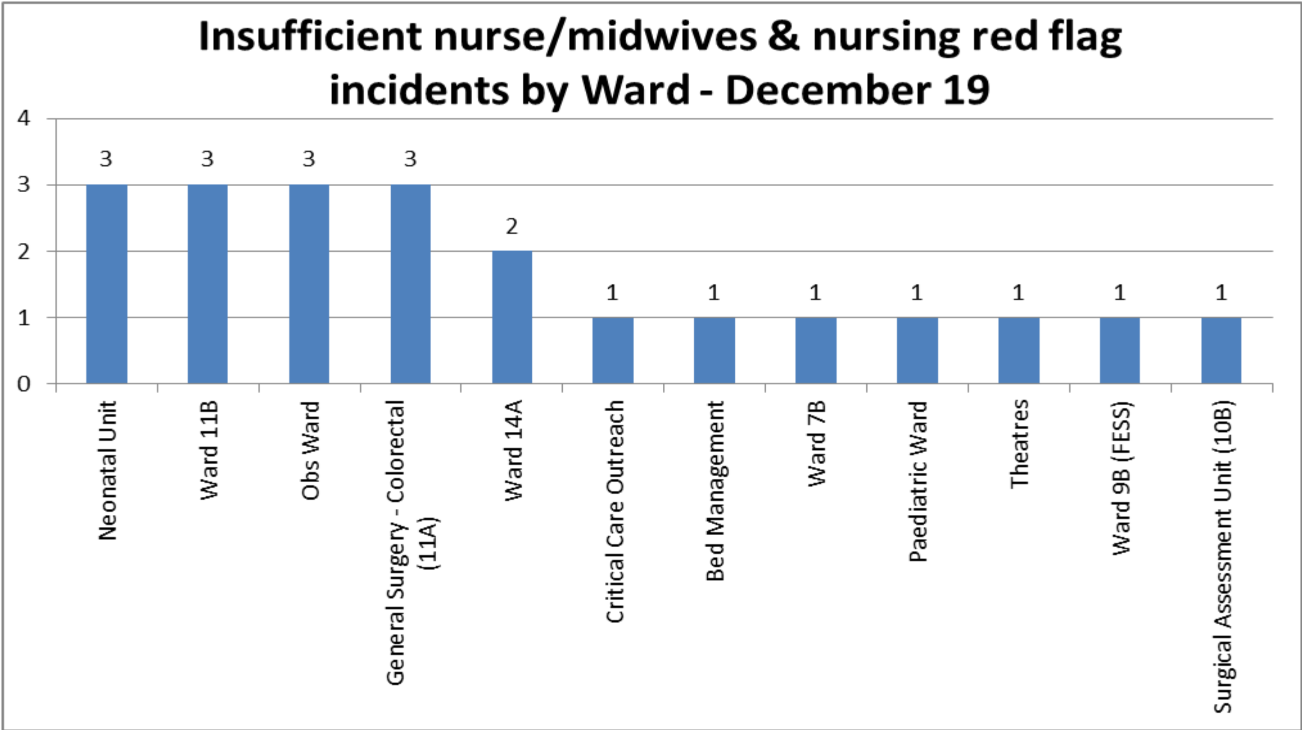
Graph 2



3b. Staffing Related Reported Incidents December 2019

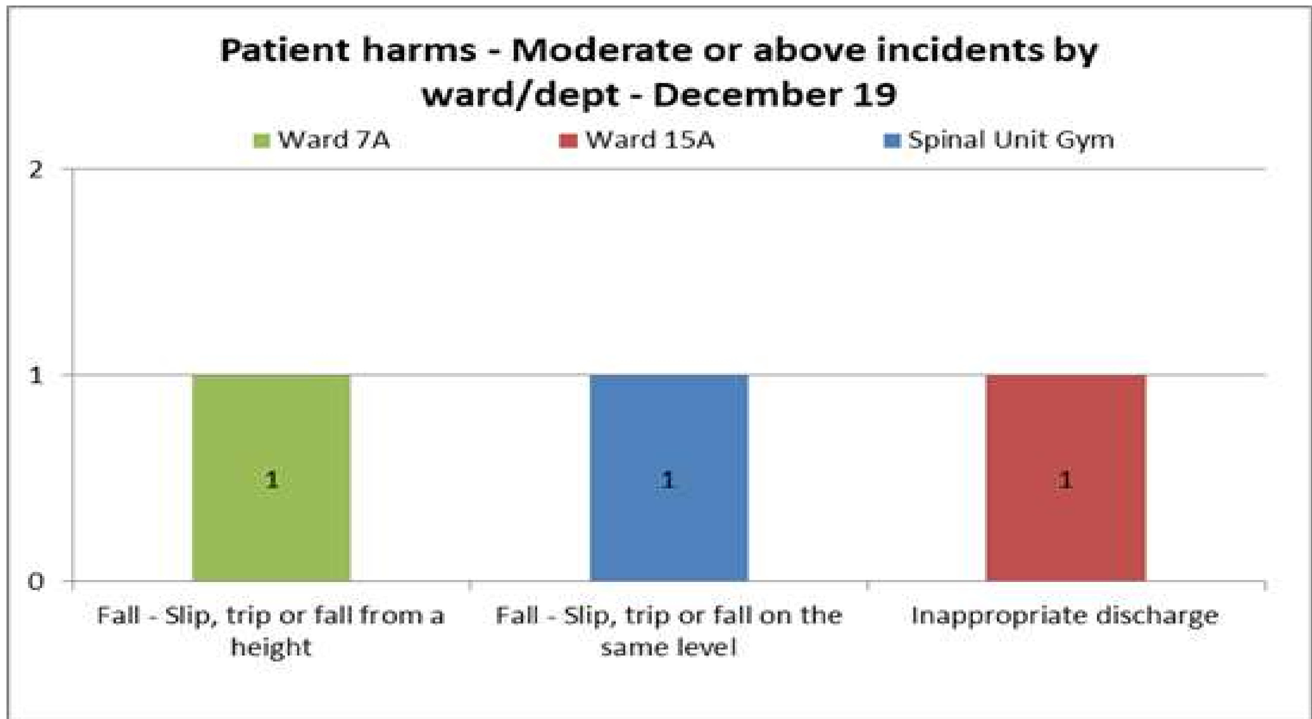
Graph 3 below reports 26 staffing incidents and 7 nursing red flags were reported in December 2019. 14 of these incidents highlight insufficient nurses/midwives and 7 highlight nurse shortfalls (red flags), 1 of these incidents linked to insufficient nurses reported as low harm. 3 of these incidents related to Neonatal, 3 relate to Ward 11B, 3 aligned to observation ward and 3 incidents related to general surgery colorectal (11A). Appropriate escalation was carried out and there was no harm to patients. In Paediatrics this was associated with increased acuity in Paediatric A&E and the Paediatric Ward which resulted in increased pressure in those areas. Maternity reported in view of suboptimal staffing levels due to short term absence. Appropriate escalation was carried out and there was no harm to patients.





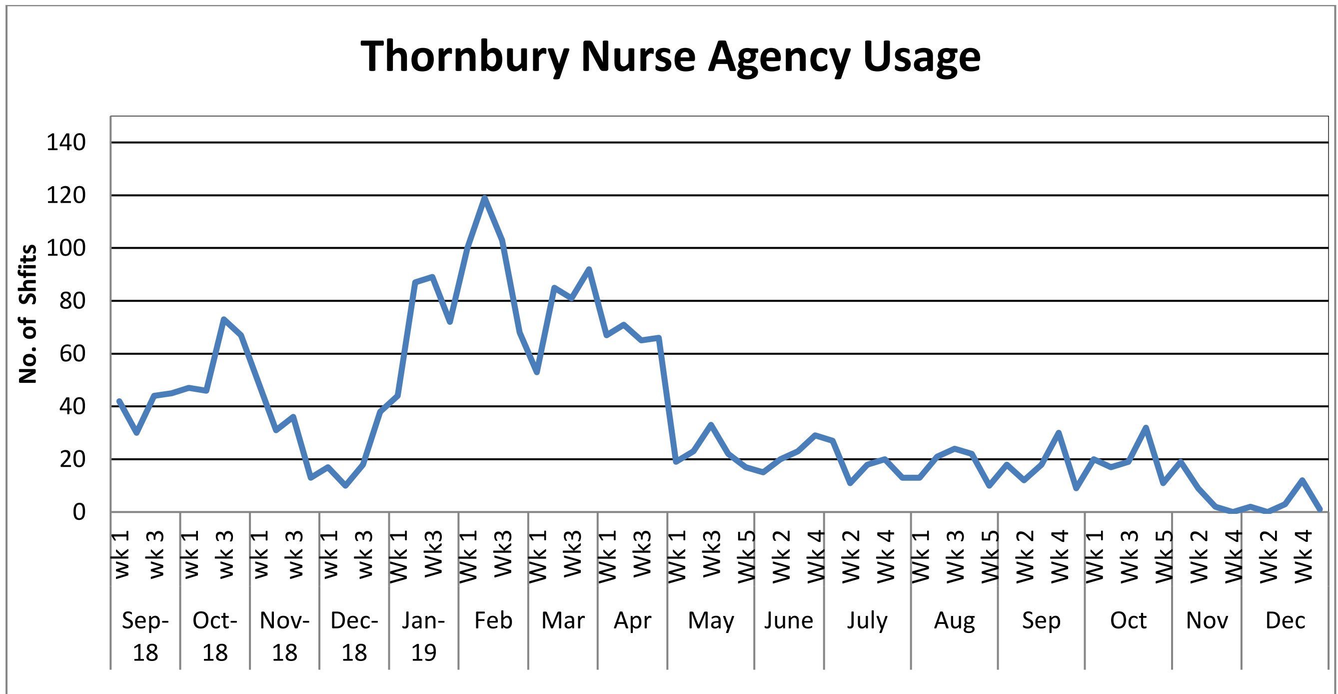
Graph 4 below - 3 moderate or above incidents were reported in December 2019, 4 less than November 2019.

Graph 4



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.



A 40% decrease in shift usage since November 2019

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) – November 2019

Ward name	Specialty	Registered nurses-Day		Care Staff-Day		Registered nurses-Night		Care Staff-Night		Patients at 23:59 each day	Day		Night		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		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)					
Ward 7A-SDGH	300 - GENERAL MEDICINE	1,462.00	1,342.00	1,488.25	1,251.71	1,049.50	1,117.00	1,059.50	1,033.50	822	91.79%	84.11%	106.43%	97.55%	3.0	2.8	5.8		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	706.00	700.75	356.50	305.00	702.75	738.25	356.00	319.50	259	99.26%	85.55%	105.05%	89.75%	5.6	2.4	8.0		
E A U	300 - GENERAL MEDICINE	1,645.50	1,511.48	1,407.92	1,282.92	1,056.25	1,028.75	1,058.50	1,105.00	573	91.86%	91.12%	97.40%	104.39%	4.4	4.2	8.6		
FESS Ward	300 - GENERAL MEDICINE	1,623.22	1,348.87	1,887.75	1,603.75	1,052.50	1,109.50	895.00	868.00	817	83.10%	84.96%	105.42%	96.98%	3.0	3.0	6.0		
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,498.25	1,407.82	1,766.23	1,477.25	1,060.50	1,093.00	1,085.00	1,071.00	791	93.96%	83.64%	103.06%	98.71%	3.2	3.2	6.4		
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,690.75	1,572.98	1,665.22	1,503.72	1,413.00	1,426.50	1,125.00	1,075.00	877	93.03%	90.30%	100.96%	95.56%	3.4	2.9	6.4	Y	
Short Stay Unit	300 - GENERAL MEDICINE	1,451.00	1,403.48	1,707.75	1,688.25	1,061.00	1,072.00	1,062.50	1,048.00	849	96.73%	98.86%	101.04%	98.64%	2.9	3.2	6.1		
Ward 15a General Med	300 - GENERAL MEDICINE	1,512.92	1,402.75	1,618.00	1,716.87	1,055.75	1,078.25	1,063.00	1,480.00	722	92.72%	106.11%	102.13%	139.23%	3.4	4.4	7.9		
Stroke Ward	300 - GENERAL MEDICINE	1,266.73	1,205.96	1,525.58	1,283.58	1,057.50	1,033.00	713.00	758.50	573	95.20%	84.14%	97.68%	106.38%	3.9	3.6	7.5		
Rehab & Discharge Lounge	314 - REHABILITATION	1,449.42	1,412.25	1,868.58	1,599.33	1,064.00	1,094.00	1,063.50	1,043.50	797	97.44%	85.59%	102.82%	98.12%	3.1	3.3	6.5		
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,772.97	1,713.22	2,354.25	1,919.25	1,073.00	1,145.00	1,488.50	1,463.50	880	96.63%	81.52%	106.71%	98.32%	3.2	3.8	7.1		
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,201.00	1,146.00	1,406.00	1,196.08	711.50	687.50	382.50	405.50	434	95.42%	85.07%	96.63%	106.01%	4.2	3.7	7.9		
Ward H	110 - TRAUMA & ORTHOPAEDICS	719.50	560.00	718.00	523.50	719.00	575.50	35.00	280.25	140	77.83%	72.91%	80.04%	800.71%	8.1	5.7	13.9		Planned hours for non registered night was 35, actual was 280.25
Surgical Ward	100 - GENERAL SURGERY	1,071.00	1,033.50	1,075.00	986.73	712.00	781.00	365.50	419.06	503	96.50%	91.79%	109.69%	114.65%	3.6	2.8	6.4	Y	
Spinal Injuries Unit	400 - NEUROLOGY	3,440.98	2,825.90	3,419.25	3,053.50	2,827.25	2,465.25	1,439.50	1,361.00	781	82.12%	89.30%	87.20%	94.55%	6.8	5.7	12.4		
Ward G	101 - UROLOGY	1,002.25	956.75	1,160.50	757.00	725.00	712.00	368.00	356.00	237	95.46%	65.23%	98.21%	96.74%	7.0	4.7	11.7		
TOTAL		**23,513.48**	**21,543.71**	**25,424.78**	**22,148.44**	**17,340.50**	**17,156.50**	**13,560.00**	**14,087.31**	**10055**	91.62%	87.11%	98.94%	103.89%	**3.8**	**3.6**	**7.5**		

Ward name	Specialty	Registered nurses-Day		Care Staff-Day		Registered nurses-Night		Care Staff-Night		Patients at 23:59 each day	Day		Night		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		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)					
A&E Nursing		4,092.58	4,338.58	2,554.75	1,832.75	3,572.00	3,613.75	1,074.00	689.00		106.01%	71.74%	101.17%	64.15%					
Ambulatory Care Unit		715.00	452.98	711.25	361.75	0.00	257.00	0.00	160.67	82	63.35%	50.86%	#DIV/0!	#DIV/0!					Zero planned hours for nights but actual was 417.67
TOTAL		**4,807.58**	**4,791.56**	**3,266.00**	**2,194.50**	**3,572.00**	**3,870.75**	**1,074.00**	**849.67**	**82**	99.67%	67.19%	108.36%	79.11%	N/A	N/A	N/A		

Ward name	Specialty	Registered nurses-Day		Care Staff-Day		Registered nurses-Night		Care Staff-Night		Patients at 23:59 each day	Day		Night		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		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)					
ITU/CCU	192 - CRITICAL CARE MEDICINE	3,824.75	3,056.25	1,145.75	932.92	3,593.25	2,957.75	1,077.50	533.00	381	79.91%	81.42%	82.31%	49.47%	15.8	3.8	19.6		

Ward name	Specialty	Registered nurses-Day		Care Staff-Day		Registered nurses-Night		Care Staff-Night		Patients at 23:59 each day	Day		Night		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		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)					
Delivery Suite	501 - OBSTETRICS																		
Maternity Ward	501 - OBSTETRICS	3,442.25	3,133.17	1,266.50	1,071.00	600.50	538.00	1,070.50	1,082.00	434	91.02%	84.56%	89.59%	101.07%	8.5	5.0	13.4		
MAU	501 - OBSTETRICS																		
TOTAL		**3,442.25**	**3,133.17**	**1,266.50**	**1,071.00**	**600.50**	**538.00**	**1,070.50**	**1,082.00**	**434**	91.02%	84.56%	89.59%	101.07%	**8.5**	**5.0**	**13.4**		

Ward name	Specialty	Registered nurses-Day		Care Staff-Day		Registered nurses-Night		Care Staff-Night		Patients at 23:59 each day	Day		Night		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		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)					
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,038.75	1,042.75	360.00	240.00	1,055.00	995.00	0.00	12.00	182	100.39%	66.67%	94.31%	#DIV/0!	11.2	1.4	12.6		Zero planned hours for non reg nights but actual was 12
Paediatric Unit	420 - PAEDIATRICS	1,918.25	1,954.75	1,317.00	1,059.00	2,032.00	1,774.98	494.50	558.00	478	101.90%	80.41%	87.35%	112.84%	7.8	3.4	11.2		
TOTAL		**2,957.00**	**2,997.50**	**1,677.00**	**1,299.00**	**3,087.00**	**2,769.98**	**494.50**	**570.00**	**660.00**	**101.37%**	**77.46%**	**89.73%**	**115.27%**	**8.74**	**2.83**	**11.57**		
PLANNED		13,032.45	11,291.62	11,278.75	9,368.98	10,361.00	9,324.00	5,156.50	4,818.31	3,356	86.64%	83.07%	89.99%	93.44%	6.1	4.2	10.4		
URGENT		14,305.78	13,308.34	15,291.78	13,712.38	10,572.75	10,790.25	9,481.00	9,802.00	7080	93.03%	89.67%	102.06%	103.39%	3.4	3.3	6.7		
W&C		6,399.25	6,130.67	2,943.50	2,370.00	3,687.50	3,307.98	1,565.00	1,652.00	1,094	95.80%	80.52%	89.71%	105.56%	8.6	3.7	12.3		
TRUST TOTALS		**33,737.48**	**30,730.63**	**29,514.03**	**25,451.36**	**24,621.25**	**23,422.23**	**16,202.50**	**16,272.31**	**11,530**	91.09%	86.23%	95.13%	100.43%	4.7	3.6	**8.3**		

Green- 80% and above
Red- Under 80%

Appendix 2: Care Hours per Patient Day (CHPPD) – December 2019

Ward name	Specialty	Registered nurses-Day: Total monthly planned staff hours	Registered nurses-Day: Total monthly actual staff hours	Care Staff-Day: Total monthly planned staff hours	Care Staff-Day: Total monthly actual staff hours	Registered nurses-Night: Total monthly planned staff hours	Registered nurses-Night: Total monthly actual staff hours	Care Staff-Night: Total monthly planned staff hours	Care Staff-Night: Total monthly actual staff hours	Patients at 23:59 each day	Day: Average fill rate - registered nurses/ midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/ midwives (%)	Night: Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
Ward 7A-SDGH	300 - GENERAL MEDICINE	1,510.22	1,504.68	1,657.50	1,385.17	1,090.00	1,150.65	1,129.75	816.75	827	99.63%	83.57%	105.56%	72.29%	3.2	2.7	5.9		
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	726.75	697.25	365.50	351.00	732.00	718.50	367.50	343.00	262	95.94%	96.03%	98.16%	93.33%	5.4	2.6	8.1	Y	
E A U	300 - GENERAL MEDICINE	1,700.75	1,498.00	1,474.00	1,292.25	1,092.67	1,085.73	1,095.50	992.17	595	88.08%	87.67%	99.37%	90.57%	4.3	3.8	8.2		
FESS Ward	300 - GENERAL MEDICINE	1,636.63	1,390.10	2,034.75	1,880.75	1,090.00	1,104.50	868.00	807.50	841	84.94%	92.43%	101.33%	93.03%	3.0	3.2	6.2	Y	
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,494.00	1,414.08	1,666.75	1,432.75	1,096.50	1,180.33	1,103.00	910.00	805	94.65%	85.96%	107.65%	82.50%	3.2	2.9	6.1	Y	
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,745.77	1,706.00	1,617.75	1,406.00	1,459.00	1,535.83	1,115.50	921.00	923	97.72%	86.91%	105.27%	82.56%	3.5	2.5	6.0		
Short Stay Unit	300 - GENERAL MEDICINE	1,504.50	1,426.50	1,774.00	1,615.00	1,093.00	1,180.25	1,133.25	928.50	871	94.82%	91.04%	107.98%	81.93%	3.0	2.9	5.9		
Ward 15a General Med	300 - GENERAL MEDICINE	1,590.47	1,419.28	1,702.00	1,721.25	1,094.50	1,104.48	1,092.75	1,284.25	742	89.24%	101.13%	100.91%	117.52%	3.4	4.1	7.5		
Stroke Ward	300 - GENERAL MEDICINE	1,285.47	1,266.93	1,510.00	1,350.25	1,096.50	1,081.50	737.00	712.50	602	98.56%	89.42%	98.63%	96.68%	3.9	3.4	7.3		
Rehab & Discharge lounge	314 - REHABILITATION	1,552.00	1,475.92	2,254.75	1,770.42	1,100.08	1,045.83	1,087.50	773.25	815	95.10%	78.52%	95.07%	71.10%	3.1	3.1	6.2		
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,890.00	1,731.25	2,244.50	2,041.25	1,115.25	1,066.75	1,489.75	1,248.75	877	91.60%	90.94%	95.65%	83.82%	3.2	3.8	6.9	Y	
Short Stay Surgical Unit	100 - GENERAL SURGERY	1,231.50	1,192.75	1,492.00	1,184.00	738.50	772.50	522.00	438.00	451	96.85%	79.36%	104.60%	83.91%	4.4	3.6	8.0	Y	
Ward H	110 - TRAUMA & ORTHOPAEDICS	744.00	579.00	737.50	331.50	744.00	504.00	0.00	95.50	77	77.82%	44.95%	67.74%	#DIV/0!	14.1	5.5	19.6		No planned hours nights to report against - 95hrs required.
Surgical Ward	100 - GENERAL SURGERY	1,130.00	1,094.25	1,147.75	842.25	738.00	747.00	438.50	400.50	530	96.84%	73.38%	101.22%	91.33%	3.5	2.3	5.8	Y	
Spinal Injuries Unit	400 - NEUROLOGY	3,580.32	3,091.40	3,507.83	3,065.33	2,908.50	2,572.00	1,509.00	1,389.00	1,042	86.34%	87.39%	88.43%	92.05%	5.4	4.3	9.7		
Ward G	101 - UROLOGY	1,006.00	834.75	1,053.00	778.75	737.00	653.00	447.00	368.00	268	82.98%	73.96%	88.60%	82.33%	5.6	4.3	9.8		
TOTAL		24,328.37	22,322.14	26,239.58	22,447.92	17,925.50	17,502.85	14,136.00	12,428.67	10528	91.75%	85.55%	97.64%	87.92%	3.8	3.3	7.1		

Ward name	Specialty	Registered nurses-Day: Total monthly planned staff hours	Registered nurses-Day: Total monthly actual staff hours	Care Staff-Day: Total monthly planned staff hours	Care Staff-Day: Total monthly actual staff hours	Registered nurses-Night: Total monthly planned staff hours	Registered nurses-Night: Total monthly actual staff hours	Care Staff-Night: Total monthly planned staff hours	Care Staff-Night: Total monthly actual staff hours	Patients at 23:59 each day	Day: Average fill rate - registered nurses/ midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/ midwives (%)	Night: Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
A&E Nursing		4,255.75	4,392.08	2,632.75	1,922.25	3,643.00	3,694.00	1,105.00	665.50		103.20%	73.01%	101.40%	60.23%					
Ambulatory Care Unit		734.75	457.75	723.25	476.75	0.00	304.33	0.00	80.50	102	62.30%	65.92%	#DIV/0!	#DIV/0!					No Planned hours for Care Staff (escalation) required 80hrs
TOTAL		4,990.50	4,849.83	3,356.00	2,399.00	3,643.00	3,998.33	1,105.00	746.00	82	97.18%	71.48%	109.75%	67.51%	N/A	N/A	N/A		

Ward name	Specialty	Registered nurses-Day: Total monthly planned staff hours	Registered nurses-Day: Total monthly actual staff hours	Care Staff-Day: Total monthly planned staff hours	Care Staff-Day: Total monthly actual staff hours	Registered nurses-Night: Total monthly planned staff hours	Registered nurses-Night: Total monthly actual staff hours	Care Staff-Night: Total monthly planned staff hours	Care Staff-Night: Total monthly actual staff hours	Patients at 23:59 each day	Day: Average fill rate - registered nurses/ midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/ midwives (%)	Night: Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
ITU/CCU	192 - CRITICAL CARE MEDICINE	3,933.00	3,134.50	1,183.00	967.00	3,698.00	3,008.00	1,116.00	492.00	360	79.70%	81.74%	81.34%	44.09%	17.1	4.1	21.1		Fill rate red no red flags

Ward name	Specialty	Registered nurses-Day: Total monthly planned staff hours	Registered nurses-Day: Total monthly actual staff hours	Care Staff-Day: Total monthly planned staff hours	Care Staff-Day: Total monthly actual staff hours	Registered nurses-Night: Total monthly planned staff hours	Registered nurses-Night: Total monthly actual staff hours	Care Staff-Night: Total monthly planned staff hours	Care Staff-Night: Total monthly actual staff hours	Patients at 23:59 each day	Day: Average fill rate - registered nurses/ midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/ midwives (%)	Night: Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
Delivery Suite	501 - OBSTETRICS																		
Maternity Ward	501 - OBSTETRICS	3,590.00	3,291.00	1,326.25	1,083.75	641.00	605.25	1,105.00	1,069.50	381	91.67%	81.72%	94.42%	96.79%	10.2	5.7	15.9		
MAU	501 - OBSTETRICS																		
TOTAL		3,590.00	3,291.00	1,326.25	1,083.75	641.00	605.25	1,105.00	1,069.50	381	91.67%	81.72%	94.42%	96.79%	10.2	5.7	15.9		

Ward name	Specialty	Registered nurses-Day: Total monthly planned staff hours	Registered nurses-Day: Total monthly actual staff hours	Care Staff-Day: Total monthly planned staff hours	Care Staff-Day: Total monthly actual staff hours	Registered nurses-Night: Total monthly planned staff hours	Registered nurses-Night: Total monthly actual staff hours	Care Staff-Night: Total monthly planned staff hours	Care Staff-Night: Total monthly actual staff hours	Patients at 23:59 each day	Day: Average fill rate - registered nurses/ midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/ midwives (%)	Night: Average fill rate - care staff (%)	Registered nurses	Care Staff	Overall	Red Flag	Comments
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,121.50	1,132.25	360.00	114.00	1,097.75	1,085.75	12.00	24.00	258	100.96%	31.67%	98.91%	200.00%	8.6	0.5	9.1		
Paediatric Unit	420 - PAEDIATRICS	2,161.50	1,679.25	1,271.50	986.25	1,917.83	1,502.33	683.50	583.50	431	77.69%	77.57%	78.33%	85.37%	7.4	3.6	11.0		
TOTAL		3,283.00	2,811.50	1,631.50	1,100.25	3,015.58	2,588.08	695.50	607.50	689.00	85.64%	67.44%	85.82%	87.35%	7.84	2.48	10.32		
PLANNED		13,514.82	11,657.90	11,365.58	9,210.08	10,679.25	9,323.25	5,522.25	4,431.75	3,605	86.26%	81.03%	87.30%	80.25%	5.8	3.8	9.6		
URGENT		14,746.55	13,798.74	16,057.00	14,204.83	10,944.25	11,187.60	9,729.75	8,488.92	7283	93.57%	88.47%	102.22%	87.25%	3.4	3.1	6.5		
W&C		6,873.00	6,102.50	2,957.75	2,184.00	3,656.58	3,193.33	1,800.50	1,677.00	1,070	88.79%	73.84%	87.33%	93.14%	8.7	3.6	12.3		
TRUST TOTALS		35,134.37	31,559.14	30,380.33	25,598.92	25,280.08	23,704.18	17,052.50	14,597.67	11,958	89.82%	84.26%	93.77%	85.60%	4.6	3.4	8.0		

Green - 80% and above
Red - Under 80%

NHS
Southport and Ormskirk Hospital
NHS Trust

TRUST BOARD
5 FEBRUARY 2020

Agenda Item	**TB007/20e**	**Report Title**	**CQC UPDATE**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Bridget Lees Deputy Director of Nursing Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ☑ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The purpose of this report is to inform the Board about the development and progress of the CQC Improvement Plan following the publication of the CQC Inspection Report on 29 November 2019. This report also outlines the governance arrangements and assurance processes going forward to ensure a continuous cycle of sustainable improvement.

KEY FINDINGS

There were 31 identified 'must do' actions relating to beaches of regulation and 92 actions CQC recommend we 'should do' to prevent the Trust from failing to comply with legal requirements in the future.

KEY THEMES

Key themes from the must and should do actions are listed below

- Risk Assessments
- Documentation
- Governance & Risk
- Policy Management
- Complaint Response times
- MCA & DoLs
- Consent
- Patient Experience
- Staffing
- Timeliness of Appraisals
- Equipment Checks
- Medicines Management
- IPC
- Health & Safety
- Mandatory Training (including resuscitation)
- Well Led

Some of the key themes from the inspection directly correlate to our four quality priorities, please see the table below for details. The quality priorities will continue to be monitored in a separate report through Quality & Safety Committee.

ASSURANCE MECHANISM AND PROCESS

The CBUs use their monthly governance meetings to review and monitor improvement against their improvement plans, evidence will be submitted monthly to a central repository, this will inform a central assurance cycle to inform risk ratings (BRAG ratings) which will be linked to the risk registers. The terms of reference for Quality Assurance Panels will be refreshed in order to escalate pace and improve assurance, the Trust will establish 'Confirm and Challenge' and 'Go See' sessions for Core Services to review their evidence and confirm BRAG status of the must and should do actions. This will enable actions to be identified for review at the Quality Assurance Panels and the BRAG status to be confirmed.
The monthly Performance Review Boards (PRBs) will then be used by the Executive Team to challenge core services in relation to progress.

The Board is asked to note:

- They key actions arising from the recent CQC inspection
- That an improvement plan has been developed in response to the findings and shared with the CQC
- The agreed assurance mechanism and process
- Progress against the CQC improvement plan

Strategic Objective(s) and Principal Risks(s)

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

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

Linked to Regulation & Governance

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

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

✓ Compliance ☐ 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)*

The Board is asked to note:

- They key actions arising from the recent CQC inspection
- That an improvement plan has been developed in response to the findings and shared with the CQC
- The agreed assurance mechanism and process
- Progress against the CQC improvement plan

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

CQC Update February 2019

1. PURPOSE OF REPORT

The purpose of this report is to inform the Board about the development and progress of the CQC Improvement Plan following the publication of the CQC Inspection Report on 29 November 2019. This report also outlines the governance arrangements and assurance processes going forward to ensure a continuous cycle of sustainable improvement.

2. BACKGROUND

Summary of Report Ratings

Following the publication of the Southport & Ormskirk Hospital Trust Inspection Report, the ratings for the whole trust remained the same as 'Requires Improvement'.

As part of the new inspection methodology, NHS England and NHS Improvement undertook a Use of Resources assessment for the first time and the Trust was rated 'Inadequate'. The overarching Trust ratings from the inspection are shown below:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔⬅ Oct 2019	Requires improvement ➔⬅ Oct 2019	Good ➔⬅ Oct 2019	Requires improvement ➔⬅ Oct 2019	Requires improvement ⬆ Oct 2019	Requires improvement ➔⬅ Oct 2019

Use of Resources ratings:

Are resources used productively?	Inadequate ●

Combined ratings:

Combined rating for quality and use of resources	Requires Improvement ●

Ratings for Southport & Formby DGH

Ratings for Southport and Formby District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Nov 2019	Requires improvement →← Nov 2019	Good ↑ Nov 2019	Requires improvement →← Nov 2019	Good ↑ Nov 2019	Requires improvement →← Nov 2019
Medical care (including older people's care)	Requires improvement →← Nov 2019	Requires improvement →← Nov 2019	Requires improvement ↓ Nov 2019	Requires improvement →← Nov 2019	Inadequate →← Nov 2019	Requires improvement →← Nov 2019
Surgery	Requires improvement →← Nov 2019	Good ↑ Nov 2019	Good →← Nov 2019	Requires improvement →← Nov 2019	Requires improvement ↑ Nov 2019	Requires improvement →← Nov 2019
Critical care	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Requires improvement →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019
End of life care	Good →← Nov 2019	Good ↑ Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019
* Outpatients	Requires improvement Mar 2018	N/A	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
* Spinal injuries	Requires improvement →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Requires improvement →← Mar 2018
Overall*	Requires improvement →← Nov 2019	Requires improvement →← Nov 2019	Good →← Nov 2019	Requires improvement →← Nov 2019	Requires improvement ↑ Nov 2019	Requires improvement →← Nov 2019

***Outpatients and North West Spinal Injuries Centre were not inspected on the Southport site and therefor the rating did not change**

Ratings for Ormskirk DGH & Community

Ratings for Ormskirk District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
* Urgent and emergency services	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
* Surgery	Requires improvement →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Requires improvement →← Mar 2018
* Maternity	Requires improvement →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Requires improvement →← Mar 2018
Services for children and young people	Requires improvement ↓ Nov 2019	Good ↑ Nov 2019	Good →← Nov 2019	Good ↑ Nov 2019	Good →← Nov 2019	Good ↑ Nov 2019
Outpatients	Good Nov 2019	N/A	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Overall*	Requires improvement →← Nov 2019	Good ↑ Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Requires improvement →← Nov 2019	Requires improvement →← Nov 2019

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health sexual health services	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019	Good →← Nov 2019
Overall*	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019

***Urgent & Emergency Care, Surgery and Maternity were not inspected on the Ormskirk site and therefor the rating did not change**

- Urgent & Emergency Services have improved across three domains and have no Inadequate domains and a Good for Caring & Well Led.

- Surgery in Southport has improved in two domains - Effective (now Good) and Well Led (now Requires Improvement).

- The Well Led improvements in Urgent & Emergency Services and Surgery also means the overall rating for the Trust in this domain has improved from Inadequate to Requires Improvement.

- The Children's and Young People services at Ormskirk has improved to Good overall, however has deteriorated from Good to Requires Improvement in Safe but has improved to Good in both Effective and Responsive domains.

- Overall Ormskirk could not move from Requires Improvement to Good as two services (Maternity and Surgery) which were previously Requires Improvement were not inspected this year

- Sexual Health and End of Life Care were also inspected – both achieving a Good rating

3. KEY FINDINGS

There were 31 identified 'must do' actions relating to beaches of regulation and 92 actions CQC recommend we 'should do' to prevent the Trust from failing to comply with legal requirements in the future.

Must Do Actions

Trust Level / Core Services	Number
Trust Level	8
Urgent & Emergency Care	2
Medical Care	10
Surgery	7
Children & Young People	4
Total	**31**

**for reporting purposes in the improvement plan in Appendix A we have merged the Medicines Management actions into one action on the improvement plan as the improvement measures are incorporated into the Medicines Management Quality Priority.*

Should Do Actions

Trust Level / Core Services	Number
Trust Level	11
Urgent & Emergency Care	18
Medical Care	15
Surgery	7
End of Life	6
Critical Care	15
Outpatients (Ormskirk)	6
Children & Young People	13
Sexual health	1
Total	**92**

4. DEVLOPMENT OF IMPROVEMENT PLAN

The Trust has begun work on addressing all of the areas for improvement identified in the report. As required under Regulation 17(3) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014, we submitted our CQC improvement plan outlining what action we are taking to meet the requirements going forward on 29 December 2019. We were only required to submit our Must Do's 'regulatory actions', however the full plan incorporating Should Do's has been completed this will be monitored / internal governance process. Appendix B provides additional detail on the Requirement notices and the action the CQC have told the Trust to take.

The improvement plan (must do) is attached at Appendix A to this report to detail the actions and timescales for completion. Actions will be tracked for completion and evidence tested through internal governance. The initial RAG ratings are currently being reviewed and will be aligned to key risks, actions / must do's will also be themed into wider priorities for assurance.

5. KEY THEMES

Key themes from the must and should do actions are listed below

- Risk Assessments
- Documentation
- Governance & Risk
- Policy Management
- Complaint Response times
- MCA & DoLs
- Consent
- Patient Experience
- Staffing
- Timeliness of Appraisals
- Equipment Checks
- Medicines Management
- IPC
- Health & Safety
- Mandatory Training (including resuscitation)
- Well Led

Some of the key themes from the inspection directly correlate to our four quality priorities, please see the table below for details. The quality priorities will continue to be monitored in a separate report through Quality & Safety Committee.

Care of the Deteriorating Patient	Care of the Older Person	Medicines Management	Infection Prevention Control
• 7 Day Services • Escalation & Communications • Paediatrics observations completed and documented as per trust policy.	• Documentation • Privacy & Dignity • MCA / DoLs & Consent	• Medicines (including controlled drugs) are stored, prescribed, administered, recorded and disposed of according to national guidance • Regulation of fridge and room temperatures	• Personal Protective Equipment (PPE) Compliance • Compliance with IPC policy compliance • Isolation and signage • Cleaning Standards

In addition services rated as Good (Critical Care, End of Life, Outpatients, Sexual Health and Children & Young People) also require improvement within areas and domains new themes

have emerged including 7 Day Services across the Trust in particular in paediatrics in relation to escalation and communication.

6. ASSURANCE MECHANISM AND PROCESS

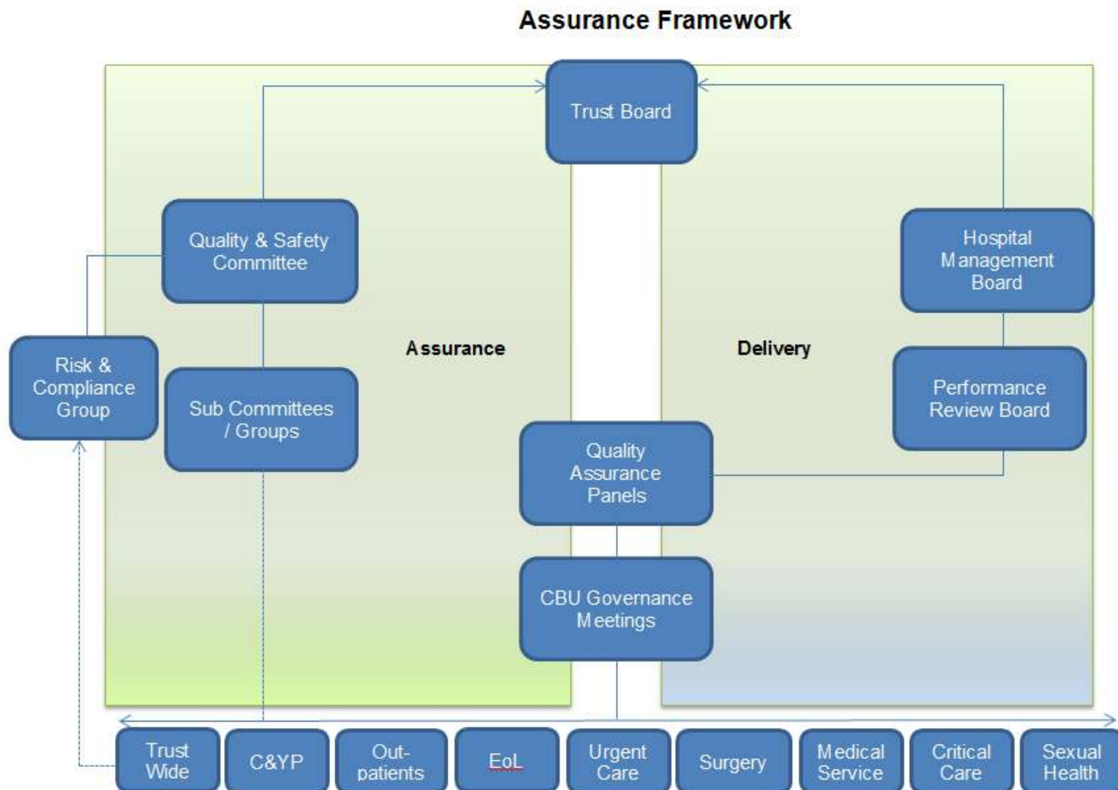
The CBUs use their monthly governance meetings to review and monitor improvement against their improvement plans, evidence will be submitted monthly to a central repository, this will inform a central assurance cycle to inform risk ratings (BRAG ratings) which will be linked to the risk registers.

The terms of reference for Quality Assurance Panels will be refreshed in order to escalate pace and improving assurance, the Trust will establish 'Confirm and Challenge' and 'Go See' sessions for Core Services to review their evidence and confirm BRAG status of the must and should do actions. This will enable actions to be identified for review at the Quality Assurance Panels. The revised Quality Assurance Panels have been scheduled in from February 2020 to test the 'Green' BRAG rated evidence and review progress against the 'Ambers'.

The monthly Performance Review Boards (PRBs) will then be used by the Executive Team to challenge core services in relation to progress.

Accountability for the development of CBU improvement plans sits with the Chief Operating Officer, the responsibility for Governance in relation to CQC compliance sits with Director of Nursing.

The overall governance and delivery structure is illustrated below;



Monthly CQC engagement meetings will continue in 2020, the Trust has a new local CQC Relationship Owner (RO) and Inspection Manage since the summer inspections. The first engagement visit is scheduled for Thursday 6 February, this will be an introduction to the new team and an opportunity to plan the engagement visits for the next six months. The engagement visits will also be used to test improvement and discuss any themes from the CQC Insight reports or subjects raised directly with the CQC.

8. KEY ACTIONS / PROGRESS

Since the publication of the report, immediate actions have been taken to address actions including:

- My Kit Check, electronic resuscitation trolley check list rolled out across both sites – soon to be extended to sepsis trolleys.
- Pump prime investment in resuscitation equipment for adult and paediatric life support training
- Investment in COSHH Cupboards for all clinical and ward areas, training underway in relation to use and legislation

In future this section will be used to include a summary of progress against trajectories and recommendations from Quality Assurance Panels and Core Service Reviews including any risks to delivery.

9. RECOMMENDATIONS & NEXT STEPS

The Board is asked to note:

- They key actions arising from the recent CQC inspection
- That an improvement plan has been developed in response to the findings and shared with the CQC
- The agreed assurance mechanism and process
- Progress against the CQC improvement plan

APPENDIX B

Requirement Notices

The table below shows the legal requirements that the Trust was not meeting. The Trust must send CQC a report that says what action it is going to take to meet these requirements.

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated Activity	Regulation
Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Regulated Activity	**Regulation**
Nursing care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Regulated Activity	**Regulation**
Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Regulated Activity	**Regulation**
Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Regulated Activity	**Regulation**
Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Southport and Ormskirk Hospital NHS Trust

Public Trust Board

5 February 2020

Agenda Item	TB007/20e	Report Title	Seven Day Services Self-Assessment Board Assurance Return
Executive Lead	Therese Patten, Director of Strategy Terry Hankin, Medical Director		
Lead Officer	Kevin Thomas, Assistant Medical Director		
Author	Rachel Flood-Jones, Project Manager		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Board is asked to receive the '7DS Self-Assessment' submission which was presented to the November Quality and Safety Committee for approval and submitted to NHSE/I on 29th November 2019.

The Seven Day Hospital Services (7DS) Programme

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers were to achieve all standards, with a focus on four priority standards (as identified in 2015 with the support of the Academy of Medical Royal Colleges.)

The four priority standards require clarification on the return as to whether the Trust is compliant, these are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions

Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

What is the 7DS Self-Assessment?

To enable providers to track their progress in achieving the four priority 7DS clinical standards, a self-assessment survey was developed. From 2016 providers have measured their delivery of 7DS using a survey tool, this was replaced in 2018 with the Board Assurance Framework Return.

Findings and Next Steps

The November 2019 return shows that current levels of compliance for 7DS provision will not meet requirements (with compliance against only Clinical Standard 6, see Appendix 2) by March 2020 and that additional work is required to deliver the required improvement trajectory.

Additional work is needed to deliver the required improvement trajectory. This paper gives an options appraisal of the next steps.

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	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*

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

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

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

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

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

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

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

Previously Presented at:

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

1.0 Executive Summary

The Board is asked to receive the Trust's Seven Day Service self-assessment return to as submitted to NHSE/I on 29th November 2019[1].

The November 2019 submission was submitted for assurance to the Quality and Safety Committee, as a subcommittee to the Board. (After having been taken for consideration to the Executive Team Meeting and Hospital Management Board.) This is in line with NHSE/I recommendation, that the method for achieving board assurance is to be decided by the provider either through the Board or through a sub-committee of the Board.

The return provides assurance to NHSE/I on the Trust's seven day service provision in line with the ten clinical standards developed by the NHS Services, Seven Days a Week Forum in 2013.

The Trust's November 2019 return shows that current levels of compliance for 7DS provision will not meet requirements (with compliance against only Clinical Standard 6, see Appendix 2) by March 2020 and that additional work is needed to deliver the required improvement trajectory.

This paper contains the latest self-assessment submission and presents an options appraisal for the next steps.

2.0 Background

The Seven Day Services (7DS) Programme

The objective of the Seven Day Services (7DS) programme is to ensure that patients, who are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. The requirement has been for seven day consultant-led services to deliver this requirement with the original deadline of March 2020.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards require clarification on the return as to whether the Trust is compliant, these are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions
Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

[1] The submission was to be presented to Trust Board at the next possible opportunity, which in line with the dates for the submission of papers and the lack of Public Trust Board in January 2020 brings us to the February Board.

Self-Assessment Returns

To enable providers to track their progress in achieving the four priority 7DS clinical standards, a self-assessment survey was developed. From 2016 providers have measured their delivery of 7DS using a survey tool, this was replaced in 2018 with the Board Assurance Framework Return.

The first of three Board Assurance self-assessments were made to NHSE/I in June 2018. At this time internal discussions took place at Executive level to decide whether a Trust programme was required to deliver seven day services. At the time the reconfiguration of service provision was dependent upon the outcome of the system Acute Sustainability Programme and subsequently Vision 2020. In view of this, no standalone programme has been established to date. Self-assessment returns have been compiled from clinical audit data and updates from clinical staff, with sign off from the responsible Executives ahead of submission.

The results of the May 2019 submission were published by NHSE in July 2019. Southport and Ormskirk NHS Hospital Trust reported compliance against two of the four priority Clinical Standards. The tables below show the Trust's position relative to both the rest of the country and to North West Peers.

July 2019 7 Day Hospital Services Self-Assessment Results - All Participating Trusts	Qty.	%
Compliance with 0 Priority Clinical Standards	3	2%
Compliance with 1 Priority Clinical Standards	13	9%
Compliance with 2 Priority Clinical Standards	55	38%
Compliance with 3 Priority Clinical Standards	41	28%
Compliance with 4 Priority Clinical Standards	33	23%
Total Number of Trusts	**145**	**100%**
July 2019 7 Day Hospital Services Self-Assessment Results - All North West England Trusts	**Qty.**	**%**
Compliance with 0 Priority Clinical Standards	1	4%
Compliance with 1 Priority Clinical Standards	3	12%
Compliance with 2 Priority Clinical Standards	10	38%
Compliance with 3 Priority Clinical Standards	8	31%
Compliance with 4 Priority Clinical Standards	4	15%
Total Number of Trusts	**26**	**100%**

3.0 November 2019 Self-Assessment Submission

What changed between the June 2019 and November 2019 Submissions?

Many improvements pertinent to the delivery of the Clinical Standards were reported in November 2019, most notably:

- Improved efficiency in patient flow through the Patient Flow Improvement Programme which has overseen the embedding of SAFER (Red to Green Board Rounds and Patients' Five Questions)
- Electronic Board Round pilot (to facilitate consultant review of the patients care on the days where resource is not available for a consultant led ward round.)
- An increase in middle grade staff for Acute Medicine.
- A 10% improvement in Consultant Review within 14 hours of emergency admission.
- Consultant of the Week in Orthopaedics.
- The approval of the Medicines Management Business Case for the recruitment to support extended evening and weekend cover (which will support CS9 – 7/7 Transfer to Community, Primary and Social Care).
- The approval of the Medicines Management Business Case will also deliver a Consultant Pharmacist in A&E and Ward Pharmacy Assistants which will support (CS3 7/7 MDT Review) for increased Medicines Reconciliations within 24 hours of admission.
- The NHSI Quality Improvement Building Quality Programme run over the summer of 2019 with teams from senior management providing assurance against CS10.

Improvement Trajectory / Gaps

Despite these improvements, the November submission saw a drop from compliance against two to compliance against only one of the four Priority Clinical Standards.

In June 2019 the return had reported that the Trust was actively working towards a formal arrangement with Aintree to provide Upper GI Endoscopy for weekends and out of hours cover (CS5 Access to Diagnostic Services.) This had not been achieved by November 2019. It was also reported in that there is a gap in the Bronchoscopy Service where again there is no formalised arrangement for out of hours and weekend cover.

The self-assessment has also identified gaps in service provision for the following areas:

- (CS2) Since the June 2019 there has been an increase in middle grade staffing for Acute Medicine which has supported the delivery of the 14 hour target, however there are **ongoing vacancies at consultant level that have not been filled, particularly for Consultant Geriatricians** (the Trust has had difficulty recruiting to this role with a current establishment of 0.6 WTE substantive Geriatrician cover against the required 8 WTE required to support the local

demographic).

- (CS2) All surgical and paediatric patients are reviewed by a consultant the day after admission, however if the patient is admitted after 12 noon, then they will not be seen until the following morning which is likely to be outside of the 14 hour time limit. **An additional three Consultants are required in order to deliver of the 14 hour standard in Paediatrics.**
- (CS2) In order to deliver a consultant led weekend service to ensure compliance with Clinical Standard 2, **further work is required to change consultant work plans to cover weekends.** In the case of an acute emergency at night or of a weekend the on call consultant will review the patient. It is understood that a dedicated project work stream is being scoped for 2020 as part of the Trust Workforce Improvement Programme.
- (CS4) An audit was undertaken in August to assess consultant and junior doctor staffing levels on the wards. It showed that there is not an issue with a shortage of doctors on the wards **but that there has been poor management of rotas and the misallocation of staff (for example cohorts of staff all attending training at the same time.)**
- (CS8) Acute Medicine: On the Ambulatory Medical Unit, there are daily consultant rounds on mornings on weekdays. This is followed by afternoon board round of all patients by consultant; any sick patients are then reviewed by the consultant. Sick patients on AMU will therefore be reviewed twice during the day on weekdays. On weekends, we there is no acute medicine consultant cover. **Only patients newly admitted over the weekend get seen by the on call consultant once over the weekend.**

The following items were highlighted as Must / Should Do Actions for 7DS service in the Trust's CQC Inspection Report 2019 and are included in the Action Plan.

No	Core Service	Regulation No	Must Do / Should Do	New Theme	Area for improvement
01 (2019)	Children & Young People	Regulation 12(2)(a)	Must Do	7 Day Services	The trust must ensure that every child is seen by a consultant paediatrician within 14 hours
18 (2019)	Critical Care	(Regulation 18)	Should Do	7 Day Services	The trust should ensure that consultant ward rounds are consistently completed twice a day during weekends.
24 (2019)	Critical Care		Should Do	7 Day Services	The trust should improve seven-day service provision to provide more continuity of care for patients and maintain national standards.
85 (2019)	Trust Wide		Should Do	7 Day Services	The trust should consider improving child and adolescent mental health services provision to a seven-day service.

4.0 Next Steps

As advised by NHSE/I, provider boards are to be engaged, sighed and involved with the 7DS programme as it directly relates to improvements in patient care and hospital flow [2]. The return is designed to ensure continuity and robust, accurate assessment for Trust's return of 7DS performance in alignment with the organisation's planned improvement trajectory.

In order to effectively deliver the four Priority Clinical Standards and 7DS provision the following is required:

- Confirmation of Trust's strategic direction to deliver 7DS and the Clinical Standards
- The method of delivery and the appropriate resource are required to do this.

Once this is agreed, a coherent plan to deliver the required improvement trajectory can be developed.

In September 2019 NHSE's Seven Day Services Improvement Programme (SDSIP) Team advised that the focus of the 7DS Programme will increasingly be on Patient Flow and how it is intrinsic to the mutual delivery of 7DS provision.

Options appraisal

The following are suggested options to support the delivery of requirements going forward:

1. The delivery of the Seven Day Service to be incorporated into the scope of the Acute Sustainability Programme with the exception of specific requirements for job planning (to be delivered through the Workforce Improvement Programme) and requirements appertaining to patient flow (to be actioned through the Patient Flow Improvement Programme.)
2. The delivery of the Seven Day Service is a dedicated Trust Programme with the exception of specific requirements for job planning (to be delivered through the Workforce Improvement Programme) and requirements appertaining to patient flow (to be actioned through the Patient Flow Improvement Programme.)
3. A dedicated resource to formalise governance to deliver compliance with the priority clinical standards and oversee the for future self-assessment submissions that are approved through the Trust Board.
4. Future self-assessment returns are prepared for the Trust Board by a dedicated and appropriate resource that links into Clinical Services for supporting evidence.

Option one would ensure a level of formalisation to ensure full board-level scrutiny and external assurance in the context of regional plans, but would be dependent upon agreement of a collaborative arrangement. Option two would require dedicated Programme

[2] NHSE /I Board assurance framework for Seven Day Hospital Services: an introduction for providers of acute services November 2018

Office resource. Options three and four would be dependent upon a single point of failure and would not mobilise wider engagement to drive transformation. Option four does not provide the same level of assurance as the others.

Appendix 1 - Original paper to QSC November 2019

NHS
Southport and Ormskirk Hospital
NHS Trust

QUALITY & SAFETY COMMITTEE

25th November 2019

Agenda Item	QS000/19	Report Title	Seven Day Services Self-Assessment Board Assurance Return
Executive Lead	Therese Patten, Interim Chief Executive Officer		
Lead Officer	Kevin Thomas, Assistant Medical Director		
Author	Rachel Flood-Jones, Project Manager		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Committee is requested to approve the self-assessment return to NHSE of the Trust's seven day service provision in line with the ten clinical standard developed by the NHS Services, Seven Days a Week Forum in 2013.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. The four priority standards require clarification on the return as to whether the Trust is compliant, these are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions
Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The new 7DS board assurance framework is based on principles that ensure continuity and robust, accurate assessment for Trust's return of 7DS performance in alignment with the organisation's planned improvement trajectory. The report is to be completed bi-annually, with sign-off by the Trust Board before submission.

Assurance for the November 2019 self-assessment submission is to be delivered through the governance route of Executive Team Meeting, Hospital Management Board and the Quality and Safety Committee. The submission will subsequently be taken with recommendations to the

December Trust Board. This process is in line with the recommendations of the NHSE 7DS briefing paper.

The report is to formally assure the Board of the Trust's position in compliance against the 10 clinical standards with a recommendation for next steps as detailed in section 2.0 of the paper.

The November 2019 return shows that current levels of compliance for 7DS provision will not meet requirements by March 2020 and that additional work is required to deliver the required improvement trajectory. The reconfiguration of service provision has since 2018 come under the scope of the regional Acute Sustainability Programme and Vision 2020, it is for this reason there has not been a stand-alone Trust Programme to deliver 7DS.

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*

1.0 Executive Summary

The Board is requested to approve the self-assessment return to NHSE of the Trust's seven day service provision in line with the ten clinical standard developed by the NHS Services, Seven Days a Week Forum in 2013.

The Seven Day Hospital Services (7DS) Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.

The new 7DS board assurance framework is based on principles that ensure continuity and robust, accurate assessment and is for Trust's self-assessment of 7DS performance in alignment with the organisation's planned improvement trajectory. The report is to be completed bi-annually, with sign-off by the Trust Board for submission.

Assurance for the November 2019 self-assessment submission is to be delivered through the governance route of Executive Team Meeting, Hospital Management Board and the Quality and Safety Committee. The submission will subsequently be taken with recommendations to the December Trust Board. This process is in line with the recommendations of the NHSE 7DS briefing paper.

The report is to formally assure the Board of the Trust's position in compliance against the 10 clinical standards.

The November 2019 return shows that current levels of compliance for 7DS provision will not meet requirements by March 2020 and that additional work is required to deliver the required improvement trajectory. The reconfiguration of service provision has since 2018 come under the scope of the regional Acute Sustainability Programme and Vision 2020, it is for this reason there has not been a stand-alone Trust Programme to deliver 7DS.

2.0 Recommendations

The recommendation to the committee is that 7DS service reconfiguration requirements are incorporated into the scope of the Acute Sustainability Programme while consultant job planning is delivered through Trust's Workforce Improvement Group. This level of formalisation will ensure full board-level scrutiny and external assurance if necessary in the context of regional plans.

NHSE's recommendation for providing board assurance as outlined in its 2018 7DS Briefing paper, states that the exact method for achieving this board assurance is for providers to decide. "This could be a specific item on a board meeting agenda, or the 7DS assessment could be reviewed by a board subcommittee and then form part of this subcommittee's report to the board – whatever method a provider decides is the best for them to gain formal board assurance of 7DS delivery." Assurance for the November 2019 self-assessment submission is to be delivered through the governance route of Executive Team Meeting, Hospital Management Board and the Quality and Safety Committee. The recommendation for future submissions is that they are prepared by the project team aligned with the development of acute 7DS provision.

3.0 November 2019 Submission

The Board is asked to review and approve the content of the self-assessment return ahead of submission to NHSE on 29th November 2019. The return has been produced within the required template. The four priority clinical standards require additional clarification on the level of service provision during the week and at weekends with an overall score of compliance or non-compliance.

Four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. The four priority standards require clarification on the return as to whether the Trust is compliant, these are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions
Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

Appendix 2.1 - Seven Day Services Self-Assessment Return November 2019 (NHSE/I Submission format)

Clinical Standard	Name of Clinical Standard	Definition of Clinical Standard	Supporting Evidence	Specialist Area	Weekday	Weekend	Overall Score
CS1	PATIENT EXPERIENCE	**Shared decision making and informed choices for families and carers 7/7.** (Patients, and where appropriate, families and carers must be involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week).	1.1 Both the Older People's Care Programme and the Deteriorating Patient Project are driving the requirement for advanced care planning discussions with patients and their families and carers. Training, processes and documentation are being designed to ensure that conversations are held with patients and their families / carers as early as appropriately possible in order to create a proactive plan for care in the last stages of life which will ensure continuity of care at any touchpoint across the patient journey 24/7. The creation of a specific Anticipatory Clinical Management Plan is the aim for patients who have been identified for End of Life or palliative care. 1.2 The Trust's Patient Flow Improvement Programme is embedding the SAFER model across wards (Senior Ownership, All Patients, Flow, Early Discharge & Review). As part of Work Stream 2 "Best Practice Ward Processes to Reduce Length of Stay" "Family expectations and participation is managed on and throughout admission to support removing choice as a delay to discharge". This will ensure shared decision making and informed choices for patients, families and carers. Patient conversations are to commence from admission when the clinician is to give the Expected Date of Discharge (EDD). Ward staff are to ensure that throughout the patient's stay, the patient (and their carers/ families) know the answers to the five questions (which are posted next to each bed): 1. What is wrong with me? 2. When am I going home? 3. How will I know when I am ready to go home/ Am I now safe enough to go home? 4. Have I got my copy of 'Your Discharge from Hospital' Booklet 5.What is my Expected Date of Discharge (EDD). This ensures that the patient and their family are sighted on the stages of their journey with a clear pathway to returning home. 1.3 In 2017 the Trust and the Patient Experience Group created the SOHT Patient Charter which incorporates pledges to 'Develop and implement systems and processes to involve Carers and Families in decision making' and 'Ensure that access to information is easy and relevant for patients, carers, families and professionals.' The Trust has a dedicated Patient Experience Matron who is responsible for acting on patient feedback and the triangulation of this with audit findings and regulator recommendations. Ongoing activity relating to the Patient Experience portfolio incorporates: • The Trust works within the mental capacity act and where it is deemed that patients do not have mental capacity to make own informed choices, decisions are made with family/carers that are in the patients best interest. • Promotion of Johns Campaign to allow open visiting for carers to support patients with additional needs. This allows increased presence of carers to be involved in decision making. National Patient Experience Surveys: • Urgent and Emergency Care Survey 2018 – 92% of patients reported that they were involved in decisions about care and treatment. • Children and Young Peoples Survey 2018 – 93% of parents reported that staff agreed a plan with them about their child's care. 95% of parents reported that staff involved them in decisions about their child's care and treatment. • Maternity Survey 2019 - in the antenatal period 99% of women reported that they were involved enough in decisions about their care. In labour and birth 97% of women reported that they were involved enough in decisions about their care. 1.4 The Trust in association with patient and community feedback and the latest studies in dementia care is committed to ensuring that both sites are dementia friendly, this requirement has been included in the ward refurbishment programme for 2020. 1.5 The Trust is part of the national Surgical Ambulatory Emergency Care Improvement Programme with a structured project work stream; one aspect of which has been to review the Patient Experience through the Surgical Ambulatory Unit. NHS Elect have supported the Trust's SAEC project group with an Experience Based Design Workshop and an App with which to capture patient feedback. The team is reviewing both the patient and staff experience in association with increased efficiencies and a reduction in length of stay for SAU patients.	Not required for NHSE Template			

Clinical Standard	Name of Clinical Standard	Definition of Clinical Standard	Supporting Evidence	Specialist Area	Weekday	Weekend	Overall Score
CS2	14 HOUR REVIEW	**All Emergency Admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest, within 14 hours of admission to hospital**	The audit for 14 hour consultant review was run in October 2019 with an increased sample size of 70 (a retrospective audit of patients who attended A&E in August and September 2019 and were subsequently admitted as detailed in **Appendix 1**). The audit shows a 10% improvement on the last sample taken from April 2019 but at 80% compliance, the Trust is therefore still falling short of the 90% standard requirement. Since the June 2019 submission there has been an increase in middle grade staffing for Acute Medicine which has supported the delivery of the 14 hour target, however there are ongoing vacancies at consultant level that have not been filled, particularly for Consultant Geriatricians (the Trust has had difficulty recruiting to this role with a current establishment of 0.6 WTE substantive Geriatrician cover against the required 8 WTE required to support the local demographic). Orthopaedic performance has also greatly benefitted from consultant recruitment which has allowed a Consultant of the Week (COW) rota to be set up from March 2019. Patients admitted are seen/discussed at consultant level within 14 hours; there is a daily Ward Round run by the on call team every day from 1,900 to 2,000 specifically to hit clinical standard 2 which is reflected in consultant job plans. All surgical and paediatric patients are reviewed by a consultant the day after admission, however if the patient is admitted after 12 noon, then they will not be seen until the following morning which is likely to be outside of the 14 hour time limit. An additional threePaediatric Consultants are required in order to deliver of the 14 hour standard. In order to to deliver a consultant led weekend service to ensure compliance with Clinical Standard 2, further work is required to change consultant work plans to cover weekends. In the case of an acute emergency at night or of a weekend the on call consultant will review the patient. A dedicated project work stream is being scoped for 2020 to undertake this piece of work in conjunction with the newly established Trust Workforce Improvement Group.	NA	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	**No, the standard is not met**
CS3	MDT REVIEW	**14 hour assessment by MDT for emergency in-patients. An integrated management plan with EDD and medicines reconciliation within 24 hours.**	Emergency admissions to the Observation ward have a consultant ward round with Occupational Therapy and Physiotherapy input 7 days a week each morning. From November 2019 the Red to Green MDT Board Round is to follow a standardised approach involving nursing, therapies, Discharge Facilitators with junior doctor / consultant input. The supporting Standard Operating Procedure confirms that the R2G Daily Board Round is designed " To ensure that all in-patients receive a MDT approach to support their in-patient stay and that patient flow is managed appropriately, with the right membership to be effective." Board Round attendance is to be monitored centrally through the Patient Flow Improvement Programme alongside the Patient Flow suite of KPIs. The Board Round SOP also confirms the standard practice that "the 'expected date of discharge' (EDD)... should be set along with the CCD at the point of admission." The last annual Medicines Reconciliation Audit undertaken in January 2019 reported that only 48% of patients had a drugs history completed with 24 hours of arrival. The CQC Inspection to the Trust August 2019 confirmed many shortfalls in Trust's management of medicines and pharmacy service, attributable in part to a chronic lack of investment. Recommendations from both the CQC and NHSI included the requirement for an extension to the existing service. At the November 2019 Trust Board a Business Case for £0.5m was approved to support extended evening and weekend cover, Consultant Pharmacist in A&E and Ward Pharmacy Assistants. The Trust has also been sucessful in winning £0.7m to support the purchase and implementation of an Electronic Prescribing and Medicines Administration system. Medicines Management is one of the Trust's 4 Quality Programmes under which 14 hour review of Medicines is to be delivered.	Not required for NHSE Template			

Clinical Standard	Name of Clinical Standard	Definition of Clinical Standard	Supporting Evidence	Specialist Area	Weekday	Weekend	Overall Score
CS4	SHIFT HANDOVERS	**Handovers by a senior decision maker at designated time and place. Handover processes including communication & documentation requirements formalised in a policy).**	The Red to Green Board Round is supported by the new Morning Handover template which is to be used by Bed Managers and Clinical Coordinators. This will inform the R2G Board Round which will feed into the Electronic Clinical Board Round. The Electronic Board Round has been developed and piloted to standardise and document the daily senior review of patients. The requirement to document daily senior cover originated from junior doctor requests for additional supervision on wards; (the Clinical Ward Board function ensures that on days that the consultant does not undertake a Board Round, patients are reviewed by a junior doctor in the first instance followed up with a remote review by the consultant). The Standard Operating Procedure for the Electronic Clinical Board Round will be written once the pilot has been signed off; this has been delayed due to inadequate IT resource to undertake the required fixes for the final iteration of the PDSA cycle. As soon as this has been completed the model will be rolled out across all wards in line with the ward refurbishment project (a private room and IT equipment is required to deliver the activity in a confidential manner to protect patient confidentiality.) An audit was undertaken in August to assess consultant and junior doctor staffing levels on the wards. It showed that there is not an issue with a shortage of doctors on the wards but that there has been 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.	Not required for NHSE Template			
CS5	ACCESS TO DIAGNOSTIC SERVICES	**Hospital inpatients must have scheduled access to diagnostic services such as X-ray, Ultrasound, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Echocardiography, Endoscopy, Bronchoscopy and pathology seven days a week. Consultant-directed diagnostic tests and completed reporting must also be available seven days a week: Within 1 hour for critical patients, Within 12 hours for urgent patients, Within 24 hours for non-urgent patients**	The Trust standards have not changed since the first return In April 2018 when the Trust reported 92% compliance with this standard. It is to be noted that Upper GI endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust. Discussions remain ongoing as to the formalisation of the arrangement. Bronchoscopy is provided over two days a week, one day on each site. On week days when the service does not run, they will be slotted into gaps in the Endoscopy rota. There is not currently a formalised arrangement for out of hours and weekend cover; in these circumstances, a call will be made to Liverpool Heart and Chest Hospital to see if there is on call capacity for the patient in question. If there is no capacity then the patient remains at Southport and Ormskirk Hospital until they can be send by a Respiratory Specialist.	Microbiology	Yes available off site via formal	Yes available off site via formal arrangement	**No the Standard is not met**
				Computerised Tomography (CT)	Yes available on site	Yes available on site	
				Ultrasound	Yes available on site	Yes available on site	
				Echocardiography	Yes available on site	Yes available off site and off site by	
				Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
				Upper GI Endoscopy	Yes available on site	No the test is only available on or off site via informal arrangement	
CS6	CONSULTANT DIRECTED INTERVENTIONS	**Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: Critical care, Interventional radiology, Interventional endoscopy, Emergency general surgery.**	The Trust continues to be compliant as per the detail provided. Interventional Endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust. The Trust has stroke thrombolysis 24/7 cover with support of Cumbria and Lancashire Telestroke network, we are involved in the redesign of the stroke pathway in North Merseyside with Aintree and Royal Liverpool University Hospital.	Critical Care	Yes available on site	Yes available on site	**Standard is met**
				Interventional Radiology	Yes mix of on site & off site by formal arrangement	Yes mix of on site & off site by formal arrangement	
				Interventional Endoscopy	Yes available on site	Yes mix of on site & off site by formal arrangement	
				Emergency Surgery	Yes available on site	Yes available on site	
				Emergency Renal Replacement Therapy	Not applicable to patients in this Trust	Not applicable to patients in this Trust	
				Urgent Radiotherapy	Yes available on site	Yes mix of on site & off site by formal arrangement	
				Stroke Thrombolysis	Yes available on site	Yes available on site	
				Percutaneous Coronary Intervention	Not applicable to patients in this Trust	Not applicable to patients in this Trust	
				Cardiac Pacing	Not applicable to patients in this Trust	Not applicable to patients in this Trust	

Clinical Standard	Name of Clinical Standard	Definition of Clinical Standard	Supporting Evidence	Specialist Area	Weekday	Weekend	Overall Score
CS7	MENTAL HEALTH	**Mental health needs identified for acute admissions to be assessed by psychiatric liaison within 1 hour for emergency care and 14 hours for urgent care 7/7**	In November 2018, Southport Core Mental Health Liaison Team commenced the provision of the 24/7 Service for the Trust. Based on the Southport site, the team accepts referrals from both A&E and the Wards . Patients are triaged against the one hour target by the Team's Support Workers and are then assessed by a Practitioner against the four hour target for either admission or discharge. KPI targets are set at 90% for Merseycare (against the national target of 75%) which are being met **(Appendix 2).**	Not required for NHSE Template			
CS8	ONGOING REVIEW IN HIGH DEPENDENCY AREAS	**All patients on the Acute Medical Unit, Acute Surgical Assessment Unit, Intensive Therapy Unit and other high dependency areas are seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.**	The Trust is not fully compliant with Clinical Standard 8 in Medicine. Acute Medicine: On the Ambulatory MU, we have daily consultant rounds on mornings on weekdays. This is followed by afternoon board round of all patients by consultant, any unwell patients are then reviewed by the consultant. So any unwell patients on AMU will get reviewed twice during the day on weekdays. On weekends, we do not have acute medicine consultant cover. Only patients newly admitted over the weekend get seen by the on call consultant once over the weekend. General Medical Wards: once patients are moved to the general medical wards, they are seen by the consultants two or three times a week. Currently, it is not possible for all consultants to do 3 ward rounds per week based on current job plans. On remaining weekdays, consultants discuss the patient with the Team on board rounds. We do not have 7 day service so over the weekend, patients are only reviewed by a consultant if they become unwell. The on call team have access to the on call consultant in case any patient requires urgent review over the weekend. Patients with high dependency needs are cared for on the Critical Care Unit based in Southport and Formby District General Hospital. Ward rounds are conducted by the Critical Care Consultant of the day, twice daily and documented on the Critical Care proforma. This process occurs seven days a week. All new patients while on EAU get 2 daily reviews one in the morning which is direct patient contact and second in the afternoon which is a 'board round'. Any unwell patients identified at board round will then get a full review as well. As reported in our last return, the Trust's Critical Care Outreach Team was extended to 24/7 cover on 1st April 2019; the team are giving a daily review of all high risk patients, patients with a NEWS 2 score of 5 or above, patients with AKI level 3 and patients for whom deterioration concerns have been flagged. The Trust's new NEWS2 Track and Trigger Policy provides clear guidance on the frequency of observations and the processes for escalation. Quality improvement work is on going to find best practice to support the delivery of the observations protocol 24/7. As documented against Clinical Standard 4, an Electronic Board Round has been developed to standardise and document the daily senior review of patients.The finalisation of the pilot for roll out across the Trust has been delayed due to inadequate IT cover to undertake the required 'IT fixes'. 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.	NA	Once daily: yes the standard is met for over 90% of patients admitted in an emergency Twice daily: yes the standard is met for over 90% of patients admitted in an emergency	Once daily: No the standard is not met for over 90% of patients admitted in an emergency Twice daily: yes the standard is met for over 90% of patients admitted in an emergency	Standard is met
CS9	TRANSFER TO COMMUNITY, PRIMARY & SOCIAL CARE	**Support services to be available 7/7 to ensure next steps for patient care are consultant led whether in hospital, community or mental health setting).**	As detailed above under 'Mental Health, the Mental Health Liaison Team has been on the Southport site providing 24/7 for the last 12 months with rapid 1 hour response to patients in crisis in ED. Targets are being met for both A&E patients being seen within 1 hour, being placed on a pathway within 4 hours or being seen from a ward within 24 hours. The Trust has limited pharmacy weekend cover (currently for a limited time each Saturday) however a business case was approved a Board level in November 2019 to extend weekend working. The requirement for number of improvements in medicines management had come from both NHSI and the August 2019 CQC Inspection, a dedicated project is now overseeing additional recruitment and a revision of processes to drive improved efficiency. The Trust has also been successful in securing £700k of funding from the 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. The Trust currently has the following support services available: 7 day pharmacy cover, weekend therapy service, 24/7 in-reach from Mersey Care into the Emergency Department for mental health. There are Daily Discharge MDT huddles and "Long Stay Tuesday" (Multi-agency discharge events) with Local Authority and community teams which cover 7/7 days and support weekend discharges; the Trust is working with local authority for Sefton to develop improvements for weekend transfers to transitional beds. At the end of 2018, the Trust employed eight Discharge Facilitators to liaise with community, primary and social care. As reported in February 2019, while this supported the transfer of patients back home, the full handover to community services fell short due to inadequate community service provision. (For example the Home First initiative which was scoped as a joint venture was put on hold for 6 months due to a lack of community resource to match Trust Resource to deliver). In May 2019, there were still no Home First Discharges being facilitated by ICRAS in North Sefton. West Lancashire are able to facilitate up to 10 patients a week and have adopted a flexible approach to time slots for discharges. Therapy services are running over 7 days a week in the hospital with a focus on discharge planning and patient flow at weekends both hospital sites. Ongoing engagement with community health care partners is needed to fulfil this clinical standard; the Trust is now working with Strata Health on the recommendation of NHSI to drive system-wide improvements to support discharge and patient flow through the hospital.	Not required for NHSE Template			

Clinical Standard	Name of Clinical Standard	Definition of Clinical Standard	Supporting Evidence	Specialist Area	Weekday	Weekend	Overall Score
CS10	QUALITY IMPROVEMENT	**All those involved in delivery of acute care to be involved in the review of patient outcomes to drive care quality improvement).**	In May 2019 the Chief Operating Officer approached NHSI/E to support the development of a Southport and Ormskirk approach to Quality Improvement Building Quality Improvement Capacity and Capability (QICC). This programme was facilitated by the PMO who managed the programme logistics with NHSI/E and supported all the projects and project leads through hands on coaching and project support. Appendix 3 outlines the programme objectives, content, outputs and next steps. The programme was delivered by NHSI/E colleagues with over 50 staff attending the initial session in June, with the opportunity for over 100 staff to be involved across the whole programme. Executive directors attended sessions and took an executive sponsor role for specific projects within the programme. Short quality improvement projects are still ongoing and there is increase appetite and confidence across senior management to undertake tests of change. The Trust's Programme Office is overseeing the delivery of the four quality priorities through the following projects / programmes: 1. Recognition and Care of the Deteriorating Patient Project (which has superseded the former Reducing Avoidable Mortality Project) 2. Medicines Management Improvement Programme 3. Infection Prevention and Control Project 4. Older People's Care Programme (incorporating the Trust's Frailty Pathway) The Patient Flow Improvement Programme (PFIP) is an operational transformation programme supported by the delivery of QI methodology and delivered by the Urgent Care Directorate with the aims of: • Reducing the number of stranded patients with a long hospital stay (20 days or over) by 40% (from 72 to 43 days) by the end of March 2020 and to reduce the number of patients with a stay of 7 days or more by 25% (from 194 to 150) by the end of March 2020. • Reducing the overall Length of Stay by 0.5 days by March 2020. • Reaching the national target of streaming of 25% of ED attendances through Ambulatory Care • Embedding the SAFER model including the roll out of the 5 Questions (including EDD) and Criteria Led Discharge As detailed against Clinical Standard 1, the Patient Flow Improvement Project is continuously reviewing patient outcomes in the context of SAFER, the discharge process and the provision of community support services in order to develop a streamlined patient journey. The Recognition and Care of the Deteriorating Patient project reviews compliance to the Trust's NEWS2 Track and Trigger Policy, to ensure that patients are monitored and escalated appropriately for the best patient outcomes. This information is triangulated against other metrics to review the efficacy of the management of deteriorating patients and Advancing Quality data (on compliance to best practice clinical process measures for key conditions: AKI, Sepsis, Stroke, Pneumonia, LRTI, Acute Bronchitis and UTI). The Trust has embedded Learning from Deaths methodology in line with the Royal College of Physicians Structured Judgement Review process, the outcomes of which are themed, analysed and reported alongside serious incident and mortality data to through the Trust's governance routes to the Mortality Operational Group, the Quality and Safety Committee and the Board of Directors (Appendix 4). Assurance is given against the Standard Hospital Mortality Indicator (SHMI) and the Hospital Standard Mortality Ratio of quality improvement activity and patient outcomes.	Not required for NHSE Template			

(Appendix 2 within NHSE/I Submission)

14 hour consultant review snapshot October 2019

BACKGROUND

This audit has been undertaken following the introduction of self-assessment for the national 7 day services project.

STANDARDS

Compliance Level	RAG rating
90-100%	
70-89%	
<69%	

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at least within 14 hours from time of hospital admission.

METHODOLOGY

- Retrospective audit of patients who attended A&E in August and September 2019 and were subsequently admitted.
- 70 CAS Cards were audited

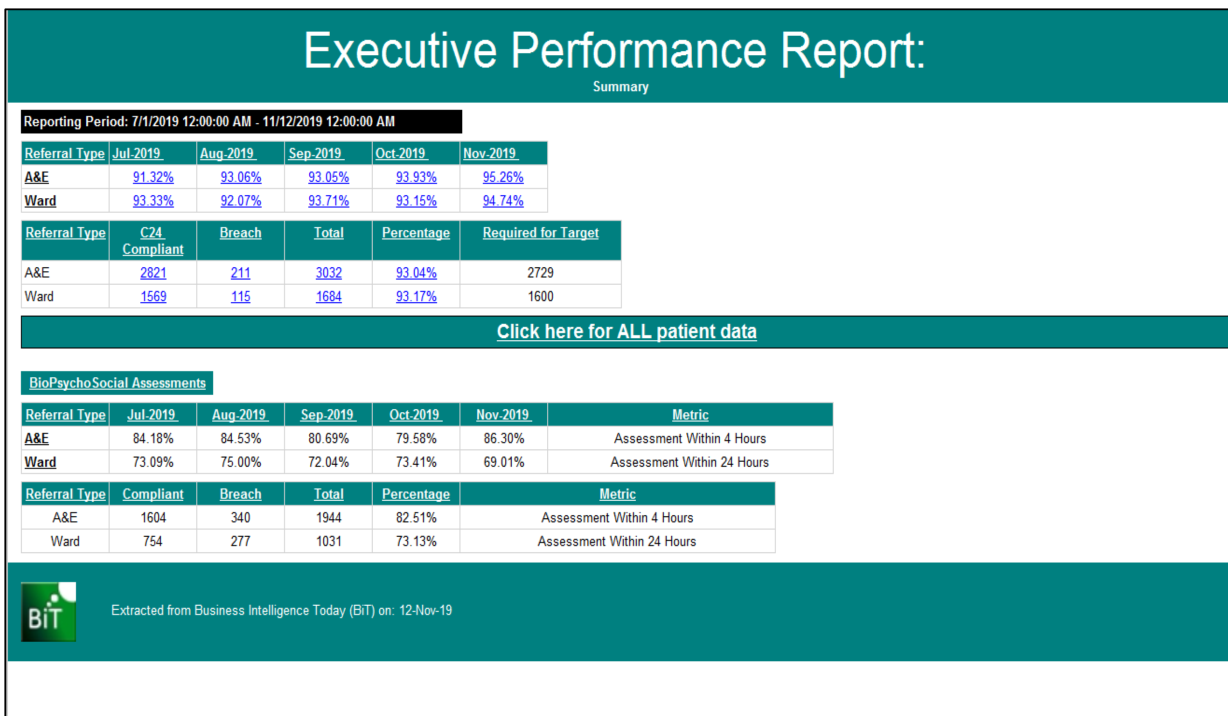
RESULTS

Time of Admission	Time of review	Time Difference	Speciality
10:49	15:05	04:16	Paediatrics
21:35	11:45	14:10	Paediatrics
17:30	19:45	02:15	Paediatrics
21:20	11:50	14:30	Paediatrics
01:05	10:41	09:36	Paediatrics
23:30	03:00	03:30	General Surg
22:03	08:12	09:07	General Surg
01:15	12:45	11:30	General Surg
16:15	10:15	18:00	General Med
23:18	08:30	09:12	General Med
22:08	07:05	08:57	General Med
10:39	18:30	07:51	General Med
23:45	09:30	09:45	General Med
09:37	15:00	05:23	General Med
10:04	16:00	05:56	General Med
14:53	18:00	03:07	General Med
12:50	10:30	21:40	General Surg
20:33	08:30	11:57	General Surg
23:49	09:00	09:11	General Surg
00:05	09:25	09:20	General Surg
16:32	08:30	15:50	Surgery
18:50	09:47	14:57	Surgery
11:27	16:00	04:33	Medicine
02:30	09:15	06:45	Medicine
22:04	11:03	12:59	Medicine
00:03	09:34	12:59	Medicine
21:00	10:00	14:00	Medicine
20:52	09:05	12:13	Surgery
21:59	10:50	12:51	Medicine

Time of Admission	Time of review	Time Difference	Speciality
17:56	10:00	16:04	Medicine
15:58	18:16	02:18	Medicine
19:07	11:00	15:03	Medicine
17:09	09:00	15:51	Medicine
02:10	09:18	07:08	Medicine
11:48	19:30	07:42	Medicine
14:04	20:20	06:16	Medicine
12:55	14:20	01:25	Medicine
21:06	10:12	13:16	Medicine
02:11	19:00	16:49	Medicine
10:47	15:42	04:55	Medicine
20:14	09:27	13:17	Medicine
12:06	17:30	05:24	Medicine
12:38	16:30	03:52	Medicine
05:42	17:39	11:57	Medicine
08:51	14:15	05:24	Medicine
15:15	08:45	17:30	Surgery
14:09	19:50	05:41	Medicine
20:52	09:55	13:03	Medicine
11:39	14:05	02:26	Medicine
20:17	12:00	15:43	Medicine
01:30	10:20	08:50	Surgery
13:05	17:00	03:55	Medicine
21:33	09:30	11:57	Medicine
00:21	08:30	08:09	Surgery
11:49	15:00	03:11	Medicine
21:08	08:45	11:37	Medicine
22:30	11:50	13:20	Medicine
17:24	10:55	17:31	Medicine
14:31	17:25	02:54	Medicine
08:39	14:30	05:51	Medicine
22:08	07:05	08:57	Medicine
09:25	16:15	06:50	Medicine
09:09	14:05	04:56	Medicine
11:48	16:00	04:12	Medicine
10:48	17:30	06:42	Medicine
09:11	16:34	07:23	Medicine
12:04	17:15	05:11	Medicine
17:48	08:02	14:14	Medicine
16:38	10:15	17:37	Medicine
05:26	13:30	08:04	Medicine

ASSURANCE LEVEL	Calculation of assurance
Full	To be used when 90%-100% of standard has achieved a score of 90% or above and rated Green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated Green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.
Assurance Level	***81% Significant***

(Appendix 3 within NHSE/I Submission)



Executive Performance Report:

Summary

Reporting Period: 7/1/2019 12:00:00 AM - 11/12/2019 12:00:00 AM

Referral Type	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019
A&E	91.32%	93.06%	93.05%	93.93%	95.26%
Ward	93.33%	92.07%	93.71%	93.15%	94.74%

Referral Type	C24 Compliant	Breach	Total	Percentage	Required for Target
A&E	2821	211	3032	93.04%	2729
Ward	1569	115	1684	93.17%	1600

Click here for ALL patient data

BioPsychoSocial Assessments

Referral Type	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Metric
A&E	84.18%	84.53%	80.69%	79.58%	86.30%	Assessment Within 4 Hours
Ward	73.09%	75.00%	72.04%	73.41%	69.01%	Assessment Within 24 Hours

Referral Type	Compliant	Breach	Total	Percentage	Metric
A&E	1604	340	1944	82.51%	Assessment Within 4 Hours
Ward	754	277	1031	73.13%	Assessment Within 24 Hours

BiT

Extracted from Business Intelligence Today (BiT) on: 12-Nov-19

(Appendix 4 within NHSE/I Submission)

Trust NHSI QI Programme Outcomes – October 2019

NHSI QI Programme Outcomes HMB.docx

(Appendix 5 within NHSE/I Submission)

Learning from Deaths – Trust Monthly Mortality Report - November 2019

Learning from Deaths Report to QSC Nov 20

Appendix 2.

Narrative of Seven Day Services Self-Assessment Return November 2019

1.0 Clinical Standard 1: PATIENT EXPERIENCE

Shared decision making and informed choices for families and carers 7/7

Both the Older People's Care Programme and the Deteriorating Patient Project are driving the requirement for advanced care planning discussions with patients and their families and carers. Training, processes and documentation are being designed to ensure that conversations are held with patients and their families / carers as early as appropriately possible in order to create a proactive plan for care in the last stages of life which will ensure continuity of care at any touchpoint across the patient journey 24/7. The creation of a specific Anticipatory Clinical Management Plan is the aim for patients who have been identified for End of Life or palliative care.

The Trust's Patient Flow Improvement Programme is embedding the SAFER model across wards (Senior Ownership, All Patients, Flow, Early Discharge & Review). As part of Work Stream 2 "Best Practice Ward Processes to Reduce Length of Stay" "Family expectations and participation is managed on and throughout admission to support removing choice as a delay to discharge". This will ensure shared decision making and informed choices for patients, families and carers. Patient conversations are to commence from admission when the clinician is to give the Expected Date of Discharge (EDD). Ward staff are to ensure that throughout the patient's stay, the patient (and their carers/ families) know the answers to the five questions (which are posted next to each bed): 1. What is wrong with me? 2. When am I going home? 3. How will I know when I am ready to go home/ Am I now safe enough to go home? 4. Have I got my copy of 'Your Discharge from Hospital' Booklet 5.What is my Expected Date of Discharge (EDD). This ensures that the patient and their family are sighted on the stages of their journey with a clear pathway to returning home.

In 2017 the Trust and the Patient Experience Group created the SOHT Patient Charter which incorporates pledges to 'Develop and implement systems and processes to involve Carers and Families in decision making' and 'Ensure that access to information is easy and relevant for patients, carers, families and professionals.' The Trust has a dedicated Patient Experience Matron who is responsible for acting on patient feedback and the triangulation of this with audit findings and regulator recommendations. Ongoing activity relating to the Patient Experience portfolio incorporates:

- The Trust works within the mental capacity act and where it is deemed that patients do not have mental capacity to make own informed choices, decisions are made with family/carers that are in the patients' best interest.

- Promotion of Johns Campaign to allow open visiting for carers to support patients with additional needs. This allows increased presence of carers to be involved in decision making.

National Patient Experience Surveys:

- Urgent and Emergency Care Survey 2018 – 92% of patients reported that they were involved in decisions about care and treatment.
- Children and Young Peoples Survey 2018 – 93% of parents reported that staff agreed a plan with them about their child's care. 95% of parents reported that staff involved them in decisions about their child's care and treatment.
- Maternity Survey 2019 - in the antenatal period 99% of women reported that they were involved enough in decisions about their care. In labour and birth 97% of women reported that they were involved enough in decisions about their care.

The Trust in association with patient and community feedback and the latest studies in dementia care is committed to ensuring that both sites are dementia friendly, this requirement has been included in the ward refurbishment programme for 2020.

The Trust is part of the national Surgical Ambulatory Emergency Care Improvement Programme with a structured project work stream; one aspect of which has been to review the Patient Experience through the Surgical Ambulatory Unit. NHS Elect have supported the Trust's SAEC project group with an Experience Based Design Workshop and an App with which to capture patient feedback. The team is reviewing both the patient and staff experience in association with increased efficiencies and a reduction in length of stay for SAU patients.

2.0 Clinical Standard 2: 14 HOUR REVIEW

All Emergency Admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest, within 14 hours of admission to hospital

The audit for 14 hour consultant review was run in October 2019 with an increased sample size of 70 (a retrospective audit of patients who attended A&E in August and September 2019 and were subsequently admitted as detailed in Appendix 1). The audit shows a 10% improvement on the last sample taken from April 2019 but at 80% compliance, the Trust is therefore still falling short of the 90% standard requirement.

Since the June 2019 submission there has been an increase in middle grade staffing for Acute Medicine which has supported the delivery of the 14 hour target, however there are ongoing vacancies at consultant level that have not been filled, particularly for Consultant Geriatricians (the Trust has had difficulty recruiting to this role with a current establishment of 0.6 WTE substantive Geriatrician cover against the required 8 WTE required to support the local demographic).

Orthopaedic performance has also greatly benefitted from consultant recruitment which has allowed a Consultant of the Week (COW) rota to be set up from March 2019. Patients admitted are seen/discussed at consultant level within 14 hours; there is a daily Ward Round run by the on call team every day from 1,900 to 2,000 specifically to hit clinical standard 2 which is reflected in consultant job plans.

All surgical and paediatric patients are reviewed by a consultant the day after admission, however if the patient is admitted after 12 noon, then they will not be seen until the following morning which is likely to be outside of the 14 hour time limit. An additional three Paediatric Consultants are required in order to deliver of the 14 hour standard.

In order to deliver a consultant led weekend service to ensure compliance with Clinical Standard 2, further work is required to change consultant work plans to cover weekends. In the case of an acute emergency at night or of a weekend the on call consultant will review the patient. A dedicated project work stream is being scoped for 2020 to undertake this piece of work in conjunction with the newly established Trust Workforce Improvement Group.

Specialist Area	Weekday	Weekend	Overall Score
(Emergency Admissions)	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	**No, the standard is not met**

3.0 Clinical Standard 3: MDT REVIEW

14 hour assessment by MDT for emergency in-patients. An integrated management plan with EDD and medicines reconciliation within 24 hours

Emergency admissions to the Observation ward have a consultant ward round with Occupational Therapy and Physiotherapy input 7 days a week each morning.

From November 2019 the Red to Green MDT Board Round is to follow a standardised approach involving nursing, therapies, Discharge Facilitators with junior doctor / consultant input. The supporting Standard Operating Procedure confirms that the R2G Daily Board Round is designed "To ensure that all in-patients receive a MDT approach to support their in-patient stay and that patient flow is managed appropriately, with the right membership to be effective." Board Round attendance is to be monitored centrally through the Patient Flow Improvement Programme alongside the Patient Flow suite of KPIs. The Board Round SOP also confirms the standard practice that "the 'expected date of discharge' (EDD)... should be set along with the CCD at the point of admission."

The last annual Medicines Reconciliation Audit undertaken in January 2019 reported that only 48% of patients had a drugs history completed with 24 hours of arrival. The CQC Inspection to the Trust August 2019 confirmed many shortfalls in Trust's management of medicines and pharmacy service, attributable in part to a chronic lack of investment. Recommendations from both the CQC and NHSI included the requirement for an extension to the existing service. At the November 2019 Trust Board a Business Case for £0.5m was approved to support extended evening and weekend cover, Consultant Pharmacist in A&E and Ward Pharmacy Assistants. The Trust has also been successful in winning £0.7m to support the purchase and implementation of an Electronic Prescribing and Medicines

Administration system. Medicines Management is one of the Trust's 4 Quality Programmes under which 14 hour review of Medicines is to be delivered.

4.0 Clinical Standard 4: SHIFT HANDOVERS

Handovers by a senior decision maker at designated time and place. Handover processes including communication & documentation requirements formalised in a policy.

The Red to Green Board Round is supported by the new Morning Handover template which is to be used by Bed Managers and Clinical Coordinators. This will inform the R2G Board Round which will feed into the Electronic Clinical Board Round.

The Electronic Board Round has been developed and piloted to standardise and document the daily senior review of patients. The requirement to document daily senior cover originated from junior doctor requests for additional supervision on wards; (the Clinical Ward Board function ensures that on days that the consultant does not undertake a Board Round, patients are reviewed by a junior doctor in the first instance followed up with a remote review by the consultant). The Standard Operating Procedure for the Electronic Clinical Board Round will be written once the pilot has been signed off; this has been delayed due to inadequate IT resource to undertake the required fixes for the final iteration of the PDSA cycle. As soon as this has been completed the model will be rolled out across all wards in line with the ward refurbishment project (a private room and IT equipment is required to deliver the activity in a confidential manner to protect patient confidentiality.)

An audit was undertaken in August to assess consultant and junior doctor staffing levels on the wards. It showed that there is not an issue with a shortage of doctors on the wards but that there has been 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.

5.0 Clinical Standard 5: ACCESS TO DIAGNOSTIC SERVICES

Hospital inpatients must have scheduled access to diagnostic services such as X-ray, Ultrasound, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Echocardiography, Endoscopy, Bronchoscopy and pathology seven days a week. Consultant-directed diagnostic tests and completed reporting must also be available seven days a week: Within 1 hour for critical patients Within 12 hours for urgent patients Within 24 hours for non-urgent patients

The Trust standards have not changed since the first return In April 2018 when the Trust reported 92% compliance with this standard.

It is to be noted that Upper GI endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust. Discussions remain ongoing as to the formalisation of the arrangement.

Bronchoscopy is provided over two days a week, one day on each site. On week days when the service does not run, they will be slotted into gaps in the Endoscopy rota. There is not currently a formalised arrangement for out of hours and weekend cover; in these circumstances, a call will be made to Liverpool Heart and Chest Hospital to see if there is on call capacity for the patient in question. If there is no capacity then the patient remains at Southport and Ormskirk Hospital until they can be seen by a Respiratory Specialist.

Specialist Area	Weekday	Weekend	Overall Score
Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	**No the Standard is not met**
Computerised Tomography (CT)	Yes available on site	Yes available on site	
Ultrasound	Yes available on site	Yes available on site	
Echocardiography	Yes available on site	Yes available off site and off site by formal arrangement	
Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
Upper GI Endoscopy	Yes available on site	No the test is only available on or off site via informal arrangement	

6.0 Clinical Standard 6: CONSULTANT DIRECTED INTERVENTIONS

Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: Critical care, Interventional radiology, Interventional endoscopy, Emergency general surgery.

The Trust continues to be compliant as per the detail provided.

Interventional Endoscopy is undertaken out of hours and at the weekend by a long standing, consistent and informal arrangement with Aintree NHS Trust.

The Trust has stroke thrombolysis 24/7 cover with support of Cumbria and Lancashire Telestroke network; we are involved in the redesign of the stroke pathway in North Merseyside with Aintree and Royal Liverpool University Hospital.

Specialist Area	Weekday	Weekend	Overall Score
Critical Care	Yes available on site	Yes available on site	**Standard is met**
Interventional Radiology	Yes mix of onsite & off site by formal arrangement	Yes mix of onsite & off site by formal arrangement	
Interventional Endoscopy	Yes available on site	Yes mix of onsite & off site by formal arrangement	

Emergency Surgery	Yes available on site	Yes available on site	
Emergency Renal Replacement Therapy	Not applicable to patients in this Trust	Not applicable to patients in this Trust	
Urgent Radiotherapy	Yes available on site	Yes mix of onsite & off site by formal arrangement	
Stroke Thrombolysis	Yes available on site	Yes available on site	
Percutaneous Coronary Intervention	Not applicable to patients in this Trust	Not applicable to patients in this Trust	
Cardiac Pacing	Not applicable to patients in this Trust	Not applicable to patients in this Trust	

7.0 Clinical Standard 7: MENTAL HEALTH

Mental health needs identified for acute admissions to be assessed by psychiatric liaison within 1 hour for emergency care and 14 hours for urgent care 7/7

In November 2018, Southport Core Mental Health Liaison Team commenced the provision of the 24/7 Service for the Trust. Based on the Southport site, the team accepts referrals from both A&E and the Wards. Patients are triaged against the one hour target by the Team's Support Workers and are then assessed by a Practitioner against the four hour target for either admission or discharge. KPI targets are set at 90% for Merseycare (against the national target of 75%) which are being met (Appendix 2).

8.0 Clinical Standard 8: ONGOING REVIEW IN HIGH DEPENDENCY AREAS

All patients on the Acute Medical Unit, Acute Surgical Assessment Unit, Intensive Therapy Unit and other high dependency areas are seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The Trust is not fully compliant with Clinical Standard 8 in Medicine.

Acute Medicine: On the Ambulatory MU, we have daily consultant rounds on mornings on weekdays. This is followed by afternoon board round of all patients by consultant; any unwell patients are then reviewed by the consultant. So any unwell patients on AMU will get reviewed twice during the day on weekdays. On weekends, we do not have acute medicine consultant cover. Only patients newly admitted over the weekend get seen by the on call consultant once over the weekend.

General Medical Wards: once patients are moved to the general medical wards, they are seen by the consultants two or three times a week. Currently, it is not possible for all

consultants to do 3 ward rounds per week based on current job plans. On remaining weekdays, consultants discuss the patient with the Team on board rounds. We do not have 7 day service so over the weekend, patients are only reviewed by a consultant if they become unwell. The on call team have access to the on call consultant in case any patient requires urgent review over the weekend.

Patients with high dependency needs are cared for on the Critical Care Unit based in Southport and Formby District General Hospital. Ward rounds are conducted by the Critical Care Consultant of the day, twice daily and documented on the Critical Care proforma. This process occurs seven days a week.

All new patients while on EAU get 2 daily reviews one in the morning which is direct patient contact and second in the afternoon which is a 'board round'. Any unwell patients identified at board round will then get a full review as well.

As reported in our last return, the Trust's Critical Care Outreach Team was extended to 24/7 cover on 1st April 2019; the team are giving a daily review of all high risk patients, patients with a NEWS 2 score of 5 or above, patients with AKI level 3 and patients for whom deterioration concerns have been flagged. The Trust's new NEWS2 Track and Trigger Policy provides clear guidance on the frequency of observations and the processes for escalation. Quality improvement work is ongoing to find best practice to support the delivery of the observations protocol 24/7.

As documented against Clinical Standard 4, an Electronic Board Round has been developed to standardise and document the daily senior review of patients. The finalisation of the pilot for roll out across the Trust has been delayed due to inadequate IT cover to undertake the required 'IT fixes'.

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.

Specialist Area	Weekday	Weekend	Overall Score
NA	Once daily: yes the standard is met for over 90% of patients admitted in an emergency	Once daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard is met
	Twice daily: yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: yes the standard is met for over 90% of patients admitted in an emergency	

9.0 Clinical Standard 9: TRANSFER TO COMMUNITY, PRIMARY & SOCIAL CARE

Support services to be available 7/7 to ensure next steps for patient care are consultant led whether in hospital, community or mental health setting.

As detailed above under 'Mental Health, the Mental Health Liaison Team has been on the Southport site providing 24/7 for the last 12 months with rapid 1 hour response to patients in crisis in ED. Targets are being met for both A&E patients being seen within 1 hour, being placed on a pathway within 4 hours or being seen from a ward within 24 hours.

The Trust has limited pharmacy weekend cover (currently for a limited time each Saturday) however a business case was approved a Board level in November 2019 to extend weekend working. The requirement for number of improvements in medicines management had come from both NHSI and the August 2019 CQC Inspection, a dedicated project is now overseeing additional recruitment and a revision of processes to drive improved efficiency. The Trust has also been successful in securing £700k of funding from the 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.

The Trust currently has the following support services available: 7 day pharmacy cover, weekend therapy service, 24/7 in-reach from Mersey Care into the Emergency Department for mental health. There are Daily Discharge MDT huddles and "Long Stay Tuesday" (Multi-agency discharge events) with Local Authority and community teams which cover 7/7 days and support weekend discharges; the Trust is working with local authority for Sefton to develop improvements for weekend transfers to transitional beds.

At the end of 2018, the Trust employed eight Discharge Facilitators to liaise with community, primary and social care. As reported in February 2019, while this supported the transfer of patients back home, the full handover to community services fell short due to inadequate community service provision. (For example the Home First initiative which was scoped as a joint venture was put on hold for 6 months due to a lack of community resource to match Trust Resource to deliver). In May 2019, there were still no Home First Discharges being facilitated by ICRAS in North Sefton. West Lancashire is able to facilitate up to 10 patients a week and have adopted a flexible approach to time slots for discharges. Therapy services are running over 7 days a week in the hospital with a focus on discharge planning and patient flow at weekends both hospital sites.

Ongoing engagement with community health care partners is needed to fulfil this clinical standard; the Trust is now working with Strata Health on the recommendation of NHSI to drive system-wide improvements to support discharge and patient flow through the hospital.

10.0 Clinical Standard 10: QUALITY IMPROVEMENT

All those involved in delivery of acute care to be involved in the review of patient outcomes to drive care quality improvement

In May 2019 the Chief Operating Officer approached NHSI/E to support the development of a Southport and Ormskirk approach to Quality Improvement Building Quality Improvement

Capacity and Capability (QICC). This programme was facilitated by the PMO who managed the programme logistics with NHSI/E and supported all the projects and project leads through hands on coaching and project support. Appendix 3 outlines the programme objectives, content, outputs and next steps.

The programme was delivered by NHSI/E colleagues with over 50 staff attending the initial session in June, with the opportunity for over 100 staff to be involved across the whole programme. Executive directors attended sessions and took an executive sponsor role for specific projects within the programme. Short quality improvement projects are still ongoing and there is increase appetite and confidence across senior management to undertake tests of change.

The Trust's Programme Office is overseeing the delivery of the four quality priorities through the following projects / programmes:

1. Recognition and Care of the Deteriorating Patient Project (which has superseded the former Reducing Avoidable Mortality Project)
2. Medicines Management Improvement Programme
3. Infection Prevention and Control Project
4. Older People's Care Programme (incorporating the Trust's Frailty Pathway)

The Patient Flow Improvement Programme (PFIP) is an operational transformation programme supported by the delivery of QI methodology and delivered by the Urgent Care Directorate with the aims of:

- Reducing the number of stranded patients with a long hospital stay (20 days or over) by 40% (from 72 to 43 days) by the end of March 2020 and to reduce the number of patients with a stay of 7 days or more by 25% (from 194 to 150) by the end of March 2020.
- Reducing the overall Length of Stay by 0.5 days by March 2020.
- Reaching the national target of streaming of 25% of ED attendances through Ambulatory Care
- Embedding the SAFER model including the roll out of the 5 Questions (including EDD) and Criteria Led Discharge

Appendix 3 – CQC 2019 Inspection Report – References to 7DS Provision

Page	Section of Report	Observation / Recommendation
5	Are Services Effective?	Key services were not always available seven days a week to support timely patient care. This included speech and language therapy, dieticians and pharmacy. This meant there was not continuity of care for patients and national standards were not always maintained.
9	Areas for Improvement: Children & Young People	The trust should consider improving child and adolescent mental health services provision to a seven-day service
12	Areas for Improvement: Critical Care	The trust should improve seven-day service provision to provide more continuity of care for patients and maintain national standards.
22	Ormskirk District General Hospital: Summary of Findings	Staff provided good care and treatment, gave patients enough to eat and drink and offered pain relief when it was needed. Managers monitored the effectiveness of the service and made sure staff were competent. Most services were available seven days a week.
24	Ormskirk District General Hospital: Services for Children & Young People	Staff provided good care and treatment, gave children and young people enough to eat and drink. Pain relief was given when it was needed. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most services were available seven days a week.
30	Ormskirk District General Hospital: Outpatients	Staff provided good care and treatment, gave children and young people enough to eat and drink. Pain relief was given when it was needed. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most services were available seven days a week.

Page	Section of Report	Observation / Recommendation
36	SDGH: Summary of Findings	Key services were not always available seven days a week to support timely patient care, this included speech and language therapy, dieticians and pharmacy. This meant there was not continuity of care for patients and national standards were not always maintained.
38	SDGH Urgent & Emergency Services: Summary of Findings	Pain relief was assessed appropriately, and measures had been put into place to enable swift administration of pain relief by nursing staff. Managers made sure staff were competent. Key services were available seven days a week.
39	SDGH Urgent & Emergency Services: Is the Service Effective	Key services were available seven days a week to support timely patient care.
44	SDGH Medical Care: Summary of this Service	Not all key services were available seven days a week. We found this at our last inspection and told the service it should consider improvements to provide an equitable service seven days a week.
46	SDGH Medical Care: Is the Service Effective?	Not all key services were available seven days a week to support timely patient care. Consultants did not lead daily ward rounds on all wards and consultants were not available on wards at weekends.
51	SDGH Surgery: Summary of this Service	The service did not always provide care and treatment based on national guidance and evidence-based practice. Compliance rates for appraisals were below the trust target and staff did not always understand how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives. Key services were available seven days a week.
53	SDGH Surgery: Is this Service Effective?	Key services were available seven days a week to support timely patient care.

Page	Section of Report	Observation / Recommendation
57	SDGH Critical Care: Key Facts & Figures	Services offered by the unit included; ventilation, hemofiltration, continuous positive airway pressure (CPAP), non-invasive ventilation (NIV), high flow and remote telemetry for an additional 10 ward patients. The unit had a rehab coordinator and a therapy led weaning service. The critical care outreach service was provided for all patients discharged from critical care and there was a follow up clinic following discharge from hospital. The unit operated 24 hours seven days per week to assist with deteriorating patients on the general wards.
58	SDGH Critical Care: Summary of this Service	Key services were not always available seven days a week to support timely patient care, this included speech and language therapy, dieticians and pharmacy.
60	SDGH Critical Care: Is this Service Effective?	Key services were not always available seven days a week to support timely patient care, this included speech and language therapy, dieticians and pharmacy. This meant there was not continuity of care for patients and national standards were not always maintained.
62	SDGH Critical Care: Areas for Improvement	The trust should improve seven-day service provision to provide more continuity of care for patients and maintain national standards.
64	End of Life Care: Key Facts & Figures	The supportive and specialist palliative care team included specialist palliative care consultants, nurses and the transform team who since 2017 have worked at the hospital via honorary contracts. The team is based at a local hospice located at an adjoining site and offers support and advice to staff, patients and their loved ones, seven days a week from 9am to 5pm and medical advice is available 24 hours a day via a telephone line.
66	End of Life Care: Is this Service Effective?	Key services were available seven days a week to support timely patient care.

Appendix 4

Southport and Ormskirk Staff consulted for November 2019 7DS Submission

Clinical Staff

Dr Ashar Ahmed, Medical Consultant
Dr Chris Goddard, Associate Medical Director for Patient Safety and Consultant Anaesthetist
Dr Paddy McDonald, Medical Consultant
Dr Raj Gedela, Head of Radiology
Dr Terry Hankin, Medical Director
Dr Kevin Thomas, Assistant Medical Director
Hazel Irizar, Head of Patient Flow
Dr Shyam Mariguddi, Clinical Director, Consultant Paediatrician
Dr May Ng, Consultant Paediatrician
Dr Eugene Toh, Orthopaedic Surgeon
Dr Helen MacKay, Orthopaedic Surgeon

Non-Clinical Staff

Janette Mills, Head of Clinical Audit
Joan Carter, Assistant Director of Operations for Urgent and Emergency Care
Kate Monaghan, Directorate Manager for Emergency Care
Jenny Large , Directorate Manager for Radiology
Vicky Rotherham, Team Manager for Southport Core 24 Mental Health Liaison Team

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 February 2020

Agenda Item	TB008/20	**Report Title**	**System Winter Plan Update**
Executive Lead	Steve Christian, Chief Operating Officer		
Lead Officer	Steve Christian, Chief Operating Officer		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	X To Note X To Receive	

Executive Summary

- What: The paper provides a progress report on winter 2019/ 20 performance. The CCG System Winter Plan has gone about to address the identified under-capacity gap set out by Venn within the transitional / intermediate care beds (40 bed gap). Whilst significant work has been put into play in the delivery of the CCG System Winter Plan the Trust has not yet felt the full benefits of the assumed bed day savings set by the CCGs within the plan. The Trust has delivered on its Internal Trust Plan and opened the 14 bed Orthopaedic Rehabilitation Unit at Ormskirk and implemented the tactical schemes (e.g. increased ACU working over the weekend and extended Pharmacy opening times over the weekend).

- So What: Trust 4 hour performance is marginally down on last year but still a significant improvement against the position from 2 years ago. This is against an overall increase in activity of 6.4% from 2018. Whilst 4 hour performance is marginally down this year against last year it is important to take note of the national position for Urgent & Emergency care. Many Trusts around us have experienced significant deterioration in performance whilst our national & regional ranking has improved considerably year on year.

- What Next: The Trust remains highlight reliant upon the wider system plan to mitigate the “out of hospital” bed gap of 40 identified by Venn, which isn't currently being met. This has been raised and escalated at the System Management Board with CCG.

- Recommendation: The Trust Board is requested to note progress and acknowledge risks outlined in the CCG System Winter Plan.

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.*

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X **SO2** Deliver services that meet NHS constitutional and regulatory standards	*If the Trust cannot achieve its key performance targets it may lead to loss of services.*
☐ **SO3** Efficiently and productively provide care within agreed financial limits	*If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.*
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
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
X Effective	☐ Annual Business Plan Priority
X Responsive	☐ Best Practice
X Safe	☐ Service Change
☐ Well Led	

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

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

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

Add actions with milestones and Leads here

Previously Presented at:

☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
X 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

Winter Update 2019/20

<u>Purpose</u>

The Board is asked to note progress of winter performance for the Southport & Ormskirk health and social care system.

<u>Background</u>

The Southport & Formby CCG supported by NHS England commissioned Venn (external consultancy) to undertake a demand and capacity review of the systems health and social care provision. The report identified the following:

- There is a 40 bed gap in terms of transitional / intermediate care beds in the community (i.e. out of hospital);
- There is largely enough capacity within the acute trust bed base (if the system meets the above gap in the community provision);
- The report noted that the Trust has excellent internal patient flow management and notable in-year improvements have been made.

Following the outputs of the Venn report the CCG agreed to lead the 2019 / 20 "System Winter Plan" which went about addressing the 40 bed gap in transitional / intermediate care – out of hospital capacity. The schemes contained within the CCG led System Winter Plan are schemes that the CCG identified as having the greatest impact in addressing the "out of hospital" 40 bed gap.

The Trust formally raised concerns in November 2019 at the Southport and Ormskirk Improvement Board (SOIB) that the CCGs assumptions contained within the CCG led System Winter Plan are not realistic in terms of delivery, assumed bed day savings and timescales.

The Trust in an attempt to best mitigate this mobilised an Internal Trust Plan which is working alongside the CCG led System Winter Plan. This has involved:

- A reconfiguration of E, F, G and H wards at Ormskirk allowing the opening of a 14 bedded Post-Operative Orthopaedic unit on H ward.
- Implementation of tactical schemes which enhances resources to support early and daily senior clinical decision making to optimise patient flows

The Trust presented the proposal to NHS England and national non-recurrent funding was secured (circa £1 million) to support implementation for 6th January 2020.

<u>Progress</u>

December: The Medically Optimised for Discharge (MOfD) peaked at 2007 "bed days lost" which averages at 66 beds occupied on average each day. This is a strong indicator to show that the CCG has not delivered on every scheme of the CCG led System Winter Plan. Due to this the hospital had to open Ward 1 as an escalation ward on the Southport site to help accommodate the increased demand for beds due to increased delays at discharge for patient MOFD. Due to this the hospital for safety reasons opened Ward 1 (December 2019) as an escalation ward on the Southport site to help accommodate the increased demand for beds. This was closed in early January and since then has been used on one occasion for a 48 hour period and was immediately de-escalated.

January: The Trust has delivered on its Internal Trust Plan and opened the 14 bed Orthopaedic Rehabilitation Unit at Ormskirk and also implemented the tactical schemes (e.g. increased ACU working over the weekend and extended Pharmacy opening times over the weekend). In addition – the Trust introduced a SAFER start campaign which focuses on every inpatient care plan having a daily senior review on the wards. The Trust

postponed non-urgent planned activity which allowed a redeployment of medical staff to support the wards and also protect the acute beds for non-elective demand.

To date, whilst the Trust has delivered its internal actions the Trust remains highlight reliant upon the CCG led System Winter Plan to deliver, and at this present moment this is not the case. Appendix one provides an outline of the CCG led System Winter Pan and can be themed under two categories:

- Schemes that have been introduced but not have the desired impact;
- Schemes delayed and not yet implemented.

This has been raised and escalated at the System Management Board with the CCGs. This non-delivery element of the CCG led System Winter Plan is primarily down to a lack of therapy provision in the community setting, and also delays being experienced for reablement capacity.

The Southport & Ormskirk system continues to review progress of the CCG led Winter Plan through the weekly UEC Director meeting to consider how to best optimise the schemes for winter. The Trust since December has raised concerns regarding the the lack of assurance in the CCG led System Winter Plan delivery. The CCG have not yet offered an evidence base to demonstrate impact of each scheme against the assumptions initially made to meet the “out of hospital” gap described by Venn.

The Finance, Investment & Performance Committee have been provided an update regarding the CCG led System Winter Plan. The paper was prepared by the Programme Director for Unplanned & Emergency Care. The paper provides formal confirmation that the Programme Director for Unplanned & Emergency Care has formally expressed concerns regarding the lack of pace in delivery of several of the Southport &Formby CCG schemes contained within the CCG led System Winter Plan.

Performance – how are we doing?

The Trust is performing well given the constraints described above. Table one outlines an overview of performance against the key metrics being monitored to assess winter performance. In summary:

- Trust 4 hour performance is marginally down on last year but still a significant improvement against the position from 2 years ago. This is against an overall increase in activity of 6.4% from 2018.

- Whilst 4 hour performance is marginally down this year against last it is important to take note of the national position for Urgent & Emergency care. Many Trusts around us have experienced significant deterioration in performance whilst our national & regional ranking has improved considerably.

- Most notable performance change is adult A&E at Southport where performance has improved from 53% in 2018 to 67% in the last 2 years - with attendances here increasing by 22%.

    - Pivotal to this change is the use of SDEC, which can be seen by shifts in overall conversion rate from 35% to 48%. Full admissions effectively decreasing from 29.6% to 24.5% although in relative terms the number of patients being admitted per day has stayed the same (26)
    - 12 Hour breaches and corridor care are marginally higher than last year but in context these are significantly lower than 2018, with ambulance handover times improving year on year

- The rates of improvement at the front door have not been matched at the back door with some significant metrics showing deterioration year on year. This is the continued challenges with whole system flow and out of hospital capacity. Over this next 12 months we need to be radical and work with system partners to modernise, in particular, the frailty pathway for this system.

		2017/18	2018/19	2019/20
		January	January	January
Trust AAE	Overall Trust Performance - 4 hour standard	80.00%	85.00%	84.00%
	National ranking on 4 hours - out of 132 Trusts (third week of January)	106th	56th	**39th**
	Regional Ranking on 4 hours - out of 21 Trusts (third week of January)	19th	4th	**2nd**
	Overall Trust Attendances	6,448	6,846	6,863
	Type 1 A&E Performance	68.76%	78.08%	77.24%
	Type 1 A&E Attendances	4,004	4,648	4,753
Southport	SDGH A&E Performance - 4 hour standard	53.03%	67.85%	67.12%
	SDGH A&E Attendances	2,642	3,132	3,245
	SDGH Ambulance Arrivals	1,045	1,109	1,064
	SDGH Total Conversion Rate (Inc Ass Wards)	35.43%	48.50%	48.07%
	SDGH Conversion Rate (Full Admissions)	29.64%	26.44%	24.47%
	SDGH Full Admissions Day Rate	26	27	26
	SDGH 12 Hour Breaches	51	11	12
	Corridor Care	752	287	415
	Ambulance handovers > 60 Minutes	104	73	48
Ormskirk	ODGH A&E Performance - 4 hour standard	99.27%	99.21%	99.01%
	ODGH A&E Attendances	1,362	1,516	1,508
	ODGH Total Conversion Rate (Inc Ass Wards)	17.69%	17.88%	17.11%
Patiet Flow	Super Stranded Patients AVG	69	74	69
	MOFD Actual Beds Lost	37	56	63
	Escalation Beds (Avg Per Day)	16	33	16

Table One – winter metrics for Southport and Ormskirk NHS Trust

Summary

- The CCG led System Winter Plan has gone about to address the identified under-capacity gap set out by Venn within the "out of hospital" transitional / intermediate care beds (40 bed gap); through a blended approach of non-bed based initiatives, community bed based initiatives and provider productivity gains.

- Whilst significant work has been put into play in the delivery of the CCG System Winter Plan the Trust has not yet felt the full benefits of the assumed bed day savings by the CCGs.

- The Trust has delivered on its Internal Trust Plan and opened the 14 bed Orthopaedic Rehabilitation Unit at Ormskirk and implemented the tactical schemes (e.g. increased ACU working over the weekend and extended Pharmacy opening times over the weekend). In addition – the Trust introduced a SAFER start campaign which focuses on every inpatient care plan having a daily senior review.

- Formal discussions continue following the Trusts escalation to the CCG and regulators regarding the concerns expressed in the inability to fully implement and optimise the commissioned schemes set out within the CCG led Winter Plan.

- Looking ahead: The Local Health Economy needs to move at pace the strategic intentions of the Acute Sustainability Programme to transform the Urgent & Emergency Care system. The priority must be developing an integrated frailty pathway given the demographic challenges particularly within the Southport & Formby area.

Steve Christian
Chief Operating Officer
28th January 2019

Appendix one – an outline of the CCG led System Winter Pan

No	Scheme name/theme	Organisation	Summary	Start date	% capacity in operation	Bed equivalent
1.	Admission avoidance >65 occupied bed days	SFCCG	Additional 7 Intermediate Care Beds to close the current gap in local provision	Oct 19	80%	7 beds (Commissioner confidence level)
2.	Prevent A&E attendances: admission avoidance >65	SFCCG	Sefton Emergency Response Vehicle (SERV) which will operate a 7 day service	Oct 19	80%	12 beds (Commissioner confidence level)
3.	Occupied beds days >65	SFCCG	Consolidate discharge to assess (CHC eligibility) within MLCSU which will release time from LSCFT Discharge Planning Team to concentrate on safe hospital discharge	Jan 20	30%	5 beds (Commissioner confidence level)
4.	Prevent A&E attendances; admission avoidance	SFCCG	High intensity users	Feb 20	10%	2 beds (Commissioner confidence level)
5.	Admission avoidance; occupied bed days>65	SFCCG	Maximise current commissioned respiratory pathways	Oct 19	70%	2.5 beds (Commissioner confidence level)
6.	Acute bed re-configuration	SFCCG	Maximise current commissioned IV pathways	Oct 19	20%	n/a
8.	Occupied bed days>65	SFCCG	Implementation of early supportive discharge (ESD stroke) commissioned services	Aug 19	70%	1.5 beds (Commissioner confidence level)
	Occupied bed days>65	Sefton MBC	Home first model including rapid response	Jan 20	Information awaited	Not applicable as thought to impact on transitional beds
9.	Prevent A&E attendances	SFCCG LSCFT	Creation of additional appointments slots in treatment rooms through review of procedures of low clinical value to reduce demand in E/E (minor injuries) to care for individuals in a more suitable clinical setting	Oct 19	100%	Not applicable
10.	Occupied bed days ?>65	WLCCG Lancs CC	Home first – enhancement of reablement and crisis care. Operates 7 days a week [not 24/7 – need confirmation of daily operating hours]. Fully phased implementation estimated in January 2020		70%-80%	2 beds (Commissioner confidence level)
11.	Patient flow	WLCCG	Commission rehabilitation beds in the community to prevent repatriation back to the acute trust		100%	1 bed (Commissioner confidence level)
12.	Admission avoidance	WLCCG VC	Short intensive support services (SISS)		100%	3 beds (Commissioner confidence level)
13.	Admission avoidance >65	Lancs ICS	Falls lifting service		Approximately 80%	2 beds (Commissioner confidence level)
14.	Occupied bed days >65	WLCCG	Additional 4 transitional beds to close the current gap in local provision		100%	4 beds (Commissioner confidence level)

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 February 2020

Agenda Item	TB009/20	Report Title	Integrated Performance Report (IPR)
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 X To Receive

Executive Summary

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

Recommendation:
The Trust Board is requested to **note** and acknowledge progress / risks outlined in the full Integrated Performance Report for December along with the Executive Summary complimenting 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
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**
X Caring	☐ Statutory Requirement
X Effective	☐ Annual Business Plan Priority
X Responsive	☐ Best Practice
X Safe	☐ Service Change
X Well Led	
Impact *(is there an impact arising from the report on any of the following?)*	
☐ Compliance	☐ Legal
☐ Engagement and Communication	X Quality & Safety
☐ Equality	☐ Risk
X 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)*	
Add actions with milestones and Leads here	
Previously Presented at:	
☐ Audit Committee	X Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
X Finance, Performance & Investment Committee	X Workforce Committee

Integrated Performance Report (IPR) Executive Summary, Steve Christian (Chief Operating Officer)

Reporting on December 2019 performance

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.

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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 Exec Lead: Steve Christian	**Cancer – 62 day standard:** Performance for November 2019 was 81.3% an increase on the October position of 74.5%. For November the Trust treated the highest number of patients within the 62 day standard for anytime across the previous 18 months. The Trust has continued challenges in workforce across a number of tumour groups. Therefore sustainability of performance above 80% is a challenge. Haematology and Head & Neck services remain under pressures due to a lack of consistent medical provision (both services have historical SLAs with other acute providers for medical cover). **Urgent & Emergency Care (updated position up to 22nd Jan):** Trust 4 hour performance is marginally down on last year but still a	**Cancer – 62 day standard:** Formal discussions are underway with other providers regarding the acute sustainability of Haematology and Head & Neck services. Meetings are planned for February 2020. Gynaecology is struggling due to 4 vacant Gynaecologist posts. The positon however is predicted to recover from March 2020 as the Trust has recently appointed in all vacant positions. **Urgent & Emergency Care:** The Medically Optimised for Discharge (MOfD) rate continues to stay above 70 patients for Q3, with

	significant improvement against the position from 2 years ago. This is against an overall increase in activity of 6.4% from 2018. Whilst 4 hour performance is marginally down this year against last it is important to take note of the national position for Urgent & Emergency care. Many Trusts within the North West region have experienced significant deterioration in performance whilst our national & regional ranking has improved considerably. Most notable performance change is adults A&E at Southport where performance has improved from 53% in 2018 to 67% in the last 2 years - with attendances here increasing by 22%. 12 Hour breaches and corridor care are marginally higher than last year but in context these are significantly lower than 2018, with ambulance handover times improving year on year. The rate of improvements at the front door has not been matched at the back door with some metrics showing deterioration year on year. **Diagnostics:** Performance for December against the 6 week wait target was 1.4% and November the Trust achieved the 1% target. This is a significant improvement.	December peaking at 2007 bed days lost which averages at 66 beds over the period. The system winter plan has not yet delivered on every scheme that was submitted as part of the CCG led system winter plan. Due to this the hospital for safety reasons opened Ward 1 (December 2019) as an escalation ward on the Southport site to help accommodate the increased demand for beds. This was closed in early January and since then has been used on one occasion for a 48 hour period and was immediately de-escalated. The Trust continues to focus on winter delivery schemes to optimise internal hospital patient flows. In January the Trust delivered on its internal winter plan schemes with critical interventions such as the opening of the 14 bed Orthopaedic Rehabilitation Unit at Ormskirk; increased ACU working over the weekend; and extended Pharmacy opening times over the weekend. In addition – the Trust has introduced a SAFER start campaign which focuses on every inpatient care plan having a daily senior review. However the Trust remains highlight reliant upon the CCG led system winter plan to mitigate the "out of hospital" bed gap of 40 identified by Venn, which isn't currently being met. This has been raised and escalated at the System Management Board with CCG and also at a previous SOIB. This non-delivery element of the system plan is primarily down to a lack of therapy provision within intermediate care, and also capacity constraints within for Home First pathways. The system continues to work through the UEC Director meetings (held weekly) to consider how best to optimise and / or introduce CCG led system winter plan schemes.
Well Led Exec Lead: Steve Shanahan /	**Workforce:** A number of key performance indicators such as staff turnover and sickness absence are below the Trust targets. This is impacting significantly on the Trust's financial performance as the Trust is reliant on temporary and high cost workforce solutions in order to maintain safe staffing and the CHPPD levels.	**Workforce:** Work continues with Liaison and the Trust's Business Intelligence team to develop Workforce Dashboards that utilise business intelligence. This will enable the Trust to easily highlight hotspot areas enabling timely interventions for improvement. The dashboards will enable the amalgamation of multiple sources of data

Jane Royds	**Sickness Absence:** The latest model hospital benchmarking data highlights as at October 2019 the data highlights that the Trust's sickness absence rate is 4.91% which has moved the Trust to the upper quartile of quartile 3. Compared to Peer Trusts the Trust is the 3rd highest performing and has exceeded the peer median of 5.22%. 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 and winter.	from different workforce systems and the initial focus will be on recruitment and retention. **Reducing agency:** Work continues on the interventions which includes an agreed formal partnership arrangement with third party organisations that can assist with insourcing to mitigate the risk regarding tax bills on pensions; The "medical" bank – went live in December 2019 and the Trust is in the process of growing and adding to its own bank; 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 Exec Lead: Terry Hankin	**Falls:** Positive progress has been achieved against the falls indicator (key element of the Care of Older People Improvement Priority) **FNOF:** Performance maintained its improvement trajectory, now being 85%. **Safe staffing:** KPI remains a challenge with a significant reliance upon temporary workforce requirements. The need to manage winter pressures and enhance escalation areas further exacerbates the challenges here. **C-Diff:** 23 cases against target of 16. However 7 successfully appealed and a further 8 to appeal. Revised rate may fall to 8.	**FNOF:** 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. **Safe staffing:** From February the Trust has introduced a new arrangement for "out of hours" cover which includes a newly formed matron tier which sits outside the on-call requirements. The rotas will specifically focus on safe staffing and raising standards of care at ward level.
Effective Exec Lead: Terry Hankin	**Sepsis:** Continued improvement in performance against Sepsis indicators has been achieved supported by the Deteriorating Patient QI Priority and Patient Flow Improvement Programme (PFIP). **90% stay on Stroke ward:** Significant decline in stroke performance	**HMSR and SHMI** The next improvement focus will be on AKI and LRTI with links/interdependency with the Care of Older People programme. **90% stay on Stroke ward:** Enhanced focus on protecting a Stroke

	due to winter bed pressure and high occupancy rates **Screening deaths:** 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.	bed at all times on the Unit**.** The SOP has been reinforced and the COO will directly monitor compliance through operational procedures.
Caring Exec Lead: Juliette Cosgrove	**Friends and Family:** 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. **Complaints:** 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.	**Friends and Family:** Over January and February we are working up a Patient Experience Improvement Plan which will use all the available data to inform priorities for 2020. Concurrently a piece of work is being scoped to improve the patient experience in relation to discharge from our hospitals, which is a key theme from the National In-patient Survey. **Complaints:** The corporate nursing team is undertaking a review of the complaints process and will be leading an improvement programme. There is a continued focus on reducing the length of time taken to respond.

Steve Christian

Chief Operating Officer

January 2020

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - December 2019

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	0	1	0	○	►	○
C-Diff	1.33	2	23	2	●	►	●
Never Events	0	0	1	0	●	►	○
VTE Prophylaxis Assessments	95%	96.9%	97.9%	140	○	▼	○
Harm Free (Safety Thermometer)	95%	99.2%	98.1%	3	○	▲	◌
Falls - Moderate/Severe/Death	1	2	14	2	●	▲	●
Patient Safety Incidents - Low, Near Miss or No Harm		808	7183	808	◌	▼	◌
Safe Staffing	90%	88.5%	91.6%	N/A	●	▼	◌
Fractured Neck of Femur	90%	85%	73.7%	17	●	▲	◌
Hospital Pressure Ulcers - Grade 2	2	9	55	N/A	●	▼	◌
Hospital Pressure Ulcers - Grades 3 & 4	1	2	15	2	●	▼	◌

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
SHMI (Summary Hospital-level Mortality Indicator)	100	98.1	99.8	N/A	○	▼	◌
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	87.1	87.1	N/A	○	▼	◌
WHO Checklist	100%	100%	100%	0	●	►	○
Stroke - 90% Stay on Stroke Ward	80%	70.4%	72.1%	8	●	▼	●
Sepsis - Timely Identification	75%	100%	98.4%	N/A	○	▲	○
Sepsis - Timely Treatment	75%	82.8%	78.6%	N/A	○	▲	●
Percentage of Deaths Screened	100%	78.8%	67.1%	17	●	▼	◌

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	15	169	15	●	►	○
Written Complaints	35	16	188	16	○	▼	◌
Complaints Average Turnaround Time	40	79.4	723.6	N/A	●	▲	◌
Friends and Family Test - % That Would Recommend - Trust Overall	90%	91.4%	91.9%	192	◉	▲	◌

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Accident & Emergency - 4 Hour compliance	94.99%	82.7%	85.6%	1870	●	▲	●
Accident & Emergency - 12+ Hour trolley waits	1	22	99	22	●	▲	●
Ambulance Handovers <=15 Mins	99%	47.6%	51.9%	845	●	▼	●
Diagnostic waits	1.01%	1.4%	3.1%	37	●	▲	●
14 day GP referral to Outpatients	93%	96.4%	94.8%	35	○	▲	○
31 day treatment	96%	96.5%	97.7%	2	○	▼	●
31 day treatment (Surgery)	94%	100%	100%	0	○	►	○
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0	○	►	○
62 day pathway Analysis	85%	81.3%	78.4%	10	●	▲	○
62 day GP referral to treatment	85%	81.3%	77.6%	10	●	▲	○
Referral to treatment: on-going	92%	92.9%	93.4%	777	○	▼	●
Bed Occupancy - SDGH	93%	92.4%	92.1%	N/A	○	▲	●
Bed Occupancy - ODGH	60%	47.8%	48.9%	N/A	●	▼	●

Reporting Frequency is monthly except for SHMI which is quarterly.

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	100%	97.5%	0	○	►	○
Duty of Candour - Evidence of Letter	100%	100%	97.4%	0	○	►	○
I&E surplus or deficit/total revenue	-4.21%	-6.7%	-6.7%	N/A	●	▲	●
Liquidity	-106	-134	-134	N/A	●	▼	●
Distance from Control Total	0%	-1.2%	-1.2%	N/A	●	►	●
Capital Service Capacity	0.21	-0.088	-0.088	N/A	●	▲	●
% Agency Staff (cost)	5.45%	11.5%	8.9%	N/A	●	▲	●
Use of Resources (Finance) Score	3	4	3	N/A	●	►	●
Distance from Agency Spend Cap	0%	158%	158%	N/A	●	▲	●
Staff Turnover	0.76%	0.6%	6.8%	N/A	○	▼	◌
Staff Turnover (Rolling)	10%	12.5%		N/A	●	▼	◌
Vacancy Rate - Medical	5%	16.8%		N/A	●	▲	◌
Vacancy Rate - Nursing	8%	17.9%		N/A	●	▲	◌
Sickness Rate	4%	5.7%	5.1%	N/A	●	▲	●
Sickness Rate (Rolling 12 Month)		5.3%	5.5%	N/A	◌	▼	◌
Personal Development Review	85%	69.2%	71.1%	N/A	●	▼	●
Mandatory Training	85%	88.4%	87.5%	N/A	○	▼	○
Care Hours Per Patient Day (CHPPD)	7.5	8	8.4	N/A	○	▼	◌
Time to Recruit	30	57	64	N/A	●	▲	◌

Efficient	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Length Of Stay	6.5	7.4	7	N/A	●	▲	●
DTOC - Number of Beds lost per month		357		357	◌	▲	◌
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	71	66	71	●	▼	◌
Stranded Patients (>6 Days LOS)	170	185	1609	185	●	▲	○
Super Stranded Patients (>20 Days LOS)	58	70	625	70	●	▲	●
New:Follow Up	2.64	2.6	2.5	N/A	○	▲	○
DNA (Did Not Attend) rate	8%	7.9%	7.2%	1656	○	▲	●
Theatre Utilisation - SDGH	80%	68.2%	61.4%	N/A	●	▲	●
Theatre Utilisation - ODGH	90%	68%	70.2%	N/A	●	▼	●
Cancelled Operations	0.61%	0.4%	0.3%	8	○	▲	○
Southport A&E Conversion Rate	20%	22.3%		1071	●	▲	◌

Board Report - December 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.	Zero MRSA bacteraemia since September 2019 - Lessons learned from single MRSA bacteraemia in August have been incorporated into training and also into action by monitoring the suppression treatment of MRSA positive patients.	2018/19 – 2019/20
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 16 for the year. Good performance is fewer than 16 for the year.	1 hospital C diff and 1 Community onset hospital associated in December - The hospital C diff was from the Frail and Elderly Short Stay (FESS) Ward, however no apparent lapses in care identified. Community occurring hospital associated C diff had been an in-patient on ward 11A and was discharged 7 days prior to becoming C diff positive; this patient is also likely to be appealable. The Trust has a total of 23 C diff cases this year which is in excess of our target however 7 of these cases have been successfully appealed through the CCGs and there is a now a total of 8 cases that are pending appeal, hence the 23 minus the actual appealed (7) and the potentially appealed (8) would effectively reduce our current total to 8.	2018/19 – 2019/20
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.	No Never Events were reported in December - The action plan relating to the Never Event reported in May 2019 is due to complete in January 2020.	2018/19 – 2019/20

Board Report - December 2019

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.	The Trust continues to maintain compliance -	
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	The Trust remains consistently compliant at 99.22% -	
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 higher in month at 2 falls with moderate/severe harm in December - work continues on the Fall Reduction Improvement Plan with further interventions planned for the next month including the testing of new equipment.	

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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.	Slight reduction in reporting in December - There was a slight decrease in the number of incidents reported from 854 in November to 808 in December. Historically reporting in the month of December is always slightly lower than November. Safeguarding incidents remain the highest category of incidents reported, these are not incidents reported against the Trust and demonstrate good awareness of safeguarding processes. The second highest category was bed management, in particularly delayed transfers from Critical Care to ward beds, these reflect the bed pressures as the Trust is in winter pressures. High numbers of reported no/low harm incidents is encouraging and indicates a strong patient safety culture.	
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%.	Reduction in trust overall performance monitored through trust processes - Reduced performance is within non registered fill rate. This is monitored and risk assessed daily through trust safe staffing processes to mitigate risks within areas identified. Flexible workforce supporting fill to trust overall requirements against patient flow. Weekly monitoring meetings	
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance showing slight improvement in month and maintaining increasing month on month improvements - Consultant of the Week now well established and patients reviewed daily by senior consultant. Also improved flow of patients through SDGH to ODGH, allowing for surgical beds for post op patients, meaning more compliance with meeting the 36hr for surgery target. Performance should improve further, with implementation of new NOF pathway in January and also the opening of the Orthopaedic Rehab ward at ODGH.	

Board Report - December 2019

Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Hospital Pressure Ulcers - Grade 2	Number of Patients with Hospital Acquired Grade 2 Pressure Ulcers.	There were 9 category 2 pressure ulcers reported in December - All incidents Category 2 and above are investigated and reviewed each week. Improvement work continues with a focus on early identification of risk factors	
Hospital Pressure Ulcers - Grades 3 & 4	Number of reported Trust acquired pressure ulcers graded between 3 and 4.	- Performance is currently off target, multiple strategies are in place to bring performance on target, with target set at zero Category 3 incidents	

Board Report - December 2019

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 continues to be acceptable - See HSMR -	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data.	Performance continues to be acceptable - Continuing work with the re-scoping of the Deteriorating Patient Project and realignment of workstreams	
WHO Checklist	WHO Checklist.	100% compliance with Time Out - This data shows that the Trust is 100% compliant with WHO Time Out only. This data tallies with Theatres WHO documentation audit so we can give assurance that Theatres are 100% compliant with Time Out performance There are 4 other aspects to WHO Safer Surgery Checklist- Inbrief, Sign In, Sign Out and Debrief. According to Theatres documentation audit we are 100% compliant with all 5 steps of the WHO Safer Surgery checklist being performed although only 90% compliant with all aspects of Inbreif documentation, 91% of Sign Documentation, 95% of Time Out documentation, 93% of Sign Out documentation and only 80% of Debrief documentation being completed.	

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NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Stroke - 90% Stay on Stroke Ward	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Please note: Indicator may change as a result of further validation.	The trust maintained performance in December at 70.37% (19/27 patients) - There were 8 breaches investigated as follows: 6 x patients due to bed capacity issues - no beds on Stroke Unit and no options available to make a HASU bed due to Trust bed occupancy. Discussed and actions put into place - increased Stroke Nurse input at bed flow meetings and discussed with patient flow team importance of identifying ring fenced bed as soon as current ring fenced ring allocated to a patient 2 x Patients - late diagnosis of Stroke which delayed referral to Stroke Team and identification of need for Stroke Unit bed 1 x Atypical Presentation 1 x Not referred by A+E although weakness documented (to be investigated and feedback to A+E)	100%, 80%, 60%, 40%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20
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 - This is against a backdrop of the total number of attendances to A&E nationally in November 2019 of 2,143,336, an increase of 5.2% on the same month last year. Of these, attendances at type 1 A&E departments were 4.7% higher when compared with November 2018 and at type 3 departments were 6.7% higher.	100%, 95%, 90%, 85%, 80%, 75%, 70%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20
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.	The Trust achieved above the 75% target of 75% November 2019 at 82.76% - This is against a backdrop of the total number of attendances to A&E nationally in November 2019 of 2,143,336, an increase of 5.2% on the same month last year. Of these, attendances at type 1 A&E departments were 4.7% higher when compared with November 2018 and at type 3 departments were 6.7% higher.	90%, 70%, 50%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20

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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	Percentage of deaths screened fell to 78.75% in November from 90.67% although remains relatively high in comparison to the summer months before improvements began - The number screened has remained relatively static, but the total number of deaths has risen - this is commensurate with a general increase in medical workload, which has been seen in other metrics throughout the organisation. It is likely that these strains are the main reason for lack of completion.	100% 80% 60% 40% 20% Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov 2018/19 2019/20

Board Report - December 2019

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.	Performance remains stable - 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.	December saw a reduction in the number of new complaints received - with the reduction relating directly to the Planned Care CBU who received 2 complaints in month compared to 8 in the previous month. Half the complaints received related to clinical treatment with a further 2 relating to discharge. Four complaints related to A&E.	
Complaints Average Turnaround Time	The average time in days from a complaint being received to closure.	Average time to close complaints 79 days in December - Responding to complaints within 40 working days continues to be a challenge, with 43 complaints currently over 40 days, the oldest of which is at 196 days. CBU's are working to address the oldest complaints. The average number of working days for all complaints closed in December was 79 working days. This was impacted by 5 complaints which were closed over 200 working days from receipt.	

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Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance improved slightly on previous month but remains below the target of 94%. - Planned care - those that would recommend has increased to 97% from 95% (with a response rate of 44.94%) Urgent care-those that would recommend has increased to 88.51% from 87.85%. (This includes a score of 88.11% that would recommend from the Adult Emergency Department which is above the National Average of 84%). Maternity - those that would recommend has decreased to 98.48% from 100%. Paediatrics - those that would recommend has stayed the same at 91.8%. (This includes a score of 91.62% that would recommend the Paediatric Emergency Department). From qualitative comments received alongside negative ratings the Trust 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	100% 98% 96% 94% 92% 90% 88% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 2018/19 2019/20

TB009_20d - IPR Detail Jan 2020 Dec Data

Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	Performance against the 4-hour standard at Trust level remained similar to the previour month at 82.7% but is lower than the same time in 2018 which was 89.59% - The Southport site saw a 4% increase in attendances and a 7% increase (261 patients) in those triaged as majors category. Significant bed pressures resulted in assessment areas continually used as escalation areas, requiring all specialty reviews to take place down in ED, which slowed cubicle turnover. Patients were routinely bedded overnight in ED as the variance between admissions and discharges continued. The number of patients receiving care delivered on the corridor increased from 196 patients in December 2018 to 657 patients as a result of poor outflow from ED. Over 70.18% of breaches against the 4-hour standard were as a result of bed pressures and lack of assessment space; 8.3% were as a result of ED delays; 8.9% were as a result of specialty delays; 7.6% were as a result of other delays (eg results, transport), and just under 5% were due to clinical reasons. ACU opened on 4 weekend dates in December with over 40 patients streamed from ED. All Sundays in January and February have been staffed with Acute Physicians to enable weekend streaming to ambulatory pathways to reduce pressure on ED. The continued use of ACU as an escalation area reduces capacity to stream during the week, with the team often reduced to working from 1 cubicle on SAU. Further discussion required on the medical workforce model for ACU given the challenges in recruitment to Acute Physicians. Medical staffing levels in ED remain challenged to meet the increase in activity, particularly on late shifts into the night, despite ongoing use of bank/ agency when it can be secured. Night shifts have 4 doctors however the shift in activity times and shift in case mix has still seen long delays overnight. The department continues to enhance its Tier 1 workforce with 6 PAs and an advert currently out for a further 2. Efforts continue to increase Tier 2 workforce. Addressing the length of stay on the wards and releasing assessment capacity is critical in enabling ED to flow and reducing the overall time that patients spend in the department. Paediatric ED saw unprecedented attendances in December (up to 50% at times) with high acuity and reliance on additional staffing to open further escalation capacity. Meetings have been held between the CD for ED, Paediatricians and W&C management team to devise a strategy.	100%, 95%, 90%, 85%, 80%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19; 2019/20
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.	The Trust reported 22 breaches across 5 separate days and all across weekends - There was a 4% increase in ED attendances at Southport, of which an additional 261 patients were majors category. As 82% of all attendances to Southport ED were triaged as majors category, this demonstrates the challenged casemix that continues to present at Southport. Assessment areas were routinely bedded in efforts to bridge the gap between admissions and discharges, resulting in specialty reviews taking place in ED instead of transferring patients to the assessment areas. Increased senior decision making capacity was put into ED to support this, and the conversion rate from attendance to admission was 30.23%, which is lower than last December. In response to increase support, An additional 11 beds were opened on the Southport site mid December to try and mitigate misalignment in the bed base, the lack of alternatives available in the system, and the increased pressure in emergency care. Staffing all ward areas remained a challenge, due to vacancies and sickness, and prevented the use of all recognised escalation areas being utilised on 3 of the 5 occasions. In efforts to reduce the pressure at weekends, ACU was open on 4 weekend dates with a total of 42 patients streamed to ambulatory pathways, enhanced Matron cover was implemented reviewing quality, safety and staffing, and ED continued to increase medical workforce where possible to enable the command and control model to continue. Despite daily huddles with system partners targeting steps required to enable discharges, concern remain that the medical resource available across the wards does not deliver daily consultant rounds across all areas or ensure that a full MDT approach is delivered to driving length of stay. Timelines have been completed on all 22 patients and demonstrated that patients had specialty reviews, consultant reviewed, commenced on treatment plans and received ongoing care whilst in the department. Timelines have been shared with CCG and NHSE.	30, 25, 20, 15, 10, 5, 0; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19; 2019/20

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Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes.	Performance in December fell to 47.61%, which is a significant reduction in the December 2018 position - Patients arriving by ambulance saw a marginal increase, and NWAS continue to use Manchester Triage and See and Treat pathways to support alternatives to ED. However, of the 4% increase in patients who self presented, an additional 261 patients were triaged as majors category. In response to the continued bed pressures, and the high numbers of patients bedded overnight each night in ED, the number of patients who reverse queued and received ongoing care on the corridor increased to 657 patients compared to 91 in December 2018. This is the highest recorded figure since June 2019. As a result of poor flow, the 4 ambulance cubicles were regularly blocked and struggled to empty to enable timely ambulance handovers. No diverts were supported across December as neighbouring Trusts continued to experience pressures, and deflections did not deliver noticeable decrease due to the geographical footprint that the Trust covers. ED continues to work closely with NWAS colleagues with further PDSAs planned in January to test opportunities to improve. The final element of the estates work to relocate the HAS screen into resus awaits completion and has been chased again over the Christmas period. Without actions to address the bed pressures and enable ED to flow, delays in ambulance handovers will continue with the risk that this puts on our patients in the community.	100% 80% 60% 40% 20% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20
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 fell in December from 0.87% in November to 1.44% in December but remain significancly lower than the previous eight months - The breaches were as follows: Colonoscopy 9/131 patients - 6.9% The breached patients from December have been dated for the month of January, All active patients due in January will be offered a date within the required timescale Cystoscopy INCLUDING GYN. 15/99pts 15.2% - Consultant activity - specialist service - spinal service - Single surgeon providing service until newly recruited consultant in place (January) and due to Christmas period, high volume of annual leave taken by surgeon. Plan to accommodate alternate weekly session with Urology/Spinal Consultant within job plan going forward. Will aim to date the patients for January, All active patients due in January will be offered a date within the required timescale by and extra session being set up. Gastroscopy - 1/119pts 0.8% The breached patient from December has been dated for the month of January, All active patients due in January will be offered a date within the required timescale MRI 1/265pts 0.4% Patient choice Non Obs Ultrasound 9/1084 pts 0.8% Patient choice Urodynamics TOTAL 2/53pts 3.8% - Urodynamics (Gyn) 2/38 1 patient requested Consultant only. Consultant unable to see patient within time frame. 1 patient cancelled appointment for 17/12, unable to get patient in under breach date due to Christmas and Bank Holidays	6% 5% 4% 3% 2% 1% 0% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher.	Trust continues to maintain performance against standard - The Trust continues to see most patients within two weeks of referral from their GP	100% 98% 96% 94% 92% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20

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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.	Trust compliant against standard - Trust continues to be compliant against 31 day decision to treat to treatment standard.	
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').	Trust compliant against standard - The continues to maintain a 100% performance against this standard	
31 day treatment (Anti-cancer drugs)	Percentage of patients receiving first definitive anti-cancer drug treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Trust maintains 100% compliance against target - All patients treated under this target were within 31 days	

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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.	November performance improved against previous months - November saw the Trust treat 62 patients against this standard (an all time high). 43 of these patients were accountable, with 10 breaches. These were across the tumour sites, with half breaches achieved by Upper GI, Urology, lung and gynaecology and whole breaches in Gynaecology, Upper GI, Haematology, Urology, lower GI	
62 day GP referral to treatment	Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer. Target 85%. Good performance is higher.	Trust performance improved in November and closed at 81.3% - This is ahead of the improvement trajectory. Improvement plan fully embedded to ensure continuing advances towards 7 day plan which will guarantee consistent performance against standards going forward.	
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.	Performance has seen a slight fall during the month to 92.93% - This performance has been impacted by a number of issues. We have closed to referrals for Clinical haematology for all but 2 week waits; we have reduced admissions to general surgery and urology at SDGH for all bar cancer and clinically urgent cases; there are workforce issues in both gynaecology and vascular services. The operational managers continue to manage this KPI closely through this period.	

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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%.	Bed occupancy at Southport has increased for the last four months but remains on target -	110%, 105%, 100%, 95%, 90%, 85%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site, based on open beds. A higher percentage is good. Threshold is 60%.	Occupancy levels at ODGH continue to show an ongoing rise at 53.7% - These figures are the highest seen since Oct 2017. The implementation of the criteria led transfer of patients in orthopaedics from the SDGH site continues to be successful prior to the opening of the additional capacity on 6th Jan 2020. These figures were however reduced as a result of the number of on the day cancellations during the month. Processes are in place to assist in managing these cancellations.	60%, 55%, 50%, 45%, 40%, 35%, 30%, 25%, 20%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20

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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.	100% compliance maintained in December - The Trust maintained 100% compliance against this statutory requirement in December. The Risk Team continue to monitor this daily and escalate as appropriate to ensure the initial discussion and apology takes place within the 10 day timescale.	
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.	100% compliance maintained in December - The Trust maintained 100% compliance against this statutory requirement in December. The Risk Team continue to monitor this daily and escalate as appropriate to ensure the Duty of Candour letter is sent within the 10 day timescale.	
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	Performance improving in absolute terms but static when compared to the year to date plan. - Although it appears that performance is improving and the deficit percentage is reducing it needs to be taken into context. The target deficit percentage year to date for December is - 5.5% and the Trust is at -6.7% meaning the Trust is 1.2% adversely away from plan (same variance as November).	

Board Report - December 2019

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.	Continued deterioration of this metric - The effect of loans being re-classified as current when they become due for repayment within 12 months of maturity means that this metric will continue to worsen. A debt restructure together with plans to return to financial balance is the solution to improving this metric but this will need national and system support.	
Distance from Control Total	Distance from Control Total.	Performance static in December - The Trust is 1.2% cumulatively away from its financial plan and the metric for this remains at a 3. The Trust has failed to qualify for the Quarter 3 non-recurrent financial support of £5.481 million (Provider Sustainability Fund and Financial Recovery Fund). However as long as the financial plan is achieved by year-end then the Trust would receive both Quarter 3 and 4 payments which would likely be paid in April.	
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.	Minor improvement on this metric - The calculation is based on the revenue for capital service divided by the value of the amount of capital service. The numerator has improved slightly and the denominator has increased meaning a slight overall improvement.	

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Southport and Ormskirk Hospital NHS Trust

Well-Led

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 deteriorated in month - As highlighted last month there are a number of plans progressing with benefits anticipated to be realised in Quarter 4. Although off framework agencies have been removed the scale of spend in this area has reached record levels in December and this is driven by a combination of activity levels and the increase in vacancy rates.	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Performance on this metric is static - This metric remains at a 4. It is an overall value based on 5 separate metrics. Four of these - Capital service cover, Liquidity, I&E margin and agency rating are all at 4. The I&E margin: distance from financial plan remains at a 3.	
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Continued material overspend against the cap - December's in month spend @ £1.334 million is now even more than November's record-breaking agency spend of £1.129m. The December split of the figure between medical and nursing agency is £667,000 medical £549,000 nursing.	

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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.	December 2019 experienced a significant decrease in staff turnover to 0.63% from 1% in November 2019. - The number of leavers reduced significantly in month to 19 from 30 in November 2019. At December's Workforce Improvement Group refreshed work streams for 2020/21 were proposed and addressing increasing labour turnover was one of those Work streams. A proposal to establish an Attraction, Attrition and Retention Group that will focus on the delivery of Trust strategy of becoming an Employer of Choice, will be presented at WIG on 11/12/19 for agreement. WIG has requested feedback on the proposed 2020/21 Work streams and will be agreed at the January 2020 WIG. Work continues in relation to improving Workforce Information available throughout the Trust to HR Performance Reports produced by the HR Business Partners have provided further detail in relation to CBU recruitment and retention narrative, hotspots and data.	1.6% 1.4% 1.2% 1% 0.8% 0.6% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 2018/19 2019/20
Staff Turnover (Rolling)	Staff Turnover (Rolling) is calculated by taking the number of leavers over the past 12 months divided by the average headcount from the last 12 months.	The rolling staff turnover has decreased to 12.5% from 13.13% in November 2019. This can be attributed to the significant reduction in monthly labour turnover in December 2019. - The number of leavers reduced significantly in month to 19 from 30 in November 2019. At December's Workforce Improvement Group refreshed work streams for 2020/21 were proposed and addressing increasing labour turnover was one of those Work streams. A proposal to establish an Attraction, Attrition and Retention Group that will focus on the delivery of Trust strategy of becoming an Employer of Choice, will be presented at WIG on 11/12/19 for agreement. WIG has requested feedback on the proposed 2020/21 Work streams and will be agreed at the January 2020 WIG. Work continues in relation to improving Workforce Information available throughout the Trust to HR Performance Reports produced by the HR Business Partners have provided further detail in relation to CBU recruitment and retention narrative, hotspots and data.	13% 11% 9% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 2018/19 2019/20
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	The medical vacancy rate has risen for the fourth month in succession to 16.78% - 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. Engagement with hard to recruit specialties include 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	18% 16% 14% 12% 10% 8% 6% 4% 2% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 2018/19 2019/20

Board Report - December 2019

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Vacancy rates remain below trajectory with actions planned for 2020 - (HCA) vacancy 48.18 wte. (RN) vacancy 133.29 wte. Recruitment to HCA vacancies planned through Feb to support delivery against fill to 48.18 wte within trajectory (end of March 2020). RN vacancy planned locally and proposed overseas against 18mth trajectory.	20%, 18%, 16%, 14%, 12%, 10%, 8%, 6%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec; 2018/19, 2019/20
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 4%. Lower is better.	December 2019's monthly sickness absence rate has increased in month to 5.68% from 5.56% last month and has exceeded the Trust target of 5% for the second consecutive month. - The monthly sickness absence rate has increased again in month. The HR team is working closely with the CBU's to understand why the rate has increased and whether this is a seasonal spike or cause for concern. Deep dive findings will be presented at CBU performance and governance meetings in order that any subsequent action can be undertaken. Additionally the team is undertaking a 3 year look back exercise to understand and identify any individual issues and trends. The reviewed Supporting Attendance Policy and is in the final stages of the ratification process.	7%, 6.5%, 6%, 5.5%, 5%, 4.5%, 4%, 3.5%; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; 2018/19, 2019/20
Sickness Rate (Rolling 12 Month)	The cumulative number of available WTE hours against the WTE hours of sickness in a 12 month period.	December 2019's rolling year to date sickness absence rate has decreased slightly in month to 5.28% from 5.30% despite the monthly sickness absence rate increasing. - Due to the consistent reduction in the sickness absence rates over the last 12 months despite the monthly increase in sickness absence rate again the net effect is a reduction in the rolling year to date sickness absence rate. The increasing monthly sickness absence rate casts doubt over attaining the Trust's target to get sickness absence levels below 5% by the end of March 2020. The latest model hospital benchmarking data highlights the progress that the Trust has made in reducing its sickness absence rate. In March 2018 the Trust has the highest level of sickness absence in the county and was at the highest end of quartile 4 on the model hospital benchmarking system. As at October 2019 Model Hospital data highlights that the Trust's sickness absence rate is 4.91% which has moved the Trust to the upper quartile of quartile 3. However in considering Peer Trusts the Trust is the 3rd highest performing and has exceeded the peer median of 5.22%	6.2%, 6%, 5.8%, 5.6%, 5.4%, 5.2%, 5%; Apr May Jun Jul Aug Sep Oct Nov Dec; 2019/20

Board Report - December 2019

Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR). Rolling 12 month figure.	PDR compliance decreased slightly in month to 69.22% in December. - PDR performance and compliance continues to be challenging and performance has been deteriorating over the last 3 months. 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, however, the Trust has realised little to no improvement. Additionally the pressure that the Organisation has been under due to demand and capacity since November will be impacting upon PDR compliance. At December's Workforce Improvement Group refreshed work streams for 2020/21 were proposed and addressing PDR compliance was one of those Work streams. The group has requested feedback on the proposed 2020/21 Work streams and will be agreed at the January 2020 Workforce Improvement Group.	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Core mandatory training remains over the Trust's 85% target at 88.44% - Core mandatory training will be reviewed in 2020 in line with a new Clinical Competency Working Group (Feb 2020) focusing on the top 10 clinical training risks.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Performance remains within previous range reported - Ongoing monitoring through trust internal processes inclusive of model hospital.	

Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Time to Recruit	The number of working days from Advert Close to Start Date. Please note that candidates requiring a Visa are included.	Time to recruit rose slightly but remains similar to the previous month at 57.1 days - The Workforce Improvement Group continues to progress the project plan to improve the timely authorisation of recruitment activity and optimisation of advertising processes	100 90 80 70 60 50 40 30 20 — Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec — 2018/19 2019/20

Board Report - December 2019

Southport and Ormskirk Hospital NHS Trust

Efficient

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Length Of Stay	The average amount of time in days that patients spent as an inpatient from an emergency admission. Excludes ZERO Length of Stay.	Average length of stay rose in month to 7.38 days - the increase in month is likely to be due to the impact of the festive period; despite additional resource in acute, there was limited availability within LA and community. The Patient Flow Improvement Programme supports utilisation of assessment areas and reducing LoS. 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. The Head of Patient Flow and Sefton CCG are working closely together to support reducing LoS with a focus on super stranded and stranded patients.	
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.	Delayed Transfers of Care have increased significantly over the last two months and currently sit at 357 for December - 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; unfortunately due to sickness on West Lancs no formal meeting has occurred in December. Extensive work on Sefton patients with clinical leads for both acute and CCG with support from LA manager is impacting on Sefton patients	
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.	Numbers remain similar to the last two months at 71 - 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; MADE event planned for January	

Board Report - December 2019

Efficient

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Stranded Patients (>6 Days LOS)	Patients who spend 7 days or more as an inpatient.	December saw an increase in month to 185 - The impact of festive period on length of stay due to reduced LA availability; daily huddles continued throughout and weekly LOS review completed. 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.	
Super Stranded Patients (>20 Days LOS)	Patients who spend 21 days or more as an inpatient.	Numbers maintained - 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; executive supports identified for ward board rounds; audit of attendance at board rounds to be implemented	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	December has seen an increase this matrix against the previous improvement trends. -	

Southport and Ormskirk Hospital NHS Trust

Efficient

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
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.	December has seen an increase in DNA rate to 7.93% - Business case for Dr Doctor system to manage this to be presented to Business Development Investment Sub Committee in January.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	December saw a marked improvement in theatre utilisation in Dec. - During December only clinically urgent and cancer cases were booked into theatres at SDGH to assist with winter pressures. This meant that only 9 fewer lists and only 6 patients were cancelled due to bed pressures as these patients take clinical priority. There were also fewer late starts to the theatre lists as a result of the need for fewer discussions over bed status.	
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	December saw a marked fall in utilisation for theatres at ODGH. - There were 36 on the day cancellations at the ODGH site. This was due to a number of reasons both clinical and none clinical. Pre admission calls have commenced for all patients on the ODGH site to prevent on the day cancellations and these calls will be cross referenced against subsequent cancellations to ensure the process is robust.	

Board Report - December 2019

Southport and Ormskirk Hospital NHS Trust

Efficient

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Cancelled Operations	Cancelled Elective Operations for Non-Clinical Reasons (within 24 hours of operation) - % of Total Electives & Daycases in Month	8 operations cancelled within 24 hours were reported as due to 'hospital reasons' - 6 were due to unavailable beds 2 were due to list overrun	1.2%, 1%, 0.8%, 0.6%, 0.4%, 0.2%, 0% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2018/19 2019/20
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 December at 22.35% and represents a declining trend - The Trust has worked hard to ensure that alternative pathways to admission wherever clinically appropriate are adopted. December saw comparable admissions via ED compared to last year against a backdrop of similar attendance levels. 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). December did experience infection control pressures due to flu and D&V. A number of care homes closed beds due to experiencing symptoms and there was a greater need for patients to go into side rooms on admission. A medical ward had 2 cohort bays created for positive flu, in addition to a large number of side rooms also used to nurse patients with flu and those with D&V symptoms. This increased the number of patients who were admitted directly to a ward instead of going through assessment areas. The local demographics and the restricted capacity and services available in the community not only create pressures in achieving discharges from the wards, but also hinder discharges directly from ED.	26%, 24%, 22%, 20%, 18% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 2018/19 2019/20

Activity Summary –December 2019

Southport and Ormskirk Hospital NHS Trust

Indicator Name	December 2018	November 2019	December 2019	Trend
Overall Trust A&E attendances	9,551	10,960	10,825	▲
SDGH A&E Attendances	4,450	4,942	4,804	▲
ODGH A&E Attendances	2,137	3,030	2,900	▼
SDGH Full Admissions Actual	1,121	1,166	1,188	▲
Stranded Patients AVG	161	177	185	▲
Super Stranded Patients AVG	52	75	75	▲
MOFD Avg Patients Per Day	45	73	71	▲
GP Referrals (*Exc. 2WW*)	2,270	2,590	2,000	▼
2 Week Wait Referrals	536	757	595	▲
Elective Admissions	148	191	153	▼
Elective Patients Avg. Per Day	5	6	5	▼

Activity Summary – December 2019

Southport and Ormskirk Hospital NHS Trust

Indicator Name	December 2018	November 2019	December 2019	Trend
Elective Cancellations	30	40	26	▼ (green)
Day case Admissions	1,464	1,803	1,750	▼ (red)
Day Case Patients Avg. Per Day	47	60	56	▲ (green)
Day Case Cancellations	29	45	39	▼ (green)
Total Cancellations (EL & Day Case)	59	85	65	▼ (green)
Total Cancellations (On or after day of admission, non clinical reasons)	7	5	8	▼ (green)
Outpatients Seen	17,997	22,367	19,013	▼ (red)
Outpatients Avg. Per Day	581	746	613	▼ (red)
Outpatients Cancellations	3,711	4,071	3,800	▼ (green)
Theatre Cases	511	575	532	▼ (red)
General & Acute Beds Avg. Per Day	376	407	406	▲ (red)
Escalation Beds Avg. Per Day	10	10	16	▼ (green)
In Hospital Deaths	78	80	102	▲ (red)

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 February 2020

Agenda Item	TB010/20	Report Title	Finance Report – Month 9 2019/20
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ☑ To Receive	

Executive Summary

This report contains the month 9 performance against the plan submitted to NHSI on 4th April 2019. As there was no Board meeting in January the report also includes a section relating to the month 8 performance.

The Month 9 financial plan has not been achieved. The CIP programme has slipped further with a projected year end shortfall of £2.1 million. The Trust is £1.8 million off plan and is working with system partners to recover the financial position.

Recommendation:
The Board is asked to **receive** the Finance Report – Month 9 2019/20.

Strategic Objective(s) and Principal Risks(s)

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

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

TB010_20 - Finance Report Month 9

☐ **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)*

Add actions with milestones and Leads here

Previously Presented at:

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

Finance Report – Month 9 2019/20

1. Purpose

1.1. This report provides the Board with the financial position for Month 9 (December 2019) and the progress on delivery of the Trust's control total.

1.2. As there was no Board meeting in January the report also includes information relating to the month 8 performance (see November's I&E in appendices).

1.3. The Trust signed up to its 2019/20 deficit control total of £26.567 million before non-recurrent funding of £18.271 million, and a net deficit of £8.296 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 9 position YTD is a deficit before PSF/FRF of £21.664 million which is £1.755 million worse than plan with a deficit of £9.788 million after PSF/FRF.

2.2. In-month positon is a deficit is £2.780 million before PSF/FRF, £0.953 after PSF/FRF, £0.258 million worse than plan.

2.3. The table below is the I&E statement for Month 9

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	166,612	125,039	124,400	(639)	13,658	13,182	(477)
PP, Overseas & RTA	1,095	823	557	(265)	91	66	(25)
Other Income	12,335	9,354	9,827	472	1,084	1,077	(7)
PSF & FRF	18,271	11,876	11,876	0	1,827	1,827	0
Total Operating Income	**198,313**	**147,092**	**146,660**	(432)	**16,661**	**16,151**	(509)
PAY	(141,037)	(105,610)	(106,190)	(580)	(11,727)	(11,632)	95
NON PAY	(53,447)	(40,417)	(41,200)	(783)	(4,620)	(4,476)	144
Total Operating Expenditure	**(194,484)**	**(146,027)**	**(147,391)**	**(1,363)**	**(16,347)**	**(16,108)**	**239**
EBITDA	**3,829**	**1,065**	**(731)**	**(1,795)**	**313**	**43**	**(270)**
Net Financing Costs	(12,149)	(9,122)	(9,120)	2	(994)	(1,009)	(15)
Retained Surplus/Deficit	**(8,319)**	**(8,057)**	**(9,851)**	**(1,793)**	**(681)**	**(966)**	**(285)**
Technical Adjustments	33	25	63	38	(14)	13	27
Break Even Surplus/(Deficit)	**(8,286)**	**(8,032)**	**(9,788)**	**(1,755)**	**(695)**	**(953)**	**(258)**
Less PSF/FRF Funding	(18,271)	(11,876)	(11,876)	0	(1,827)	(1,827)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,557)**	**(19,908)**	**(21,664)**	**(1,755)**	**(2,522)**	**(2,780)**	**(258)**

2.4. As the Trust has not achieved the Quarter 3 financial plan it will not be eligible for the PSF/FRF funding for the quarter of £5.481 million but is still available if the Trust can achieve its control total by the end of the financial year.

2.5. The Trust has not formally confirmed a revised forecast outturn to NHSE/I; any change will need to be confirmed at month 10 following discussions with NHSE/I.

2.6. The 2019/20 CIP programme is £1.802 million behind plan at month 9; the forecast outturn has been reduced to £4.168 million against the £6.314 million plan leaving an unidentified gap of £2.146 million.

2.7. Although the monthly average deficit before PSF/FRF is £2.4 million, as previously highlighted a number of non- recurrent items have been actioned in the Quarter 3 YTD position.

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

2.9. If the increase in monthly pay spend is sustained then this will increase the underlying position.

3. Month 8 Financial Position

3.1. The month 8 I&E financial position was as follows:

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
Total Operating Income	**197,104**	**130,432**	**130,509**	77	**16,959**	**16,964**	5
PAY	(139,989)	(93,883)	(94,558)	(675)	(11,610)	(12,014)	(404)
NON PAY	(53,296)	(35,797)	(36,725)	(928)	(4,442)	(4,692)	(250)
Total Operating Expenditure	**(193,284)**	**(129,680)**	**(131,283)**	**(1,603)**	**(16,052)**	**(16,706)**	**(654)**
EBITDA	**3,820**	**752**	**(774)**	**(1,526)**	**907**	**258**	**(649)**
Net Financing Costs	(12,149)	(8,128)	(8,111)	17	(1,020)	(999)	21
Retained Surplus/Deficit	**(8,329)**	**(7,377)**	**(8,885)**	**(1,509)**	**(113)**	**(741)**	**(628)**
Technical Adjustments	33	39	51	12	11	13	2
Break Even Surplus/(Deficit)	**(8,296)**	**(7,337)**	**(8,834)**	**(1,497)**	**(102)**	**(728)**	**(626)**
Less PSF/FRF Funding	(18,271)	(10,049)	(10,049)	0	(1,827)	(1,827)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(17,386)**	**(18,883)**	**(1,497)**	**(1,929)**	**(2,555)**	**(626)**

3.2. Month 8 followed a similar pattern to month 7 in that pay had increased in month (compared to the average prior to month 7), mainly in nursing and was accompanied by higher agency spend.

4. Month 9 : Income and Activity Performance

4.1. Elective activity performance had been improving but has deteriorated in November and December.

4.2. Non elective activity has once again over-performed in month.

4.3. Trust activity and income performance at month 9 YTD is as follows:

- Elective – activity is 4.1% below plan; £625,000 loss of income.
- A&E – activity 6.4% above plan; £459,000 of additional income.

- Non Elective – activity is 1.3% below plan; £3,711,000 additional income due to case mix.
- Outpatients – activity is 3.2% above plan; £678,000 of additional income.

4.4. 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.

5. Month 9 : Expenditure

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

5.2. Prior to month 7 underlying expenditure levels were fairly consistent.

5.3. At the last Board meeting in November it was reported that there was a £200,000 increase in October’s pay expenditure.

5.4. The most material increase was within nursing staff with October 2019 seeing the largest monthly nurse expenditure and WTE date. This trend continued into November.

5.5. This monthly trend continued into December with a further increase of £120,000 in the month although this is attributed to winter schemes and is funded (Ward 1 and tactical schemes).

5.6. Non pay underlying monthly expenditure remains consistent with previous months with the reduction this month relating to the application of the CNST CIP under “miscellaneous” (£250,000)

6. Month 9 : Bank and Agency spend

6.1. Monthly agency spend has increased in December to £1,334,000 (11.0% of the pay bill); Medical staff £667,000; Nursing £549,000

6.2. Month 9 YTD agency spend is £9.441million (8.8% of the pay bill); Medical staff £4.932 million; Nursing £3.623 million.

6.3. Total Bank spend is consistent with previous months; October is £920,000 (7.63% of the total pay bill) bringing YTD spend to £8.410 million (7.8% of the total pay bill).

6.4. The Trust spent £2.255 million in December on bank and agency staff which is the highest monthly spend to date.

6.5. 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. Month 9: Cost Improvement Plan (CIP) Performance

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 both the targets with the performance to date.

	Annual Plan £000	Annual Budget £000	Month 9 Budget £000	Month 9 Actual £000	Month 9 Var £000	YTD Budget £000	YTD Actual £000	YTD Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	379	119	(260)	2,828	1,205	(1,623)	1,456	1,021
19/20 Plan - Expenditure (non pay)	1,724	1,724	164	334	170	1,234	1,168	(66)	1,503	1,366
19/20 Plan - Income (other op income)	325	325	39	32	(7)	207	306	99	402	201
19/20 Plan - Income (BPT)	1,800	300	29		(29)	212		(212)		
19/20 Plan - Total	**6,314**	**6,314**	**611**	**485**	**(126)**	**4,481**	**2,679**	**(1,802)**	**3,361**	**2,588**

7.4. The forecast outturn against the £6.314 million target has reduced to is £4.168 million leaving an unidentified gap of £2.146 million (see separate agenda item).

8. 2019/20 Forecast Outturn

8.1. Despite achieving the financial plan in the first half of the year the Trust has been signalling that it would not achieve the plan at the year end based on current financial performance.

8.2. The Trust is working with system partners and the Regulator to support the delivery of the Trust's financial plan in line with national reporting.

9. Recommendations

9.1. The Board is asked to receive the Finance Report – Month 9 2019/20.

List of Appendices

1. **Activity run rate by month**
2. **Statement of Comprehensive Income (Income & Expenditure Account) – Month 9**
3. **Statement of Comprehensive Income (Income & Expenditure Account) – Month 8**
4. **Expenditure run rate by month**
5. **WTE run rate by month**
6. **Statement of Financial Position (Balance Sheet)**
7. **Capital Expenditure**
8. **Cashflow Forecast**

1. Activity run rate by month

	2018/19				2019/20								
	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
AandE	6,896	7,269	6,756	7,595	7,176	7,446	7,162	7,783	7,224	7,393	7,677	8,104	7,488
Day Case	1,444	1,878	1,731	1,854	1,707	1,706	1,605	1,815	1,801	1,825	1,887	1,684	1,657
Elective	138	180	175	179	144	187	183	177	175	153	193	182	149
Non Elective (Including Short Stay)	2,644	2,741	2,480	2,646	2,368	2,505	2,340	2,662	2,707	2,559	2,771	2,802	2,807
Non Elective Non Emergency	285	241	254	262	75	78	60	76	62	69	72	79	66
Outpatients (Including Procedures)	12,855	14,926	14,462	15,302	15,075	15,615	14,366	16,778	14,066	15,287	16,049	15,422	13,263

2. Statement of Comprehensive Income (Income & Expenditure Account) – Month 9

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	166,612	125,039	124,400	(639)	13,658	13,182	(477)
PP, Overseas & RTA	1,095	823	557	(265)	91	66	(25)
Other Income	12,335	9,354	9,827	472	1,084	1,077	(7)
PSF & FRF	18,271	11,876	11,876	0	1,827	1,827	0
Total Operating Income	**198,313**	**147,092**	**146,660**	(432)	**16,661**	**16,151**	(509)
PAY	(141,037)	(105,610)	(106,190)	(580)	(11,727)	(11,632)	95
NON PAY	(53,447)	(40,417)	(41,200)	(783)	(4,620)	(4,476)	144
Total Operating Expenditure	**(194,484)**	**(146,027)**	**(147,391)**	**(1,363)**	**(16,347)**	**(16,108)**	**239**
EBITDA	**3,829**	**1,065**	**(731)**	**(1,795)**	**313**	**43**	**(270)**
Net Financing Costs	(12,149)	(9,122)	(9,120)	2	(994)	(1,009)	(15)
Retained Surplus/Deficit	**(8,319)**	**(8,057)**	**(9,851)**	**(1,793)**	**(681)**	**(966)**	**(285)**
Technical Adjustments	33	25	63	38	(14)	13	27
Break Even Surplus/(Deficit)	**(8,286)**	**(8,032)**	**(9,788)**	**(1,755)**	**(695)**	**(953)**	**(258)**
Less PSF/FRF Funding	(18,271)	(11,876)	(11,876)	0	(1,827)	(1,827)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,557)**	**(19,908)**	**(21,664)**	**(1,755)**	**(2,522)**	**(2,780)**	**(258)**

3. Statement of Comprehensive Income (Income & Expenditure Account) – Month 8

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	165,535	111,381	111,219	(162)	14,042	14,010	(31)
PP, Overseas & RTA	1,095	732	492	(240)	92	38	(53)
Other Income	12,203	8,270	8,750	480	999	1,088	89
PSF & FRF	18,271	10,049	10,049	0	1,827	1,827	0
Total Operating Income	**197,104**	**130,432**	**130,509**	77	**16,959**	**16,964**	5
PAY	(139,989)	(93,883)	(94,558)	(675)	(11,610)	(12,014)	(404)
NON PAY	(53,296)	(35,797)	(36,725)	(928)	(4,442)	(4,692)	(250)
Total Operating Expenditure	**(193,284)**	**(129,680)**	**(131,283)**	**(1,603)**	**(16,052)**	**(16,706)**	**(654)**
EBITDA	**3,820**	**752**	**(774)**	**(1,526)**	**907**	**258**	**(649)**
Net Financing Costs	(12,149)	(8,128)	(8,111)	17	(1,020)	(999)	21
Retained Surplus/Deficit	**(8,329)**	**(7,377)**	**(8,885)**	**(1,509)**	**(113)**	**(741)**	**(628)**
Technical Adjustments	33	39	51	12	11	13	2
Break Even Surplus/(Deficit)	**(8,296)**	**(7,337)**	**(8,834)**	**(1,497)**	**(102)**	**(728)**	**(626)**
Less PSF/FRF Funding	(18,271)	(10,049)	(10,049)	0	(1,827)	(1,827)	0
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(17,386)**	**(18,883)**	**(1,497)**	**(1,929)**	**(2,555)**	**(626)**

4. Expenditure run rate by month

RUN RATE Month on Month - £(000)

As at 31 December 2019

Southport and Ormskirk Hospital NHS Trust

Class	STAFF GROUP	STAFF TYPE	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
PAY	Consultants	Substantive	(1,319)	(1,395)	(1,324)	(1,118)	(1,238)	(1,239)	(1,234)	(1,321)	(1,235)	(1,396)	(1,282)	(1,267)	(1,246)
		Bank	(70)	(101)	(78)	(104)	(98)	(70)	(65)	(112)	(65)	(75)	(84)	(80)	(77)
		Agency	(187)	(179)	(206)	(272)	(279)	(279)	(201)	(275)	(266)	(341)	(264)	(290)	(363)
	Consultants Total		(1,577)	(1,675)	(1,608)	(1,494)	(1,615)	(1,587)	(1,500)	(1,708)	(1,566)	(1,812)	(1,630)	(1,636)	(1,686)
	Other Medical	Substantive	(1,263)	(1,319)	(1,307)	(1,256)	(1,337)	(1,305)	(1,327)	(1,297)	(1,313)	(1,431)	(1,328)	(1,316)	(1,323)
		Bank	(142)	(137)	(115)	(167)	(165)	(167)	(195)	(155)	(174)	(171)	(146)	(182)	(139)
		Agency	(208)	(244)	(273)	(316)	(256)	(257)	(277)	(288)	(255)	(235)	(247)	(258)	(304)
	Other Medical Total		(1,612)	(1,699)	(1,695)	(1,739)	(1,758)	(1,730)	(1,799)	(1,740)	(1,742)	(1,837)	(1,722)	(1,756)	(1,766)
	Nurses & Midwives	Substantive	(3,571)	(3,704)	(3,672)	(3,388)	(3,954)	(3,818)	(3,797)	(3,745)	(3,722)	(3,771)	(3,749)	(3,820)	(3,769)
		Bank	(543)	(595)	(588)	(684)	(609)	(637)	(645)	(632)	(671)	(656)	(684)	(665)	(669)
		Agency	(262)	(427)	(415)	(436)	(372)	(397)	(319)	(303)	(400)	(370)	(458)	(455)	(549)
	Nurses & Midwives Total		(4,375)	(4,726)	(4,675)	(4,508)	(4,935)	(4,852)	(4,761)	(4,680)	(4,793)	(4,796)	(4,891)	(4,941)	(4,987)
	Scientific, Technical & Theraputic	Substantive	(1,307)	(1,320)	(1,319)	(1,260)	(1,437)	(1,349)	(1,329)	(1,323)	(1,348)	(1,372)	(1,384)	(1,360)	(1,367)
		Bank	(12)	(9)	(12)	(12)	(7)	(7)	(7)	(8)	(6)	(5)	(5)	(4)	(12)
		Agency	(15)	(12)	(8)	(14)	(4)	(8)	(20)	(35)	(26)	(72)	(28)	(39)	(38)
	Scientific, Technical & Theraputic Total		(1,334)	(1,341)	(1,339)	(1,286)	(1,448)	(1,364)	(1,355)	(1,366)	(1,380)	(1,449)	(1,417)	(1,403)	(1,417)
	Other Staff	Substantive	(1,981)	(1,965)	(2,008)	(1,731)	(2,284)	(2,156)	(2,147)	(2,090)	(2,115)	(2,150)	(2,120)	(2,126)	(2,128)
		Bank	(28)	(27)	(19)	(34)	(38)	(17)	(27)	(34)	(40)	(28)	(24)	(26)	(23)
		Agency	(58)	(59)	(50)	(54)	(59)	(54)	(48)	(64)	(78)	(34)	(112)	(87)	(80)
	Other Staff Total		(2,067)	(2,051)	(2,077)	(1,818)	(2,381)	(2,227)	(2,223)	(2,188)	(2,232)	(2,213)	(2,256)	(2,239)	(2,231)
	Pay Reserves	Substantive	184	232	798	(176)	(57)	(56)	149	(191)	(54)	914	(0)	0	501
	Pay Reserves Total		184	232	798	(176)	(57)	(56)	149	(191)	(54)	914	(0)	0	501
	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)	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)	(46)	(39)	(46)
	Apprenticeship Levy Total		(39)	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)	(46)	(39)	(46)
PAY Total			(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)	(12,014)	(11,632)
NON-PAY	Supplies & Services Clinical		(2,228)	(2,249)	(2,227)	(2,413)	(2,263)	(2,325)	(2,259)	(2,420)	(2,264)	(2,227)	(2,382)	(2,299)	(2,334)
	Supplies & Services General		(200)	(203)	(199)	(212)	(186)	(172)	(173)	(164)	(189)	(219)	(211)	(191)	(204)
	Non-Executive Directors						(6)	(6)	(6)	(8)	(4)	(6)	(6)	(10)	(6)
	Establishment Expenses		(295)	(298)	(292)	(268)	(191)	(226)	(232)	(221)	(245)	(242)	(237)	(231)	(249)
	Premises & Fixed Plant		(993)	(953)	(917)	(775)	(1,018)	(1,035)	(991)	(985)	(1,055)	(948)	(1,061)	(1,132)	(1,109)
	Miscellaneous		(659)	(638)	(654)	(595)	(717)	(720)	(716)	(735)	(717)	(666)	(740)	(723)	(460)
	Services From Other NHS Bodies		(209)	(287)	(253)	(328)	(103)	(61)	(69)	(145)	(188)	(136)	(137)	(106)	(114)
	Non Pay Reserve		0	0	0	0	(7)	7	0	0	0	0	0	0	0
	Non Pay CIP		0	0	0	0	0	0	0	0	0	0	0	0	0
NON-PAY Total			(4,583)	(4,628)	(4,543)	(4,590)	(4,491)	(4,538)	(4,446)	(4,678)	(4,662)	(4,443)	(4,775)	(4,692)	(4,477)
NON-OPERATING EXPENDITURE			(942)	(939)	(940)	(479)	(1,031)	(1,023)	(1,037)	(1,006)	(1,042)	(1,016)	(998)	(1,005)	(1,015)
Grand Total			**(16,346)**	**(16,868)**	**(16,119)**	**(16,137)**	**(17,761)**	**(17,418)**	**(17,009)**	**(17,608)**	**(17,506)**	**(16,694)**	**(17,733)**	**(17,710)**	**(17,124)**

Class	Type	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
PAY	Substantive	(9,296)	(9,511)	(8,871)	(8,975)	(10,351)	(9,964)	(9,723)	(10,016)	(9,822)	(9,248)	(9,908)	(9,928)	(9,378)
	Bank	(795)	(869)	(813)	(1,001)	(918)	(898)	(940)	(942)	(956)	(936)	(944)	(956)	(920)
	Agency	(730)	(920)	(952)	(1,092)	(970)	(995)	(864)	(966)	(1,024)	(1,050)	(1,109)	(1,129)	(1,334)
PAY Total		(10,820)	(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)	(12,014)	(11,632)

5. WTE run rate by month

WTE worked

As at 31 December 2019

Southport and Ormskirk Hospital NHS Trust

STAFF GROUP	STAFF TYPE	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Consultants	Substantive	102	94	99	97	96	95	94	94	95	95	95	95	97
	Bank	4	4	5	5	5	5	3	5	3	3	4	5	4
	Agency	9	8	10	12	12	12	9	12	12	13	14	13	13
Consultants Total		115	107	114	114	114	111	106	111	110	111	113	114	115
Other Medical	Substantive	220	223	229	228	231	230	221	232	229	221	221	221	226
	Bank	10	10	10	11	13	11	9	12	12	9	12	16	12
	Agency	18	21	24	28	20	23	24	22	20	20	21	23	22
Other Medical Total		247	254	263	266	263	264	254	267	261	250	254	261	260
Nurses & Midwives	Substantive	1,098	1,094	1,101	1,110	1,106	1,121	1,110	1,109	1,107	1,102	1,121	1,142	1,124
	Bank	161	172	176	208	178	185	186	189	196	187	197	199	194
	Agency	42	62	59	69	63	60	54	57	66	65	75	84	91
Nurses & Midwives Total		1,302	1,329	1,336	1,387	1,347	1,367	1,350	1,355	1,369	1,354	1,394	1,425	1,409
Pay Reserves	Substantive	-	-	-	-	-	-	-	-	-	-	-	-	-
Pay Reserves Total		-	-	-	-	-	-	-	-	-	-	-	-	-
Scientific, Technical & Theraputic	Substantive	397	397	402	400	400	396	383	391	396	404	401	400	399
	Bank	2	2	3	2	2	2	1	2	2	1	1	2	2
	Agency	3	3	2	2	1	1	4	6	5	6	5	5	5
Scientific, Technical & Theraputic Total		402	401	406	405	402	399	388	399	403	411	407	408	406
Other Staff	Substantive	771	760	772	773	810	802	805	797	803	804	824	818	810
	Bank	12	9	11	14	15	13	10	14	14	13	12	12	12
	Agency	11	7	10	8	8	10	13	10	12	9	11	10	10
Other Staff Total		793	777	793	795	833	825	828	821	829	826	848	839	833
Grand Total		**2,860**	**2,868**	**2,912**	**2,967**	**2,959**	**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**	**3,047**	**3,023**
SUMMARY BY STAFF TYPE														
	Substantive	2,588	2,569	2,603	2,608	2,642	2,643	2,613	2,623	2,630	2,626	2,663	2,677	2,657
	Bank	190	198	205	240	213	215	210	222	227	213	226	234	225
	Agency	82	101	104	119	103	108	103	107	115	113	126	135	142
Grand Total		**2,860**	**2,868**	**2,912**	**2,967**	**2,959**	**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**	**3,047**	**3,023**

6. Statement of Financial Position (Balance Sheet)

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	31/12/2019		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	121,143	(1,924)	287
Other assets	966	1,413	447	(74)
TOTAL NON CURRENT ASSETS	**124,033**	**122,556**	**(1,477)**	**213**
CURRENT ASSETS				
Inventories	2,382	2,388	6	29
Trade and other receivables	11,678	14,795	3,117	1,056
Cash and cash equivalents	1,042	1,183	141	(660)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**18,366**	**3,264**	**425**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(21,111)	1,660	(254)
Provisions	(199)	(246)	(47)	(1)
PFI/Finance lease liabilities	(1,153)	(1,153)	0	0
DH revenue loans	(20,487)	(60,282)	(39,795)	(2,687)
DH Capital loan	(411)	(400)	11	0
Other liabilities	(1,025)	(4,347)	(3,322)	1,161
TOTAL CURRENT LIABILITIES	**(46,046)**	**(87,539)**	**(41,493)**	**(1,781)**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(69,173)	(38,229)	**(1,356)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**53,383**	**(39,706)**	**(1,143)**
NON CURRENT LIABILITIES				
Provisions	(207)	(160)	47	0
DH revenue loans	(82,953)	(54,442)	28,511	229
PFI/Finance lease liabilities	(13,831)	(12,933)	898	(53)
DH Capital loan	(1,000)	(600)	400	0
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(68,135)**	**29,856**	**176**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(14,752)**	**(9,850)**	**(967)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,214	0	0
Retained earnings	(112,432)	(122,282)	(9,850)	(967)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(14,752)**	**(9,850)**	**(967)**

7. Capital

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M9 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Year end £'000		
			Original Plan	Revised Plan	Actual	Variance	Actual	Actual	Revised Plan Jan 2020	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0090	1,000	450	583	(133)	206		997	789	208
	Beds / Trolleys	G0060		31	31				62	31	31
	Sub total MEDICAL DEVICES		**1,000**	**481**	**614**	**(133)**	**206**		**1,059**	**820**	**239**
PHARMACY	**E Prescribing**								**110**		**110**
IM&T	Electronic Patient Record Bluespier	G0100	111								
	Electronic Patient Record PDS	G0101	69								
	Electronic Patient Record Careflow	G0102	149	269	11	258	288		487	299	188
	Vitalpac	G0007	10	25	25				25	25	
	Patient Service Signposting	G0103	184	138	106	32			184	106	78
	eDMS Evolve	F6447	80	43	43				43	43	
	SQL Server Upgrades										
	Windows 10 Project	G0104	318	473	471	2	88		600	559	41
	Telephony System Replacement	G0059	50				45		50	45	5
	Baby Tagging	G0105	50	50		50	48		48	48	
	Cyber Security	G0071	80	60	23	37	16		93	39	54
	Fixed Network Infrastructure	F6498	120	90	44	46			120	44	76
	PAS Replacement	F6409		7	7				7	7	
	Data Storage Infrastructure	G0106	25						191		191
	Wireless Network Upgrade	G0073		2	1	1			2	1	1
	Windows tablets - community midwives								50		50
	IM&T Contingency	G0107	450	213	150	63	56		255	206	49
	Sub total IM&T		**1,696**	**1,370**	**881**	**489**	**541**		**2,155**	**1,422**	**733**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	350	222		222	1		222	1	221
	6 Facet Survey	G0150	90	55	55				55	55	
	Nurse Call System	G0151	100	100		100			250		250
	Upgrade Ventilation Plants	G0152	100								
	Fire compartmentation	G0052	100	4	4				4	4	
	Fire Precautions - Fire Doors	G0019	100		2	(2)			20	2	18
	Legionella Prevention	G0153	50								
	Spinal Lift & Ramp	G0154	85						85		85

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M9 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Year end £'000		
			Original Plan	Revised Plan	Actual	Variance	Actual	Actual	Revised Plan Jan 2020	Actual	Variance
ESTATES	Spinal isolation works	G0099	150	312	308	4			312	308	4
	SDGH Ward Upgrades	G0155	600	879	629	250	29		972	658	314
	Library Extension	G0156	145	145		145			145		145
	Capital Team	F6305	160	119	127	(8)			160	127	33
	CCTV	G0157	50								
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,080**	**1,836**	**1,125**	**711**	**30**		**2,225**	**1,155**	**1,070**
	ESTATES CONTINGENCY										
	Estates Contingency Fund										
	Ward E	G0159		206	101	105	101	3	500	206	294
	Y Block (approved CIG 07/19)								25		25
	Doctors Mess (18/19)	F6420			(1)	1				(1)	1
	Spinal Ward Bathrooms & Storage	G0158		238	211	27	18		238	229	9
	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	G0083			(1)	1	6			5	(5)
	Waste Management	G0080					1			1	(1)
	EBME Lift										
	HR Move - Further Alterations to LRC	F6301		34	13	21	1		34	14	20
	Compressors - sterile services								20		20
	Piped air paediatrics								30		30
	Southport theatre forward wait								63		63
	Paediatric flooring								50		50
	Bereavement room roof								50		50
	Sub total ESTATES CONTINGENCY SCHEMES			**506**	**350**	**156**	**128**	**3**	**1,038**	**481**	**557**
	Sub total ESTATES SCHEMES		**2,080**	**2,342**	**1,475**	**867**	**158**	**3**	**3,263**	**1,636**	**1,627**

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2019/20 £'000	M9 YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Year end £'000		
			Original Plan	Revised Plan	Actual	Variance	Actual	Actual	Revised Plan Jan 2020	Actual	Variance
FACILITIES	Catering equipment	G0026	75	77	18	59	84		102	102	0
	Vehicle Replacement	G0145	50	(27)		(27)			23		23
	Sub total FACILITIES		**125**	**50**	**18**	**32**	**84**		**125**	**102**	**23**
	CONTINGENCY	**F6301**	**202**		**51**	**(51)**	**1**			**52**	**(52)**
	Capital plan excluding donations and IFRIC 12		**5,103**	**4,243**	**3,039**	**1,204**	**990**	**3**	**6,712**	**4,032**	**2,570**
OTHER	Donated assets	000000	100	75	50	25			100	50	50
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,214	1,214	209	1,005			1,214	209	1,005
	Sub total Donations and IFRIC 12		**1,314**	**1,289**	**259**	**1,030**			**1,314**	**259**	**1,055**
	TOTAL CAPITAL SPEND		**6,417**	**5,532**	**3,298**	**2,234**	**990**	**3**	**8,026**	**4,291**	**3,625**

8. 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	Actual Nov-19 £'000s	Actual 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)	(315)	(529)	1,025	398	1,324	(3,201)
Income recognised in respect of capital donations	(9)	1	0	(34)	0	0	(8)	0	0	0	0	(50)	(100)
Depreciation and Amortisation	594	593	601	571	572	572	573	572	574	604	604	603	7,033
Impairments and Reversals	0	0	0	0									0
(Increase) in Inventories	59	(86)	200	(143)	(74)	216	(105)	(44)	(30)	45	30	52	120
(Increase) in Trade and Other Receivables	(949)	(2,096)	(1,115)	1,143	1,947	1,011	(2,702)	179	(1,047)	(2,131)	(2,131)	1,496	(6,395)
Increase in Trade and Other Payables	3,517	(1,123)	(1,871)	(1,887)	5,822	(512)	514	(2,786)	(601)	(4,245)	(1,580)	2,273	(2,479)
Increase in Provisions	1	(8)	(3)	10	0	(14)	14	(1)	(4)	(21)		(41)	(67)
Net Cash Inflow/(Outflow) from Operating Activities	1,620	(3,724)	(2,214)	(1,433)	6,876	1,399	(1,836)	(2,395)	(1,637)	(4,723)	(2,679)	5,657	(5,089)
Cash Flows from Investing Activities													
Interest Received	3	4	5	5	8	17	(1)	5	6	6	6	7	71
(Payments) for Intangible Assets	(57)	0	(2)	(152)	127	0	(2)	(5)	(107)	(83)	(85)	(324)	(690)
(Payments) for PPE and investment property	(190)	(117)	(186)	40	(1,144)	(325)	(189)	(227)	(1,118)	(1,021)	(645)	(1,587)	(6,709)
Receipts from disposal of fixed assets	0	0	0	0	0	0	0	0	38	0			38
Receipt of cash donations to purchase capital assets	9	(1)	0	34	0	0	8	0	0	21		29	100
Net Cash Inflow/(Outflow) from Investing Activities	(235)	(114)	(183)	(73)	(1,009)	(308)	(184)	(227)	(1,181)	(1,077)	(724)	(1,875)	(7,190)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0						519	500	590	1,609
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	2,458	5,400	3,664	5,873	29,567
Loans repaid to DH	(200)	0	0	0	0	0	(2,941)	0	0			(9,135)	(12,276)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(596)	(8)	(8)		(272)		(932)
Capital element of PFI, LIFT	(16)	(15)	(118)	(16)	(15)	(119)	(15)	(16)	(119)	(16)	(15)	(118)	(598)
Interest Paid	(190)	(234)	(225)	(195)	(228)	(545)	(207)	(243)	(244)	(205)	(236)	(525)	(3,277)
Interest element of finance lease	0	0	0	0			(240)	0	0		(158)		(398)
Interest element of PFI, LIFT	(80)	(81)	(209)	(80)	(81)	(209)	(81)	(80)	6	(81)	(80)	(425)	(1,481)
PDC dividend (paid)/refunded	0	0	0	0	0	0	0	0	65		0	0	65
Net Cash Inflow/(Outflow) from Financing Activities	1,962	1,120	1,826	1,880	(332)	(881)	(4,080)	3,346	2,158	5,617	3,403	(3,740)	12,279
NET INCREASE/(DECREASE) IN CASH	**3,347**	**(2,718)**	**(571)**	**374**	**5,535**	**210**	**(6,100)**	**724**	**(660)**	**(183)**	**0**	**42**	**0**
Cash - Beginning of the Period	1,042	4,389	1,671	1,100	1,474	7,009	7,219	1,119	1,843	1,183	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**	**1,843**	**1,183**	**1,000**	**1,000**	**1,042**	**1,042**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 February 2020

Agenda Item	TB011/20	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, two new risks have been added onto the risk register.

- **2130** – Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff (16). This risk has been added due to concerns about the infrastructure and resources to deliver and monitor a comprehensive clinical skills programme.
- **2161** - Failure to achieve financial control totals (16). This risk has been added at the request from FP&I to amalgamate the short and long term financial risks.

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

- **1942** - Eradicating the Trust's deficit by 2023/24
- **2072** - Failure to achieve 2019/20 financial control total

These risks have been closed and replaced with one Finance risk – **2161** as above.

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

- **1688** - Inadequate Staffing Levels in Anaesthetic Department.
- **1902** - Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC
- **2052** - Older Peoples Care
- **1862** - Maintaining safe quality nursing care with current level of nursing & HCA vacancies. **This risk will be reviewed at Risk & Compliance Group in February with a view to downgrading the risk to high (12) due to the controls in place to mitigate staffing levels should they fall below funded establishments.**
- **2056** - Missing Patient appointments/admissions
- **2122** – Medicines Management
- **2130** – Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff
- **2161** - Failure to achieve financial control totals

Work is ongoing between the Project Management Office, Chief Operating Officer and Executive Medical Director to add two new risks relating to Fragile Services and Medical Staffing. These are due to be taken to Risk & Compliance Group in February for approval onto the Risk Register.
The risk relating to Patient Flow and Capacity was discussed at Risk & Compliance Group in January. This risk is currently rated High (12) and it was considered that this was appropriate to remain at this level.

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		
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

JANUARY 2020 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 28/01/2020

Risk ID	Principle Objective(s)	Risk	Executive Lead	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
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	=20	=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	Risk closed - new risk added to consolidate short and long term financial risks (ID 2161)
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	12↓	=12	=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	=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	10↓	10↓	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	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	=16	Risk closed - new risk added to consolidate short and long term financial risks (ID 2161)
2122	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services	Medicines Management	Executive Medical Director				!15	=15	=15
2130	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	Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff	Director of HR and OD						!16
2161	SO3 - Efficiently and productively provide care within agreed financial limits	Failure to achieve financial control totals	Director of Finance						!16

TRUST RISK PROFILE AS AT 28/01/2020

	CONSEQUENCE (impact/severity)				
LIKELIHOOD (frequency)	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)					
Likely (4)				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 2130 - Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff 2161 - Failure to achieve financial control totals	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

<table>
<tr><td>Strategic Objective</td><td colspan="4">SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services</td><td>Link to BAF</td><td></td></tr>
<tr><td>Opened</td><td>ID</td><td>ADO/Exec Lead</td><td>Risk Lead</td><td colspan="3">Title</td></tr>
<tr><td>14/11/2019</td><td>2122</td><td>Executive Medical Director</td><td>John Williams</td><td colspan="3">Medicines Management</td></tr>
<tr><td>Description</td><td colspan="6">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.</td></tr>
<tr><td>Controls</td><td colspan="3">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</td><td>Gaps in Controls</td><td colspan="2">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
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 wellbeing and sickness rates due to workload pressure.
Lack of central wireless monitoring system for temperatures in drug storage areas.
Lack of EPMA (electronic prescribing) Trustwide.
Anti-coagulant clinics run on minimal staffing
Unable to update to Drug Library for IV pumps in a timely manner</td></tr>
</table>

								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	16/01/2020	01/03/2020
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**		
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 projects for the Medicines Management Optimisation Programme have now been confirmed with the priority work streams up and running, (Safe and Secure Handling of Medicines, Recruitment to Business Case, Leadership, Enhanced Weekend Working.) The programme is being phased and communications modelled. The 2019,3,6,9 month Meds Management Improvement Action Plan is now part of the Safe and Secure Handling of Meds Project. The Project group is meeting regularly and has commenced process mapping (for the management of TTOs in the first instance). All areas identified by the CQC and NHSI for improvement are to be mapped and clear roles and responsibilities will developed out of this to support the full embedding of best practice. The Action Tracker for the Controlled Drugs SUI have now been transferred into the project work stream of the same which will be delivered as a task and finish group. The Leadership and Recruitment work streams are making steady progress, supported by consultation with Chief Pharmacist from Leeds Teaching Hospital is being driven through a series of workshops. The consultation process for Enhanced Weekend Working is ongoing with staff. The recruitment of a Project Manager for EPMA is ongoing with clarity required on the approach to the procurement of the EPMA system. Clarity is also being sought to ascertain whether there are any capital funds for the Automated Ward Drugs Storage System and the Centralised Temperature Monitoring System.								

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 True loss to follow ups are datix'd and sent to Directorate Manager Risk stratification as per corporate policy for all high risk patients more than 12 weeks overdue Additional validation completed by RTT trackers as part of specialty review Re-training of staff Alerts on Medway for Ophthalmology patients Weekly monitoring with meeting and reports 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 communication via CCG's to alert to loss to follow up process Clinic outcome sheets now retained and outcomed on the day					Gaps in Controls	Paper based process which is fragmented electronic process to eliminate paper processes Logistical issues of clinics being held across sites causing issues transferring paper listing forms in various modes RTT trackers have reduced capacity to review pathways. GP's may not alert the loss to follow up in all cases.		
Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Catastrophic (5)	20	20	Extreme risk	5	Moderate risk	24/01/2020	25/02/2020
Assurance	Highlighted to the Board. Patients lost to follow-up reported when identified via Datix weekly report to exec team Full list of all open referrals including EMIS referrals being daily reviewed Weekly report to CCG Trend report being discussed at weekly meeting to ensure appropriate actions and learning in place					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 Capacity to address issues due to reduced tracking team		
Action Plan	Delivery against the Trust overarching lost to follow up action plan					Action Plan Due Date	14/02/2020	Action Plan Rating	Moderate Progress Made
Latest Month Progress	Weekly meetings continue to take place. CCG have confirmed they have a level of assurance to enable them to step down from the fortnightly meetings and review via SIRG. SOPs have been ratified at Planned care Clinical governance meeting and circulated to the other CBUs for note. BDISC was cancelled in Dec and Jan, awaiting date for review of business case for substantive tracking posts.								

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	Claire Blackman	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		Gaps in Controls	
	Safe Care monitored daily M-Fri and aligned to Staffing Huddles Daily staffing huddles with Matrons & Senior nurse Review Health roster Policy & compliance ratified July 2019 NHSP contract to support flexible workforce pipeline Nursing establishments uplifted & ratified at Trust Board May 2019 Staffing data reviews through support and challenge meetings within CBU's 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 Workforce Committee & Trust Board on a monthly basis Tier 2 nurse agency in place and review process to assure on fill Contract booking for RN agency to support fill rate on day shifts during winter pressured months Weekend Matron Rota commenced Jan 2020 to support safe staffing Nursing and Midwifery Recruitment and Retention Group being re-established Jan 2020		Trustwide Recruitment and Retention Group to be established Absence of current workforce Strategy/Plan 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	27/01/2020	20/02/2020

Assurance		Gaps in Assurance	
	Monthly staffing report CQC inspection Quality and safety reports Complaints Incident reporting Bi annual staffing reports 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 Temporary staffing weekly review meetings with HoN'S /DDoN'S /ADoN Workforce, Resource Lead, Finance		Delay in Bi-annual staffing report (commenced)

Action Plan		Action Plan Due Date		Action Plan Rating	
	Full details in smart-sheets - E roster compliance Prioritise template upload Clarify capacity to upload templates for new NER Continue 2 weekly meeting with HoN/M & Matrons 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		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		Completed Completed Completed Moderate Progress Made Actions Almost Completed Completed Completed Completed Completed

	Inform Ward managers/Matrons of final e roster rota Upload new templates Smart sheets has detailed plan - Recruitment Identify HR recruitment team to support recruitment process Advertise relevant posts (RN, HCA, B4) Monthly review of vacancies, turnover & progress through trust 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 - completed Confirm JD & P spec - In AFC process awaiting update 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	The Nursing and Midwifery Recruitment and Retention Group being re-established Jan 2020 and the weekend Matron rota commenced with effect from January 2020 to support safe staffing. A proposal to BDISC in January 2020 to commence overseas recruitment opportunities for up to 70 RN's. 10 Apprentice Nurse posts advised – to recruit by March 2020.				

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

Improvement plans developed and agreed with trust Board
Improvement groups developed across Trusts, including CBUs
development of a shared drive to enable evidence to be uploaded
Development of a CQC Improvement Plan (Must Do Regulatory Actions) submitted to CQC 29.12.19
Identified PMO support for 4 Quality Priorities (linked to delivery of the CQC improvement plan)
Review of Terms of Reference for Quality Assurance Panels to test evidence and monitor improvement for Must & Should Do actions
Identified support for Quality Improvement methodology for Medical Core Services to support pace of quality improvement
Review of governance arrangements for CQC Improvement Plan to utilise core service directorate meetings, CBU governance meeting and Performance Review Boards

Gaps in Controls

CQC identified 31 must do' actions relating to beaches of regulation and 92 actions CQC recommend we 'should do' actions
Gaps in some areas of mandatory training e.g. Resus
Gaps in compliance with ward and matrons checklists

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	28/01/2020	25/02/2020

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
Internal assurance panels
Medicines management improvement plan developed & agreed with NHS E & I & shared with CQC
Letter submitted to CQC identifying improvements made since inspections
New CQC Improvement Plan submitted to CQC 29.12.19

Gaps in Assurance

Engagement of key leaders from 'ward to board'
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
Proposed changes to governance structure in relation to CQC improvement plan not yet embedded

Action Plan

Incorporate any Red Must Do Actions into CBU Risk Register
Monitor facilities focus group action plan through quality assurance panels
Factual accuracy to be completed within agreed time scales of 10 days.
work with communications team to engage widely with staff
develop training for staff across the organisation
Key leaders to access training with lead CQC executive/manager
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.

Action Plan Due Date

17/07/2019
28/02/2020
29/11/2019
30/09/2019
28/06/2019
22/10/2019
29/11/2019

Action Plan Rating

Completed
Little or No Progress Made
Completed
Completed
Completed
Actions Almost Completed
Moderate Progress Made

Latest Month Progress

The CQC risk has been updated to reflect the development and submission of the new CQC Improvement Plan, shared with CQC 29.12.19. The risk has also been aligned with the improvement plans for the Trust's four quality improvement priorities and updated to reflect the proposals to strengthen the governance structure in relation to the CQC Improvement Plan to ensure improvements

	are embedded and sustained.

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire		Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**	
13/06/2019	2052	Director of Nursing & Quality	Megan Langley	Older Peoples Care	

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

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	24/01/2020	11/02/2020
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**	29/05/2020 30/04/2020 30/04/2020 31/12/2019 30/04/2020 29/05/2020 29/05/2020	**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	The Falls Risk assessment and care bundle on all wards. All falls with harm are now presented at the harm free care panels for learning lessons. The quarterly falls review panels commence in February 2020. The Trust Falls Improvement Plan has been approved and launched and is now being used to develop the targeted work streams to deliver the reduction in falls and other objectives outlined in the plan. Two sets of falls alarms are being trailed with a view to making a recommendation regarding the purchase of on-going equipment to improve patient safety. Red walking frames have been purchased and are being used on one ward as a trial also to see if their improved visibility has an impact on patient safety, maintenance of function/mobility and experience. The nutrition policy is in final draft to be reviewed at the NHMCG February meeting and then sent to Policy approval group. The care plan has been simplified to improve compliance and understanding and ensure all patients needs are met and will also be approved in the February NHMCG Meeting. Following the approval, a roll-out plan will be developed to ensure appropriate education and support in implementing the care plan to ensure MUST screening compliance improves and repeat MUST as well as timely referral the Dietetic service for support. 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- this has been completed by all RNs on ward 10B who found this beneficial. The new mouth care assessment, care plan, products and accompanying education have been rolled-out on 5 wards to date with a plan to complete roll-out across the organisation by April 2020. Education is provided on the wards and also on the older peoples care training programme. Excellent feedback from staff regarding the quality of mouth care provided on the wards who have implemented this. The blueprint for resource boxes is to be approved at the next Dementia and Delirium Meeting in February. Production of some of the resources has commenced and a charitable funds bid will be written for the remaining items. Support now being provided by Dementia & Delirium Specialist and Admiral Nurse to increase pace with this piece of work. The creation of activity planners and the endPJparalysis initiative to get patients up, dressed and moving is on-going and the Dementia and Delirium Team are supporting this piece of work. Patient information leaflets about the importance of getting up, dressed and moving if able, as well as what should be brought to hospital have been trailed on ward 9B and are to be shared with the patient experience group for feedback with a view to these being given out on admission in future. The Dementia and Delirium Team has commenced immediate work on identifying people who have a diagnosis of Dementia and flagging these on Medway. They are also focusing on currently ensuring that cognitive impairment is recognised, promoting use of the Delirium Guideline and appropriate investigation, diagnosis, support with care and follow-up. The new Enhanced levels of care, cognitive impairment risk assessment and cognitive impairment care plan are now in all areas of the organisation and the old versions have been removed. The CCG are in discussion with GPs regarding follow-up or escalation of people discharged with Delirium and these discussions are to continue as part of the monthly homefirst meetings attended by all key stakeholders.									

Strategic Objective	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	Link to BAF	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
06/12/2019	2130	Director of HR & OD	Tracy Gunn	Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff

Description	If the Trust fails to have in place the right infrastructure and resources to deliver and monitor a comprehensive clinical skills programme for the multi-professional workforce then this will result in a breach of regulatory requirements (NMC, HEE, GMC, and CQC) and may reduce patient & staff safety, increase staff turnover & poor quality of care, and has the potential for legal action and reputational damage.

Controls		Gaps in Controls	
	Induction & Mandatory Training Policy MIAA Audit (Sept 2018) reported 'substantial assurance' (Induction & Mandatory Training Policy) Full implementation of the National Core Skills Framework (CSF) for core mandatory training subjects Full training needs analysis for CSF aligned subjects mapped on ESR OLM All Trust employees have access to ESR Manager & Employee Self Service (as appropriate) to review team & individual training competences & compliance dashboard Ward Manager mandatory training dashboards All staff have access to ESR eLearning modules to update mandatory training Progress towards achieving the NW Streamlining Project Clinical induction programme under review for April 2020 New role specific training report under development to be circulated monthly on completion of Resuscitation TNA mapped in OLM early 2020 Task & Finish Group set up to review core mandatory & resuscitation training TNA's & processes led by Deputy Director of Nursing (Quality)		Outstanding list of role specific/clinical skills training each requiring a full training needs analysis based on ESR role profiles & mapped in OLM Insufficient capacity in the training department at the right skill level to deliver the outcomes of the improvement action plan Limited clinical capacity in nurse education team to deliver improvement action plan No Trust funded budget to fund consumables, equipment & a maintenance programme Limited clinical skills facilities at both sites leads to conflicting priorities between nurse & medical education Clinical skills training for nurses scheduling restricted to June 2020 No governance arrangements in place to review, approve or monitor role specific training / clinical skills competence Use of subject matter experts to deliver training causes conflict with service delivery & increases class cancellations CBU ability to release staff to attend training leads to high DNA rates & regular Datixes New starters do not currently have access to mandatory eLearning modules prior to commencement date

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	9	High Risk	17/01/2020	18/02/2019

Assurance		Gaps in Assurance	
	Core mandatory training reported monthly via HR dashboard at Workforce Committee Core mandatory training reported monthly to Board via IPR Core mandatory training monitored via CBU Performance Review Boards (PRB) Monthly reports circulated to Exec, senior leaders & managers across the Trust including Trust compliance, CBU compliance, subject compliance, individual compliance New role specific training report circulated Jan 2020 onwards MIAA Audit (Sept 2018) reported 'substantial assurance' (Induction & Mandatory Training Policy)		Workforce Committee report should be added to HR/OD annual reporting cycle CQC highlighted gaps in assurance of medicines management and resuscitation competence No assurance currently provided through Workforce Improvement Group (WIG) Gaps in governance arrangements Medical Education Committee currently inactive & no confirmed assurance committee for escalation

Action Plan		Action Plan Due Date		Action Plan Rating	
	Recruitment of an interim (18 months) with the expertise & capacity to deliver & expedite the delivery of the training action plan Establish a Clinical Skills Working Group (CSWG) & Terms of Reference to deliver this action plan with representation from the relevant business units - Training, Nursing, Medical, AHP & Performance teams. Recruitment of a Head of Nurse Education post to deliver this training action plan in conjunction with the		01/04/2020 28/02/2020 01/04/2020 02/03/2020 01/06/2020 01/06/2020 01/06/2020		Little or No Progress Made Little or No Progress Made Moderate Progress Made Little or No

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	Training Department to ensure a sustainable & governed model of clinical skills training is achieved and delivered annually Review of the current Standard Operating Procedure to deliver a governance framework / sign off process for the management of clinical skills / role specific training needs analyses (TNA's) A TNA of the Top 10 training risks to be completed by each Subject Matter Expert (SME) to identify: staff numbers, staff groups, training delivery, consumables, budget, equipment & facilities requirements per annum. Clinical skills training programme of Top 10 risks established for nurses, AHP's, medics, undergraduate medical & nursing students Top 10 TNA's to be mapped on to OLM. Single point of failure as one staff member with capability to update OLM - this will delay process so TNAs will need to be placed in priority order by the CSWG Establish a governance framework for the ongoing management of clinical skills - TNA completion & mapping, recording & reporting and monitoring mechanisms Establish an effective reporting & monitoring process to ensure the CBU's can effectively manage and monitor mandatory & Top 10 training compliance within their areas via the PRB and Board IPR - to include each subject compliance % rate and DNA % rate per month Director of Medical Education & Head of Medical Education to re-establish the Medical Education Committee/Group to manage and monitor mandatory & clinical skills training for trainees & undergraduate students Fully implement the NW streamlining project to reduce repetition of mandatory training for new starters at induction Update Induction & core mandatory training policy to reflect any changes in practice from this action plan Review of eLearning alternatives to face to face training to improve accessibility for staff to remain compliant Create a training matrix that reflects training requirements for staff groups / training hours required / cost of training by staff group to organisation		01/06/2020 01/06/2020 02/03/2020 30/04/2020 01/06/2020 31/07/2020 31/12/2020		Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Moderate Progress Made Actions Almost Completed Moderate Progress Made Moderate Progress Made Little or No Progress Made
Latest Month Progress	Job Description agreed through AfC and post approved through PAG for Head of Nurse Education. Statement of case to be presented as part of NR Business Plan for 2020/21 for an Interim Training Manager. Implementation of NW streamlining project to reduce repetition of mandatory training for new starters is almost complete. First meeting of the Clinical Competency Working Group scheduled for 06/02/2020.				

<table>
<tr><td colspan="2">Strategic Objective</td><td colspan="6">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</td><td colspan="2">Link to BAF</td><td></td></tr>
<tr><td>Opened</td><td>ID</td><td colspan="2">ADO/Exec Lead</td><td colspan="2">Risk Lead</td><td colspan="5">Title</td></tr>
<tr><td>13/11/2017</td><td>1688</td><td colspan="2">Chief Operating Officer</td><td colspan="2">Mandy Marsh</td><td colspan="5">Inadequate Staffing Levels in Anaesthetic Department</td></tr>
<tr><td>Description</td><td colspan="10">Staffing Levels within the 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.</td></tr>
<tr><td>Controls</td><td colspan="6">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</td><td>Gaps in Controls</td><td colspan="3">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</td></tr>
<tr><td>Risk Levels</td><td>Likelihood</td><td>Consequence</td><td>Risk Rating (Initial)</td><td>Risk Rating (Current)</td><td>Risk Level (Current)</td><td>Risk Rating (Target)</td><td>Risk Level (Target)</td><td>Date of Last Review</td><td colspan="2">Date of Next Review</td></tr>
<tr><td></td><td>Likely (4)</td><td>Catastrophic (5)</td><td>20</td><td>20</td><td>Extreme risk</td><td>5</td><td>Moderate risk</td><td>09/01/2020</td><td colspan="2">10/02/2020</td></tr>
<tr><td>Assurance</td><td colspan="6">Monthly Planned Care governance meetings
PC risk review meeting with ADO/HoN</td><td>Gaps in Assurance</td><td colspan="3"></td></tr>
<tr><td>Action Plan</td><td colspan="6">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.</td><td>Action Plan Due Date</td><td>18/12/2017
10/02/2020</td><td>Action Plan Rating</td><td>Completed
Moderate
Progress Made</td></tr>
<tr><td>Latest Month Progress</td><td colspan="10">Staffing levels remain at critical level, from Feb 20 we will have a total of 20 vacancies against an establishment of 52. 4 x consultant vacancies and 1 suspension. 7 x SAS vacancies (appointed to 2 posts but not commenced as yet)5 x trainees and 3 x vacancies on the new ICU rota (junior level- appointed to 1 but not commenced as yet). Cons JD's back to RC for review (valid 6 months only). LAS interviews on 16/01/20 for CT1/2 trainee vacancies.</td></tr>
</table>

<table>
<tr><td colspan="2">Strategic Objective</td><td colspan="7">SO3 - Efficiently and productively provide care within agreed financial limits</td><td>Link to BAF</td><td></td></tr>
<tr><td>Opened</td><td>ID</td><td colspan="2">ADO/Exec Lead</td><td colspan="2">Risk Lead</td><td colspan="5">Title</td></tr>
<tr><td>21/01/2020</td><td>2161</td><td colspan="2">Director of Finance</td><td colspan="2">Steve Shanahan</td><td colspan="5">Failure to achieve financial control totals</td></tr>
<tr><td>Description</td><td colspan="10">If the Trust fails to achieve its annual financial control total then the Trust could be put into financial special measures and it would lose the non-recurrent financial recovery funding (FRF)</td></tr>
<tr><td>Controls</td><td colspan="6">People and Activities Group (PAG)
Hospital Management Board (HMB)
PMO in place to assist the drive for internal efficiencies identified through Model Hospital, GIRFT, Collaboration at Scale
System Board set up to manage financial recovery of the health economy
Monthly run rate reports, Trust and CBU</td><td>Gaps in Controls</td><td colspan="3">Latest System Recovery Plan (13.12.19) shows a £4.4 million unmitigated risk for the Trust against its deficit control total for 2019/20 of £26.567m (before PSF and FRF)
Future clinical sustainability model still to be agreed
Accuracy of PLICS and Model Hospital data
Access to capital funding</td></tr>
<tr><td rowspan="2">Risk Levels</td><td>Likelihood</td><td>Consequence</td><td>Risk Rating (Initial)</td><td>Risk Rating (Current)</td><td>Risk Level (Current)</td><td>Risk Rating (Target)</td><td>Risk Level (Target)</td><td>Date of Last Review</td><td colspan="2">Date of Next Review</td></tr>
<tr><td>Likely (4)</td><td>Major (4)</td><td>16</td><td>16</td><td>Extreme risk</td><td>9</td><td>High Risk</td><td>21/01/2020</td><td colspan="2">21/02/2020</td></tr>
<tr><td>Assurance</td><td colspan="6">Acute Sustainability Programme Board
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</td><td>Gaps in Assurance</td><td colspan="3">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/Q2 position not sustainable going into further quarters.</td></tr>
<tr><td>Action Plan</td><td colspan="6">Develop CIP Plan for 2020/2021
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
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</td><td>Action Plan Due Date</td><td>31/03/2020
31/03/2020
31/03/2020</td><td>Action Plan Rating</td><td>Moderate
Progress Made
Actions Almost Completed
Completed</td></tr>
<tr><td>Latest Month Progress</td><td colspan="10">System met with NHE/I on 24.01.20 to discuss current position re 2019/20.
Trust has improved its forecast outturn in line with discussion at Private Board on 8.01.20.
Further discussion with Regulator to take place w/c 4.2.20 to discuss System Forecast Outturn position.
Progress on CIP plans for 2020/21 was also discussed. System to submit latest position on 31.01.20.
Draft plans need to completed for submission 05.03.20.</td></tr>
</table>

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 February 2020

Agenda Item		**Report Title**	**Vision 2020 and the Single Improvement Plan**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Donna Lynch, AD Strategy & Improvement		
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.

All priorities, with the exception of finance, are currently rated as Amber, the finance risk has moved from amber to red, with two additional risks scored as red. The priorities for 2019/20 are:

Quality: January rating - Amber

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

Operations: January rating - Amber

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

Workforce: January rating – Amber

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

Finance: January rating – Red

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

Strategy: January 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 seven rated as amber, after mitigation is in place. This movement in risks is as a result of two additional red finance risks, reflective of the deteriorating financial position and the reduction of one red workforce, in relation to QI training which has been resolved.

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 is produced for 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

A review of the Quality Improvement Plan and governance / assurance processes is currently being undertaken. We submitted our CQC improvement plan outlining what action we are taking to meet the requirements going forward on 29 December 2019. We were only required to submit our Must Do's 'regulatory actions', however the full plan incorporating Should Do's has been completed and is going through the internal governance process. An Improvement Plan Gantt chart is being developed to ensure evidence is submitted within agreed timescales and Quality Assurance Panels, Go See visits and mock inspections are factored into the year to enable us to track continuous improvement.

Recruitment against the Medicines Management Workforce Business Case for extended weekend working, A&E Consultant Pharmacist and ward pharmacy assistants is continuing. Extended weekend working commences in January (11.01)

EPMA: The plan and resource are to be confirmed for the delivery of the electronic prescribing and medicines administration (EPMA) system. (£700k of funding has been secured from the NHS England Integrated Digital Care Fund) is confirmed. 18 months which will support patient safety and the discharge process.

The latest NHS Digital's Standard Hospital Mortality Indicator (SHMI) for the Trust is 99.62 (with 1,335 deaths against an expected level of 1,340 for the period July 2018 to June 2019.)

An updated Programme Initiation document for recognition and care of the deteriorating patient was reviewed by the Quality and Safety Group in January. In response to feedback, National Early Warning Signs (NEWS) data will be included in the project performance reporting to ensure the Trust maintains a quality improvement focus on the recognition and subsequent proactive management of deteriorating patients.

Care of Older Peoples Programme - Roll out of Get up, Get dressed, Keep moving roll out has paused due to disruptions in the refurbishment work on ward 9A. The piece of work has therefore bene paused and is being reviewed with a reschedule in January 2020. The team continue to develop an activity planner and patient information leaflets.
The Nutrition policy and care plan are being revised as an urgent piece of work and will be shared with the NHMCG in January before launch as the position of lead dietitian has been recruited to and the lead has started in post. The new roll-out plan will be shared following approval of the policy and care plan.
West Lancashire HomeFirst pathway regularly achieving target of 6 patients per week. Southport and Formby HomeFirst Pathway has been agreed and launched on 6th January 2020.
Falls Improvement Plan approved and launched, trial of two new sets of alarms commences on 6th January on wards 9B and 14A. New risk assessment, care bundle rolled out across the organisation.

Discharge Quality - First meeting to review the End of Life pathways has taken place, next meeting scheduled for 10th January to review other pathways and a third meeting to review the documentation and communication before then setting an action plan based on outcomes.

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 32.84% April 2019 - December 2019 compared to 25.79% in April 2018 – December 2018. Improvement trajectories are currently being set for 2020/21.

Key Achievements/Progress in Month – Quality & Safety

CQC Inspections completed, draft report for factual accuracy checking has been received and submitted back to CQC within timescale on 29th October. Final Report was published 29 November 2019, currently working with CBUs to develop Quality Improvement Plans for submission back to CQC by 29th December 2019

Work relating to the 4 quality priorities continues to move forward

Key Risks/Issues	Mitigating Actions	RAG
PMO reviewing full suite of documentation for 4 quality priorities including driver diagrams, PID, Highlight Reports and Gantt Charts	Assurance from PMO that all documentation will be complete by December 2019 in time for 'Stop the Line' event in late December 2019 / early January 2020. New Quality Programme Manager in place started December 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 Participate in the development of the system winter plan, Ward 1 opened w/c 08/12/19	R

Operational Performance (Exec Lead: Steve Christian)

RAG Rating

Progress

<u>Constitutional Standards:</u>

Cancer 62 Day
Performance for November 2019 was 81.3% an increase on the October position of 74.5%. The Trust has challenges in workforce across a number of tumour groups. The sustainability of performance above 80% is a challenge. Haematology and Head & Neck services remain under pressures due to workforce constraints (both services have historical SLAs in place). Formal discussions are underway with other providers regarding Haematology and Head & Neck services considering future models of care. In addition Gynaecology are struggling due to 4 vacant Gynaecologist posts. The positon however is predicted to recover from February 2020 as the Trust has recently appointed 4 consultants.

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. 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 November against the 6 week wait target was 0.87% an improvement of 1.29% over the October position. This is the first time in 18 months that the Trust can report being compliant. Non-obstetric Ultrasound has improved remarkably however Cystoscopy remain the areas of most concern, with 14 waiters over 6 weeks – this is the only modality to be in double figures.

A&E 4 Hour Performance
The Trusts reported 4 hour A&E performance in December was 82.7%. The Trust was ranked 22nd nationally out of 135 acute Trusts.

Length of Stay
December had a significant rise to 7.25 days for Non Elective Average LoS (over a 0.5 day increase). The Medically Optimised for Discharge (MOfD) rate continues to stay above 70 patients for Q3, with December peaking at 2007 bed days lost which averages at 66 beds over the period. The system winter plan has not generated a robust increase in the alternatives to hospital and as such the hospital for safety reasons opened Ward 1 on Southport site to help accommodate the increased demand for beds, as systems to avoid admission and accelerate discharge have not generate the capacity required to sustain the attendance pattern through ED resulting in longer hospital stays. The Trust continues to focus on winter delivery schemes to optimise patient flows. This month the Trust delivered on its internal winter plan schemes with critical interventions such as the opening of the 14 bed Orthopaedic Rehabilitation Unit at Ormskirk; increased ACU working over the weekend; and extended Pharmacy opening times over the weekend. In addition – the Trust has introduced a SAFER start campaign which focuses on every inpatient care plan having a daily senior review. However the Trust remains highlight reliant upon the wider system plan to mitigate the "out of hospital" bed gap of 40 identified by Venn, which isn't currently being bridged. This has been raised and escalated at the System Management Board with CCG and also at SOIB with Regulators. This non-delivery elements of the system plan are primarily down to therapy provision within intermediate care and reablement capacity within Home First pathways.

NB: Overview of the Operational Improvement Programmes captured within the "Operational Performance Highlight Report"

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)	Workforce across the medical cohort continues to be a significant challenge for the Trust. The use of agency continues. CBUs have been requested to review use of agency and if possible to highlight potential reductions to allow for savings in a safe manner. Areas of concern have actions in place to mitigate if possible. Work has been ongoing to ensure compliance with the 18 Week RTT target with winter approaching. Improvements have been seen in Diagnostics. Cancer Improvement have plans in place to recover performance. 4 hour performance will continue to be under pressure however actions are being taken across the Trust to allow for improved patient flow.	R
• The Winter Plan	The Trust has referenced previously the concerns that the schemes put forward by the system will not address the gap in bed provision. The Trust has already seen a large increase across both sites. Building works have commenced on E Ward to allow for cascade of existing patient cohorts. This will allow the Orthopaedic Rehab Ward to be housed on H Ward. Areas for escalation have been assessed on the Southport site with the most feasible plan to open Ward 1 temporarily. Additional Medical Workforce has been approved to assist Paediatric A+E at Ormskirk. All other Winter Plan Schemes are on track with some already commenced.	

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 December following Carter at Scale sign off.*
- *Tier 2 agency cascade implemented, with further enhancements for nursing showing significant reduction in November of c60% compared to October.*
- *Allocation Ward shift modelling completed with demand established to reflect peaks in demand supporting reduction in off framework nursing utilisation.*
- *Supporting Attendance Policy 6 month review was completed on 11th December 2019 and will be presented at January's JNC.*
- *November 2019's monthly sickness absence rate has increased significantly in month from 4.94% to 5.56% and has exceeded the Trust target of 5% for the first time in 4 months.*
- *The significant monthly increase in the Trust's sickness absence rate has resulted in the rolling year to date rate increasing for the first time in 12 months. The HR team will work with the CBU's to understand why the rates have increased and whether this is a seasonal spike or cause for concern. Those deep dive findings will be presented at CBU performance and governance meetings in order that any subsequent action can be undertaken.*
- *PDR compliance decreased slightly in month to 69.22% in December 2019. PDR performance and compliance continues to be a challenge and improvement has been deteriorating over the last 3 months. At December's Workforce Improvement Group refreshed work streams for 2020/21 were proposed and addressing PDR compliance was one of those work streams. The group has requested feedback on the proposed 2020/21 Work streams and will be agreed at the January 2020 WIG.*
- *Alternative medical bank launched on 10 December 2019 – shifts live and being booked via Patchwork.*
- *HR Transformation Programme and implementation of an electronic Employee Relations system to support the recommendations following the Baroness Dido Harding Report is now underway. A new fixed term HR Business Partner – Project Lead commenced in post December 2019 to support the Transformation agenda.*
- *Enhancement to nurse rostering dashboard in progress with greater support being provided to check and challenge processes.*

CLINICAL WORKFORCE PLAN

- *The Clinical Workforce Plan – to be reviewed following current cycle of business planning. Proposal presented to Workforce Improvement Group to develop detailed workforce plans to meet needs of all clinical areas as priority strategic area including key stakeholders from core staff groups.*

RECRUITMENT AND RETENTION

- *Further improvement in time to hire in December at 51.9 working days average – this is better than the national median model hospital benchmark and peer trust median for the first time with a 6 day improvement over the prior period. There have been significant improvements in time to approve vacancy requests, time to advertise roles, time to shortlist, updating offers post interview, time to check references and time to complete OH checks with 4 of 9 specific metrics showing as green (RAG rating) against the 30 day target requirements.*
- *Focussed pieces of recruitment being undertaken to fill medical vacancies. Especially hard to fill areas such as Radiology, Obstetrics and Gynaecology and Care of the Elderly.*
- *Scoping of international recruitment options for nurses. Will be presented at BDISC in January.*
- *Continued recruitment to fully establish the Trust recruitment team; final candidate accepted post on 8th January.*
- *HCA recruitment events held in December has created pipeline of 14 offers and 18 interviews scheduled for event on 25th January.*
- *Plan for nursing recruitment events in place for 2020 with first publicised and scheduled for 25th January.*
- *Permanent recruitment agency contracts completed to support international medical recruitment in hard to fill specialities.*
- *Recruitment training delivered to managers in December with ongoing schedule of dates available in 2020.*
- *Opportunities for automation being reviewed with supplier meeting scheduled for 24th January.*

WORKFORCE

AMBER

Key Achievements/Progress (2)

LEARNING AND DEVELOPMENT

- *HR continues to work with CBU's to increase mandatory training compliance rates to stretch target of 95%. Current compliance 88.44% (Dec 2019)*
- *Extreme Risk 2130 – Clinical competency of the multi-professional workforce – to be reviewed at Board Feb 2020 for BAF approval*
- *Task & Finish Group meeting weekly to address Resuscitation training at all levels - new Resus TNA will be on OLM by end of Jan 2020 – new compliance report to be circulated to CBU's for action. Training will be in place to address and target key high risk groups.*
- *Clinical competency working group scoping NMC Standards – training requirements for Band 5 nurses*
- *Clinical induction updated – new programme by Jan, moving to a 2 week programme by April 2020*
- *QI training – on hold – awaiting direction from COO/PMO*
- *Quality of appraisals – HR delivering appraisal training – new OD approach to be developed for 2020 in line with new leadership programme and values & behaviours framework*
- *Triumvirate Development Programme – coaching sessions held 13th/14th Nov – next steps to be agreed with COO for 2020*
- *"At our Best " – Leading the Southport & Ormskirk Way – 2 x 5 day cohorts to commence Feb & March 2020 delivered by Aspire Development*
- *Foundation Medical Leadership Programme – funding received £40k, scoping exercise completed, tender document prepared for advert Jan 2020 for 1 x Cohort Spring 2020*
- *Apprenticeship Levy – bi-monthly Apprenticeship Steering Group re-instated – focus on workforce transformation via new roles, upskilling etc.*
- *Leading Healthy Workplaces – bespoke training day piloted Feb & March to be launched April 2020*
- *Customer Service training – due for roll out March 2020 onwards*
- *Mental health Training – due for roll out March 2020 onwards*
- *IT training – basic skills training being scoped for 2020*

TALENT MANAGEMENT

- *NHS Leadership Academy TM Diagnostic Assessment Report – available 2020 for review at WFC Feb 2020*

HEALTH & WELLBEING

- *Health & Wellbeing Strategy approved at Workforce Committee in September 2019. Health and Wellbeing Diagnostic Framework being undertaken to assist in identifying priorities for health and wellbeing action plan; consultation and participation from key stakeholders is still taking place, a paper will be presented at the February Workforce Committee.*
- *Reviewed and updated the Health and Wellbeing (sickness absence) action plan for NHSI project, two areas identified Theatres and Ward 7A. Theatres: diagnostic tool completed, draft action plan and highlight report to be discussed with senior managers in Theatres to gain support. Work on Ward 7A not yet gained momentum due to capacity issues on the ward.*
- *Work ongoing to support SEQOHS (Safe, Effective, Quality Occupational Health Service) re-accreditation in 2020.*
- *Flu campaign – The Trust has achieved 91% uptake from healthcare workers in this year's campaign, we have exceed the CQUINN target for 2019/2020 which was 80% of frontline healthcare workers to be vaccinated.*
- *Health education and promotion this year to focus on mental health support and MSK – improving physical activity.*
- *Leading Healthy Workplaces training in almost completed, roll out of pilot in February 2020.*

WORKFORCE

AMBER

Key Achievements/Progress (3)

OD, CULTURE AND STAFF ENGAGEMENT

- *So Proud Big Brews (staff engagement approach) – 2020 programme under development – executive /senior leadership buy in required*
- *Values & Behaviours Framework – staff engagement conversations/survey to focus on the development of a values & behaviours framework for launch April 2020*
- *Coaching - in-house coaching service launched Oct 2019 / Coaching Peers Support Group held bi-monthly*
- *Coaching – online modules purchased for launch March 2020 – available for all staff to access for a 12 month period*
- *Staff Survey – final response rate 47%. Increase from 40% last year and above national average of 43%. Awaiting data from Quality Health*
- *Staff FFT – Quarter 4 - re-opens Jan-March 2020*
- *Team development – Sexual Health, Maternity, Ward 7a, new Rehab Ward (ODGH), SONAAS referrals*
- *Belbin team development tool to be available via OD for delivery in 2020*
- *Corporate Induction – moved to Monday @ ODGH. New programme including outcomes of the NW Streamlining project fully embedded April 2020. Discussion required with CEO re: content*
- *Relocation of HR - further cabling, networking and infrastructure work underway to support the additional workstations, contractors have been sourced and work has begun.*

HR IMPROVEMENT PRIORITIES

- *Workforce Improvement Group - held monthly – driver diagrams & action plans in place – reports into Hospital Improvement Board*
- *2020 priority workstreams shared with Workforce Improvement Group for review and feedback.*
- *Core mandatory training remains above the Trust target at 88.44% (31/12/19)*
- *Clinical competence of the multi-professional workforce – extreme risk*
- *Continued reduction of YTD sickness absence rate – 0.68% reduction since December 2018*
- *Employee Relations Policy review*
- *Increase PDR compliance*
- *Continue to reduce Time to Hire*
- *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	6-month review of Supporting Attendance Policy completed on 11th December. review training and support material will be reviewed and rolled out to support the management process. Health and Wellbeing support to hotspot areas continuing in conjunction with HR. Monitor monthly and rolling sickness absence levels.	A
Development of admin and clerical staff bank	Initial scoping exercise completed with NHSP to provide support to development of admin and clerical bank. Project ongoing.	A
CBU's failing to meet trajectories of improvement for PDRs	Key focus at WIG on how to support the Trust to increase PDR compliance which remains challenging. Trajectory set and progress assessed at Performance Review meetings across CBUs and Corporate Services. Task and finish group to be established in January 2020 for a focussed action approach.	A
Lack of recruiting manager ownership in key responsibilities to improve Time to Hire	Completed one session of training in December with another planned for the same month. A further training session to be held in January 2020.	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.	New HR Business Partner for Specialist Services and Estates and Facilities appointed and commences in post 2nd March 2020.	A
Capacity & skill level of the Education & Training Team to deliver the core mandatory & clinical competency extreme risk project whilst providing service delivery across the breadth of other agendas including Learning & Development, Leadership & Management, Talent Management and Organisational Development	Submitted a SOC for an interim E&T Manager	R
Corporate induction – conflict between delivering the outcomes of the NW Streamlining Project to reduce repetition of face to face mandatory training at induction to eLearning in advance of commencement and the Trust's concerns about the removal of face to face mandatory training from the Corporate induction day	Initial conversation with CEO to explore concerns and options	A

2019/20 FINANCIAL PLAN (1)

RAG Rating

Key Achievements/Progress

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

<u>Current performance</u>
The month 9 year to date (YTD) position before Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) is a deficit of £21.7 million which is £1.8 million worse than plan.

The in-month position before PSF/FRF is a deficit of £2.8 million, £0.3 million worse than plan.

The Trust's forecast outturn, based on month 6 performance and shared with NHSI/E on 1 November 2019, was £3.6 million overspend against the deficit plan. However, since then, both month 7 and month 8 expenditure levels are higher than the trajectory allowed to achieve this forecast outturn. Also, further pressures have emerged such as Paediatric A&E and the impact of the Job Planning round. The forecast outturn was revised to £4.4 million overspend against the plan. At Private Trust Board on 8th January Board challenged the management team to hold overspend against Plan to no more than £3.6 million

The overall income plan is on schedule to be achieved by the year end. At month 9 the Trust activity and income performance is as follows:

- ✓ Elective – activity is 4.1% below plan; £625,000 loss of income.
- ✓ Outpatients – activity is 4.8% above plan; £672,000 of additional income
- ✓ A&E – activity 6.4% above plan; £459,000 of additional income.
- ✓ Non Elective – activity is 1.8% below plan; £3,209,000 additional income due to case mix

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.

Underlying expenditure levels continue to rise with bank and agency showing no sign of a reduction. In December the Trust spent £2.3 million on bank and agency staff compared to £2.1 million in November. The Trust breached its NHSI agency target cap of £4.891 million in September. YTD month 9 agency spend is £9.441 million (8.8% of the pay bill); Medical staff £4.932 million; Nursing £3.623 million. Monthly agency spend in December is £1,334,000 (11.0% of the pay bill); Medical staff £667,000; Nursing £549,000.
Total Bank spend is consistent with previous months, December is £920,000 (7.6% of the total pay bill) bringing YTD spend to £8.410 million (7.8% of the total pay bill).

The 2019/20 CIP programme is £1.802 million behind plan at month 9. the forecast outturn is.

<u>Key actions</u>
Appoint substantively to vacancies, particularly nursing and medical staff where high vacancy rates are driving the £2 million monthly spend on bank/agency staff.
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.

<u>Cost Improvement Programme</u>
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 was required to deliver £6.3 million of expenditure reductions.
<u>Progress re plan</u>
At month 9, the Trust had transacted £3.361 million of CIPs. The Trust is forecasting delivery of £4.168 million against the £6.314 million plan leaving an unidentified gap of £2.146 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
<u>Key actions</u>
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.
The Board approved a revised plan with a total spend of £8.0 million on 8th January 2020 following receipt of additional funding for electronic prescribing (£0.7m), winter planning (£0.5m) and IT (HSLI funding £0.409m).

Progress re plan
Actual spend YTD December is £3.298 million (planned spend year to date of £5.532 million) with a further £0.993 million committed expenditure. The MRI replacement scanner project (£1.2 million investment) will now be completed in Quarter 4. Ormskirk ward as part of the winter plan was opened on schedule at the beginning of January.

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*
Theatre Efficiency – productivity improvement; reduce late starts and cancellations; improve patient experience. Improvements have been evident in this area although performance has recently been adversely impacted due to the impact of non elective pressures.
Outpatient Efficiency – reduce DNA rates; reduce waiting times; opportunity to reduce number of clinics. A business case to address these issues is ready to go through the Trust's governance process in January 2020
Model Hospital
Focus with the NHSI Model Hospital team
- ✓ Procurement (significant savings have been delivered as part of the 2019/20 CIP).
- ✓ Medical Job Planning - appropriate medical job plans; reduction in WLI's . Early indications suggest the job planning exercise will result in additional payments to consultant staff (circa £0.2 million per annum).
- ✓ Nursing – e-Rostering and review of Clinical Nurse Specialists
- ✓ HR - improvement in "time to recruit"; improved retention rates; reducing reliance on agency. The HR business case will result in a temporary increase in HR resource to enable these projects to be implemented.
- ✓ Facilities Management car parking tender and catering; portering capacity and demand analysis; catering efficiency
- ✓ Medicines Management – the pharmacy business case has been agreed and will be implemented from December 2019 (£0.5 million per annum).

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2019/20 FINANCIAL PLAN (3)

RAG Rating

Key Achievements/Progress

<table>
<tr><th>Key Risks/Issues</th><th>Mitigating Actions</th><th>RAG</th></tr>
<tr><td>Underlying expenditure levels will not reduce to pre Q4 2018/19 levels, which is the basis of the expenditure plan.</td><td>Nurse establishment business case funding was allocated in month 1 and has enabled a more meaningful analysis can take place of nurse overspends and mitigating actions to bring back into balance. Due to the high vacancy rates (Band 5 at 20%) the monthly spend levels remain too high.</td><td>R</td></tr>
<tr><td>Income plan has been revised down following contract discussions with S&F CCG and WL CCG.
There is a risk that not all of the conditional income elements will be achieved. The conditional income element only applies to the S&F CCG "cost based contract".

<table>
<tr><th></th><th>Annual Plan</th><th>M9 YTD Plan</th><th>M9 YTD Actual</th><th>M9 YTD Var</th></tr>
<tr><td></td><td>£</td><td>£</td><td>£</td><td>£</td></tr>
<tr><td>Repatriation</td><td>600,000</td><td>450,000</td><td>0</td><td>(450,000)</td></tr>
<tr><td>Business Cases</td><td>1,300,000</td><td>637,898</td><td>637,898</td><td>0</td></tr>
<tr><td>CQC Contingency</td><td>300,000</td><td>225,000</td><td>21,200</td><td>(203,800)</td></tr>
<tr><td>BPT</td><td>850,000</td><td>637,500</td><td>83,470</td><td>(554,030)</td></tr>
<tr><td>Contingency - Other Conditional</td><td>450,000</td><td>337,500</td><td>0</td><td>(337,500)</td></tr>
<tr><td>Total</td><td>3,500,000</td><td>2,287,898</td><td>742,568</td><td>(1,545,330)</td></tr>
</table></td><td>Repatriation – the plan was to deliver an element of this from T&O although recovery of the elective plan has stalled due to non elective winter pressures.
Best Practice Tariff opportunities have been shared with CBU's but will not deliver the full target.
Repatriation target of £1 million ; £0.5 million of this should be available from T&O. Elective plan is recovering following improved efficiencies although winter may hinder progress.
Despite the forecast underperformance against the S&F CCG conditional income plan the contract (£74.9 million) is forecast to deliver due to over performance.

The total income plan is forecast to deliver at the year end.</td><td>R</td></tr>
<tr><td>CIP target of £6.3 million, mainly from expenditure reductions.</td><td>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.
Performance is below plan and forecast to be £2.1 million away at year-end. Schemes identified above will not mitigate the shortfall on other schemes.</td><td>R</td></tr>
</table>

ACUTE SUSTAINABILITY

RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

Phase 2 of the programme is underway including a broadening of the case for change aligned with the system management board portfolio, commencement of the diagnosis of population needs for acute services and developing the definition of a core DGH model and specification of developing enabling strategies around workforce, digital and estates. An engagement and involvement plan is in the final stages of development with a view to commence post 23rd January (Joint Committee in public). The system QIA process is underway with the first star chamber postponed in January 2020 due to system pressure and rebooked for February. A Trust Board strategy session in January was held aligning the programme with the development of the next stage in Vision 2020 and agreeing to undertake an organisation risk diagnostic and develop an agreed sustainability test for the board to discuss.

CLINICAL SCENARIOS

The models are currently undergoing a system QIA

ESTATES SOLUTIONS

To continue to be developed in line with emerging scenarios that will fall

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

Strategic Board session agreeing next steps to review organisation risk and develop sustainability framework

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

NHS Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
5 February 2020

Agenda Item	TB013/20	Report Title	Equality Diversity and Inclusion Annual Report 2018-19
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

What:
Equality Diversity & Inclusion Report for 2018/2019. This document includes information about our patient's workforce and our local population and outlines the Trust's commitment to promoting equality diversity and inclusion in all its functions and to valuing the diversity of staff patients and the local communities.

So What:
The report provides information on the various reports that the Trust is obliged to complete to meet is contractual legal and NHS England reporting requirements, all the various reports contained in this report have been through the Trusts various groups committees and board

The reports provides information on the following:

- Our population & workforce
- Equality Act 2010
- Public Sector Equality Duty
- Equality Impact Assessment (Analysis)
- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- Equality Delivery System (EDS2)
- Other Trust Information

What Next?
The reports will go to the various Trust groups / committees, the report will also be uploaded onto the Trust website.

A copy of the report will also be sent to the CCG as part of the equality section of the quality contract update

Recommendation:
The trust board is asked to receive the Equality Diversity & Inclusion Report for 2018/2019

	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.*

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

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

The report will go to the various Trust groups / committees, the report will also be uploaded onto the Trust website.

A copy of the report will also be sent to the CCG as part of the equality section of the quality contract update

Previously Presented at:

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

NHS
Southport and Ormskirk Hospital
NHS Trust

EQUALITY, DIVERSITY & INCLUSION ANNUAL REPORT 2018-2019

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1.FOREWORD

Welcome to the Southport and Ormskirk NHS Trust Equality Diversity & Inclusion Report for 2018/2019. This document includes information about our patient's workforce and our local population and outlines the Trust's commitment to promoting equality in all its functions and to valuing the diversity of staff patients and the local communities.

The provision of high quality patient care is our key driver and the principles of equality, diversity and human rights are intrinsic to the Trust's core business. We are committed to delivering high quality services that are accessible, responsive and appropriate to meet the needs of all our patients. In this respect, patient pathways have been designed to reduce variations in care and improve outcomes, whilst recognising the needs of individual patients.

We aim to be an employer of choice and ensure that all our staff have equality of access to jobs, to promotion and to training opportunities.

The Trust is committed to creating an environment where everyone is treated with dignity, fairness and respect and to developing a culture of support and inclusion for all our employees and for those patients who access our services.

2. ABOUT US

Our Hospitals
Acute care is provided at Southport and Formby District General Hospital and Ormskirk and District General Hospital. This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities. Women's and children's services, including maternity, are provided at Ormskirk hospital.

The North West Spinal Injuries Centre at Southport hospital provides specialist care for spinal patients from across the North West, North Wales and the Isle of Man.

Our vision and values
The Trust aims to establish and embed exemplary healthcare. Our values are expressed through "Scope", developed from what staff told us was important to them about the Trust.

They are:
Supportive
Caring
Open and honest
Professional
Efficient

Objectives of the Trust strategy
The Trust's corporate strategy contains five objectives or "strategic domains":

- Work with our partner organisations to provide lifelong, integrated care across the local health economy
- Ensure excellence in treatment and care
- Deliver performance, within resources, comparable with the best the NHS can offer
- Empower and develop staff to achieve their objectives
- Maintain organisational sustainability

3. OUR POPULATION

Southport and Ormskirk Hospital NHS Trust provides healthcare to a population of 258,000 people across Southport, Formby and West Lancashire.

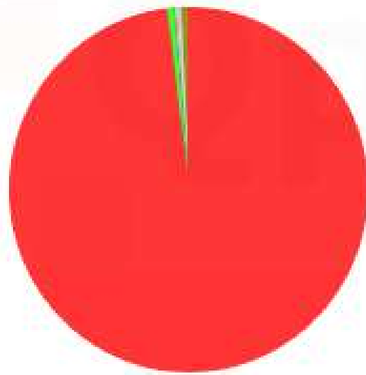
After a review of the 2011 census for the local demographics of Sefton and West Lancashire the following information is available that covers ethnicity and commonly used languages:

Sefton: Ethnicity Population Summary: Census 2011

Ethnicity		% Percentage of the Population in Sefton
White		97.40%
Mixed		1.1%
Asian		0.5%
Black		0.3%
Other		0.7%
Totals		**100%**

Source: ONS, 2011 Census: Note: BME includes all other ethnicities besides White. Within Sefton, 97.4% of the population has a White ethnic background and 2.6% of the Sefton population has a Black, Minority Ethnic background (BME).

Sefton's most commonly used languages:
98.0% of people living in Sefton speak English. The other top languages spoken are 0.6% Polish, 0.1% Portuguese, 0.1% All other Chinese, 0.1% Latvian, 0.1% Spanish, 0.1% Lithuanian, 0.1% Arabic, 0.1% Bengali, 0.1% Turkish.



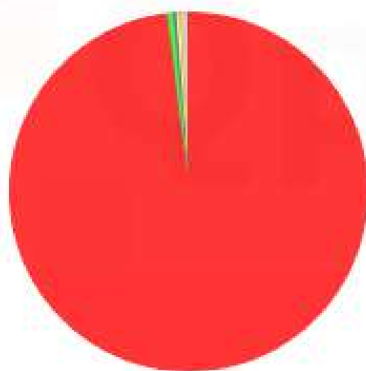
	Language	%
1.	English	98.00%
2.	Polish	0.60%
3.	Portuguese	0.10%
4.	All other Chinese	0.10%
5.	Latvian	0.10%
6.	Spanish	0.10%
7.	Lithuanian	0.10%
8.	Arabic	0.10%
9.	Bengali	0.10%
10.	Turkish	0.10%
11.	Other	0.60%

West Lancashire: Ethnicity Population Summary: Census 2011

Ethnicity		% Percentage of the Population in West Lancashire
White		98.10%
Mixed		0.7%
Asian		0.9%
Black		0.1%
Other		0.2%
Totals		**100%**

Source: ONS, 2011 Census: Note: BME includes all other ethnicities besides White. Within West Lancashire, 98.1% of the population has a White ethnic background and 1.9% of the West Lancashire population has a Black, Minority Ethnic background (BME).

West Lancashire's most commonly used languages: 98.0% of people living in West Lancashire speak English. The other top languages spoken are 0.5% Polish, 0.3% Latvian, 0.3% Portuguese, 0.1% Hungarian, 0.1% Slovak, and 0.1% Russian.



	Language	%
1.	English	98.00%
2.	Polish	0.50%
3.	Latvian	0.30%
4.	Portuguese	0.30%
5.	Hungarian	0.10%
6.	Slovak	0.10%
7.	Russian	0.10%
8.	Other	0.60%

4. THE LEGAL CONTEXT

The Equality Act 2010
The Equality Act 2010 ("the Act") provides the legislative framework to protect the rights of individuals and advance equality of opportunity for all. The Act harmonises and simplifies previous equality legislation with the aim of delivering an accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The Act consolidated 116 separate pieces of equality legislation, principally:
Sex Discrimination Act 1975
Race Relations Act 1976
Disability Discrimination Act 1995

The Act introduced the new terminology of "protected characteristics" to which it then applies, in a consistent way, the traditional elements of direct and indirect discrimination, victimisation and harassment.

The protected characteristics are as follows:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race (includes ethnic or national origins, colour or nationality)
- religion or belief (Including lack of belief)
- sex
- sexual orientation

Public Sector Equality Duty
The Equality Duty is a duty on public bodies and others carrying out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees.

The Equality Duty supports good decision-making – it encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective. The Equality Duty therefore helps public bodies to deliver the Government's overall objectives for public services.

The Equality Duty has three main aims. It requires the Trust, in the exercise of all its functions, to have "due regard" to the need to:

- eliminate discrimination, harassment, victimisation and other conduct prohibited by the Act

- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it

- foster good relations between people who share a relevant characteristic and those who do not share it

(in respect of the protected characteristic of marriage and civil partnership, only the duty to eliminate discrimination applies)

Having "due regard" means that the Trust must always consciously think about the three aims of the Equality Duty as part of process of day to day decision-making. This means that consideration of equality issues influences the Trust's decision-making process in how we act as employers; how we

develop, evaluate and review policy; how we design, deliver and evaluate services and how we commission and procure from others.

Equality Impact Assessment (Analysis)
Equality Impact Assessment/Analysis (EIA) is a requirement for all Policies and is part of the Cost Improvement Programmes (CIPs) process which contains both a quality impact assessment and an equality impact assessment. The responsible manager must complete both sections. These steps will help the Trust to ensure that it pays due regard to its obligations under the Public Sector Equality Duty of the Equality Act 2010.

The Trust in 2018-2019 aims to develop the Equality Impact Assessment Template which will increase the level of guidance in the template and will increase staffs understanding of completing the EIA.

Further information about the Equality Act 2010 can be found at the Equality and Human Rights Commission. http://www.equalityhumanrights.com/

Workforce Race Equality Standard (WRES)
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 complement 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 WRES 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.

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.

Q1/ 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.

Q2/ 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%

Q3/ 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:

Q5/ 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.

Q6/ 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.

Q7/ 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.

Q8/ 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

Workforce Race Equality Standard Indicators:
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		
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	**Non - Clinical Staff**		
		Band	**BME**	**White**
		Band 1	7.17%	84.75%
		Band 2	1.29%	93.89%
		Band 3	4.0%	86.40%
		Band 4	0.61%	95.09%
		Band 5	1.96%	90.20%
		Band 6	1.96%	94.12%
		Band 7	3.45%	86.21%
		Band 8a	4.76%	90.48%
		Band 8b	0.00%	100%
		Band 8c	0.00%	100%
		Band 8d	14.29%	85.71%
		Band 9	0.00%	100%

occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.

2017-18		
VSM	16.67%	83.33%
CQIR	0.00%	100%
IRPM	0.00%	100%
WCOO	0.00%	100%

Clinical Staff

Band	BME	White
Band 2	9.68%	80.24%
Band 3	2.97%	91.82%
Band 4	0.00%	96.08%
Band 5	7.10%	87.33%
Band 6	5.32%	90.05%
Band 7	1.35%	91.89%
Band 8a	8.62%	86.21%
Band 8b	0.00%	91.30%
Band 8c	0.00%	100%
Band 8d	0.00%	100%
VSM	0.00%	100%
FMWC	0.00%	100%
MT02	80%	0.00%
WHO3	0.00%	100%
WHO7	16.67%	66.67%

Med & Dental Consultant

BME	White
42.06%	42.99%

Med & Dental Consultant Non –Consultant Career Grade

BME	White
56.38%	28.72%

Medical & Dental Trainee Grades

BME	White
23.91%	66.30%

Board- Ex- Non Exec

BME	White
18.18%	84.62%

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

3 Relative likelihood of

Disciplinary Process: Overall breakdown of cases by ethnic origin

	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.	categorised in line with WRES requirements as at 31.3.2019 **2018-19** <table><tr><th>WRES Category</th><th>Head Count</th></tr><tr><td>BME</td><td>1</td></tr><tr><td>White</td><td>23</td></tr><tr><td>Not Stated</td><td>1</td></tr><tr><td>Total</td><td>25</td></tr></table>
4	Relative likelihood of staff accessing non-mandatory training and CPD	Training: The information below highlights the ratio of BME and White staff accessing training in 2018-19 **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>0.84</td></tr></table>

NHS Staff Survey (WRES):
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	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,	White staff: 25.7% BME staff: 26.5%	White staff: 23.9% BME staff: 33%

	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**.	Average (median) for combined Acute and Community Trusts White staff– 26.4% BME staff- 28.6%	
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%

Board Representation Indicator (WRES):
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 = White: 14.29% BME: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%

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

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 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

Workforce Disability Equality Standard (WDES)
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.

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 questions 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.

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 hav 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%

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
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 Metrics

<table>
<tr><td colspan="5">For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff.</td></tr>
<tr><td colspan="2" rowspan="2">Metric:</td><td colspan="3">Data for reporting year</td></tr>
<tr><td colspan="3">Non – Clinical</td></tr>
<tr><td rowspan="20">1</td><td rowspan="20">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.</td><td colspan="3">2018-19</td></tr>
<tr><td>Cluster

Cluster 1
Cluster 2
Cluster 3
Cluster 4</td><td>Disabled

4%
4%
0%
0%</td><td>Non-Disabled

58%
67%
69%
89%</td></tr>
<tr><td colspan="3">Clinical</td></tr>
<tr><td colspan="3">2018-19</td></tr>
<tr><td>Cluster

Cluster 1
Cluster 2
Cluster 3
Cluster 4</td><td>Disabled

2%
2%
3%
0%</td><td>Non-Disabled

70%
71%
64%
86%</td></tr>
<tr><td colspan="3">Cluster 5:
Med & Dental Consultant</td></tr>
<tr><td colspan="3">2018-19</td></tr>
<tr><td colspan="2">Disabled

0%</td><td>Non-Disabled

58%</td></tr>
<tr><td colspan="3">Cluster 6:
Med & Dental Consultant Non –Consultant Career Grade</td></tr>
<tr><td colspan="3">2018-19</td></tr>
<tr><td colspan="2">Disabled

2%</td><td>Non-Disabled

64%</td></tr>
<tr><td colspan="3">Cluster 7:
Medical & Dental Trainee Grades</td></tr>
<tr><td colspan="3">2018-19
2017-18</td></tr>
<tr><td colspan="2">Disabled

1%</td><td>Non-Disabled

94%</td></tr>
</table>

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.	**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

	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.	

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

5. EQUALITY GOVERNANCE

The Equality Act 2010 and the Human Rights Act 1998 provide the legal framework within which the Trust operates its equality governance. Additionally, the Health & Social Care Act 2008, NHS England, the Operating Framework and the NHS Constitution all highlight the need to reduce discrimination in services, improve accessibility and reduce health inequalities for all.

The refreshed Equality Delivery System (EDS2) is the framework by which the Trust can demonstrate how it is performing on issues of equality and health inequality to its patients, staff, communities and commissioners.

At Board level the lead accountability sits with the Director of HR and there is a Non-Executive Director who also acts as an Equality Champion.

The Trust's Valuing People Group, reports through the Workforce Committee and ensures that the Trust complies with externally set standards and establishes, monitors and reviews content and methods of assurance to the Workforce Committee and Patient Experience Groups in relation to all areas of Equality and Diversity.

Governance Structure: Fig 1.

6. THE EQUALITY DELIVERY SYSTEM (EDS2)

The EDS2 is a public commitment of how NHS Organisations plan to meet the needs and wishes of local people and staff, and meet the duties placed on them by the Equality Act 2010. It also sets out how, they recognise the differences between people, and how they aim to make sure that any gaps and inequalities are identified and addressed.

The EDS2 is split into four measurable areas:
1. Better Health Outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

Against these four areas there are a set of 18 outcomes. These range from service quality to how staff, are managed in the Trust.

In February 2019 the Trust undertook its EDS2 assessment against the EDS2 goals 1 & 2 and invited key stakeholders to the assessment process Healthwatch Lancashire and representatives from Sefton CCG attended

The EDS2 partner's assessment graded the Trust as follows:

Equality Delivery System 2: Goal 1		
1. 'Better health outcomes for all'	**Verified by: Stakeholders**	
individual Outcome grades for Goal 1:	**2017-18**	**2018-19**

EDS2 Outcome 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**Developing**	**Achieving**
EDS2 Outcome 1.2 Individual people's health needs are assessed and met in appropriate and effective ways	**Developing**	**Achieving**
EDS2 Outcome 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**Developing**	**Achieving**
EDS2 Outcome 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Developing**	**Achieving**
EDS2 Outcome 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	**Developing**	**Achieving**

Equality Delivery System 2: Goal 2		
2. 'Improved patient access and experience'	**Verified by: Stakeholders**	
individual Outcome grades for Goal 2:	**2017-18**	**2018-19**
EDS2 Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**Developing**	**Achieving**
EDS2 Outcome 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	**Developing**	**Achieving**
EDS2 Outcome 2.3 People report positive experiences of the NHS	**Developing**	**Developing**
EDS2 Outcome 2.4 People's complaints about services are handled respectfully and efficiently	**Developing**	**Achieving**

Equality Delivery System 2: Goal 3		
Goal 3. 'Empowered, engaged and well-supported staff'	**Verified by: .**	**Staffside 2019**
Individual Outcome grades for Goal 3:	**2017-18**	**2018-19**
EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Developing**	**Achieving**
EDS2 Outcome 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Developing**	**Developing**
EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all staff	**Developing**	**Developing**

EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	**Developing**	**Developing**
EDS2 Outcome 3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Developing**	**Developing**
EDS2 Outcome 3.6 Staff report positive experiences of their membership of the workforce	**Developing**	**Developing**

Equality Delivery System 2: Goal 4		
4. 'Inclusive Leadership'	**Verified by:**	**Staffside 2019**
Individual Outcome grades for Goal 4:	**2017-18**	**2018-19**
EDS2 Outcome 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Developing**	**Achieving**
EDS2 Outcome 4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Developing**	**Achieving Board Only** **Developing Other committees**
EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Developing**	**Developing**

EDS2 assessment comparison between 2017-2018 and 2018-19
The information above highlights the difference in the Trust EDS2 assessment scoring for each goal and outcome between last year 2017-18 and this year 2018-19. Of the 18 outcomes the Trust has seen 10.5 outcomes improve from developing to achieving.

The Trust has seen a significant improvement in goals 1 and 2 which are patient focused with 8 of the 9 outcomes progressing from developing to achieving in 2018-2019

For goals 3 and 4 which covers workforce and the organisation being well lead, of the 9 outcomes the Trust has seen an improvement from developing to achieving in 2.5 outcomes.

The EDS2 outcome 3.3: Training and development opportunities are taken up and positively evaluated by all staff, the assessment panel have highlighted that if the Trust can provide additional evidence they would change the scoring from developing to achieving, evidence has been requested.

For goal 4 outcome 4.2 the assessment panel requested that the scoring should be divided into two as the board was achieving the objective but thought other committees at the Trust were developing

The EDS2 assessment completed by the Trust and its partners highlights its commitment of how Southport and Ormskirk Hospital Trust aims to meet the needs of local people and staff, and meets the duties placed on it by the Equality Act 2010. It also sets out how, the Trust recognises the differences between people and how we aim by working in partnership with our partners from the diverse communities to aim to make sure that any gaps and inequalities are identified and addressed.

The Trust will continue to be active members of the EDS2 Merseyside Collaborative Group that consists of NHS Merseyside organisations who aim to work together on implementing the EDS2 toolkit to develop robust and effective equality objectives across the area jointly and collectively on a number of key priority areas that advance equality of opportunity.

- Committee meeting

7. CARING FOR OUR PATIENTS

Learning Disability

The Trust has a learning disability liaison service which supports care of a patient with a learning disability in a number of ways. The service can be contacted by patients, carers, and community teams regarding any reasonable adjustments required to support access to health services within the Trust i.e. quiet waiting areas in out-patients, specific appointment times, and facilities for carers/ family to stay with patient. The Trust has purchased a number of beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission.

Patients who have moderate to severe learning disability can be assessed to have their own funded carer to stay with them throughout admission. This supports familiarity in a strange environment, support with nutritional needs and compliance with treatment which contributes to a positive patient experience and outcome for the patient. The use of Medway alerts allows us to identify patients who have a learning disability and benefits the patient by allowing the communication of any necessary reasonable adjustments, the use of the LD health/hospital passport also supports the sharing of information of the needs of the patient. The service also has a strong relationship with both West Lancashire and Sefton Community LD teams, which enhances care and communication for both planned and unplanned admissions of a patient with a learning disability.

Accessing Trust Services

The Trust are legally obligated under the Public Sector Equality Duty 2010 to ensure that our services are fully accessible for all people who access Trust services and the provision of a high quality communication service is an essential element that demonstrates compliance with the act.

The Trust aim to actively promote information on the Accessible Information Standard which was implemented on 31 July 2016; the Accessible Information Standard will begin to address any disparity in the care received by disabled people. It will ensure that information is provided to all people who access Trust services in a way they can understand.

Southport and Ormskirk Hospital NHS Trust aim to provide a full range of interpreting and translation services to ensure that the services provided by the Trust are equally and easily accessible to the diverse communities it serves.

The Trust offers the following interpretation and translation services and will provide other services as requested:
Foreign language translation of Trust documents
Braille translation of Trust documents
Face-to-face and telephone interpretation
British Sign Language interpreting
Easy-read or large font translation of Trust documents
Moon Literacy

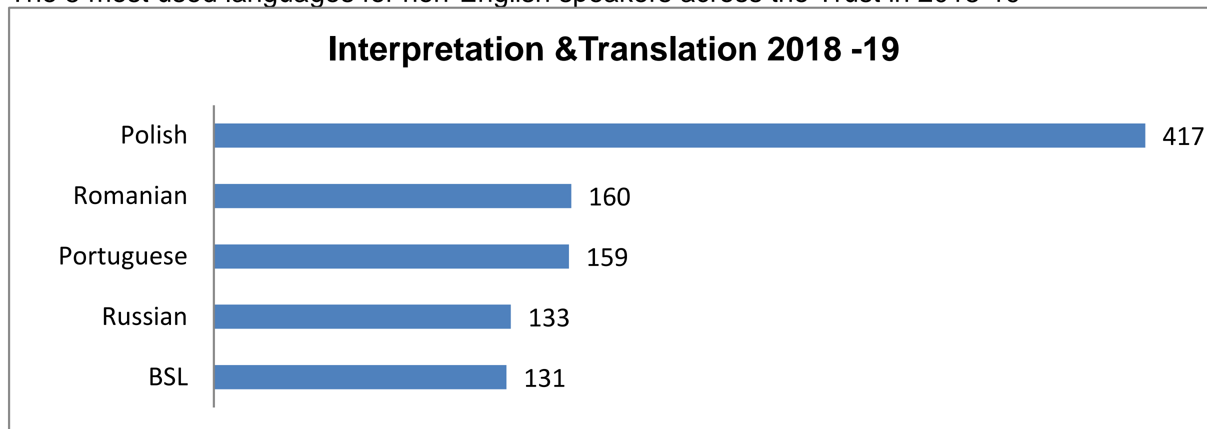
The Trust has an Interpretation and Translation Service Policy CORP 30 (Appendix A) that provides general guidance for staff on the process and organisations they should use for interpretation & translation.

The Trust has been an active member of the Translation & Interpretation collaborative group that has consisted of all Merseyside NHS Trusts and CCG's and the group have complied a best practice guidance for translation and interpretation.

Monitoring and analysing quarterly translation / interpretation use across the Trust
In order for the Trust to understand who is using our services and to obtain an understanding of the various languages used by carers and patients who access Trust services, quarterly translation and interpretation usage is compiled by the Trust. The information allows the Trust to analyse what languages are most frequently used. We are then able to cross reference the information against the local demographics of the various localities.

7.4 Translation / interpretation use across the Trust April 2018 to March 2019 Trustwide

The 5 most used languages for non-English speakers across the Trust in 2018-19



The chart above highlights the top 5 most used different languages and the number of occasions an interpreter was used for non-English speakers across the Trust from April 2018 to March 2019 in total the Trust provided interpreters for 34 different languages.

The 5 most common languages requested for interpretation and translation were as follows (1) Polish (2) Romanian (3) Portuguese (4) Russian (5) British Sign Language (BSL).

The chart above also highlights the use of British Sign Language (BSL) interpreter's for members of the Deaf Community April 2018 to March 2018 in total a BSL interpreter was used on 131 occasions.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) 2005, covering England and Wales, provides a statutory framework for decision-making in relation to people who lack capacity to make decisions for themselves.

The MCA applies to everyone involved in the treatment, care, or support of someone who lacks capacity (including carers and family carers). The Trust staff providing care and treatment to these individuals have a legal obligation to comply with the MCA and associated Mental Capacity Act 2005 Code of Practice. The Trust has a policy which outlines the working practice to embed the requirements of the Act into usual custom, practice and commissioned contracts.

The Mental Health Act 2007 has amended the MCA to introduce a system known as the "Deprivation of Liberty Safeguards" (DoLS). The safeguards came into force on 1st April 2009. The manager must look at all the circumstances of the individual's case and take into account all relevant information, in deciding whether an individual is being deprived of their liberty as a result of their admission to hospital for care and treatment.

The Trust has a named clinical lead for MCA & DOLS.

Patients with Mental Health Needs

The Trust recognises the evidence that one third of all inpatients are likely to have some sort of mental illness. This means that managing patients with mental health needs is a mainstream part of Trust activity.

Within the Accident and Emergency department there is a designated room for mental health patients under 136 mental health section. The clinical team in the department work closely with Mersey Care NHS Trust to ensure timely assessments and plans for care are implemented. The frail elderly unit have an in reach service from a mental health practitioner to support/advise on the care of patients on the ward .The wards work closely with the mental health liaison nurses from Mersey Care completing timely referrals for mental health assessments. The mental health liaison nurses are

integral part of the MDT when best interest meetings are held. Patients are assessed as individual and care is tailored to their needs, additional support with close or continuous supervision is available. Side room facilities are available, with open visiting for relatives / families to support the patient as required.

Carers Support
The Trust has signed up to John's Campaign to welcome carers whenever they are needed. The campaign recognises the rights of carers to stay with people with dementia at all times. This may be during the day or night. The Trust has purchased a number of beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission. There are also a number of areas in the Trust which have facilities for carers to utilise to have some quiet space away from the patient bedside. There is a relative's room on critical care, Ward 15a has developed a room for carers to rest and make refreshments, and there is the OASIS room to support family members of patients who are receiving end of life care. For patients on the Regional Spinal Unit, carers who are not local residents are supported in finding local accommodation, for individual cases the Spinal Unit Action Group may also offer an amount of financial support towards this. On the Paediatric unit there is a parent's room where they store food and make refreshments. Comfort bags are available with showering facilities for parents who have children admitted as an emergency.

The Trust Patient Experience Strategy – 'Developing The Experience of Care' is a two year strategy which was launched in July-17. The strategy was co-produced and used themes from complaints, listening events and results from National Surveys to develop and implement eight pledges which aim to improve the patient, family and carer experience. The pledges include implementation of a carer/family charter, improving access to information, improving the collection and profile of patient feedback within the Trust and reviewing discharge processes

8. PATIENT INFORMATION

Patient Profile Highlights
Headlines: As of March 2018 Southport and Ormskirk Hospital NHS Trust provided services to 35,886 Inpatients and 92,638 Outpatients a total of 128,524 of which:

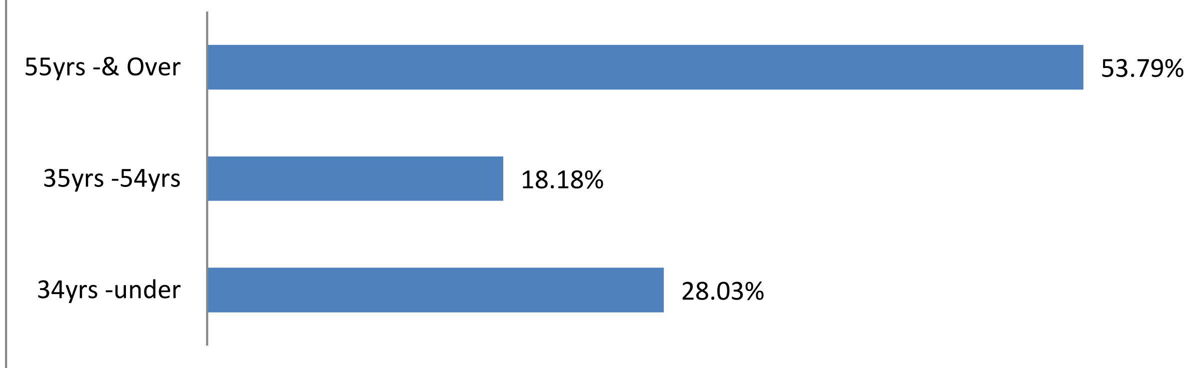
Gender: 56.64% of patients are Female 43.34% Male and 00.02% Not Known
Age: 28.03% of the patients are aged 34yrs and under, 18.18% of patients are 35yrs to 54yrs of age and 53.79% are aged over 55 years of age
Ethnicity: The patients accessing Trust services consists of 4.29% from Black Minority and Ethnic groups 89.32% White and 6.39% Not Stated or Unspecified.
Religion & Belief: the 4 highest religions & beliefs for patients accessing Trust services are as follows 41.21% Church of England, 18.93% Roman Catholic, 20.53% unknown 3.54% Christian, 2.39% Methodist
Marital Status: 43% of patients are Married or in a Civil Partnership, 34.7% Single, 8.2% Widow / Surviving Civil Partnership, 5.7% Divorced/Dissolved Civil Partnership, 4.3% All Others 4.1% Unknown

Patient data below provides a general overview of patient gender, age, ethnicity, religion and belief, marital status. Appendix A provides a more comprehensive overview of all the data for the 5 protected characteristics. Data figures in the various graphs are rounded up to the nearest point.

Gender: 56.64% of the patients are Female 43.34% are Male and 00.02% Not Known

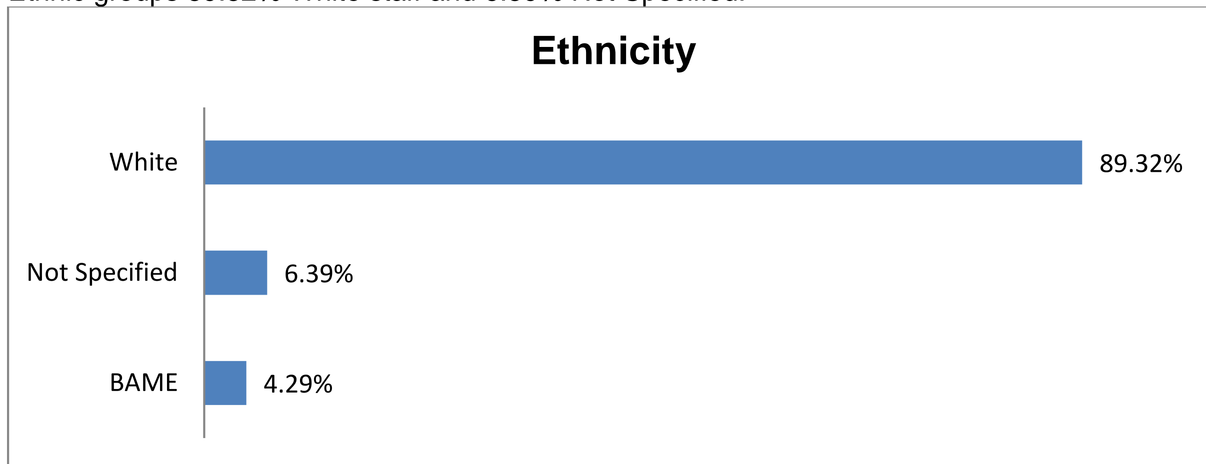
Gender	Headcount	Percentage %
Female	75,997	56.64%
Male	58,161	43.34%
Not Known / Specified	15	00.02%
Grand Total	**1234,173**	**100%**

Age Profile: 28.03% of Patients are aged 34yrs and under, 18.18% of patients are 35yrs to 55yrs of age and 53.79% are aged over 55 years of age



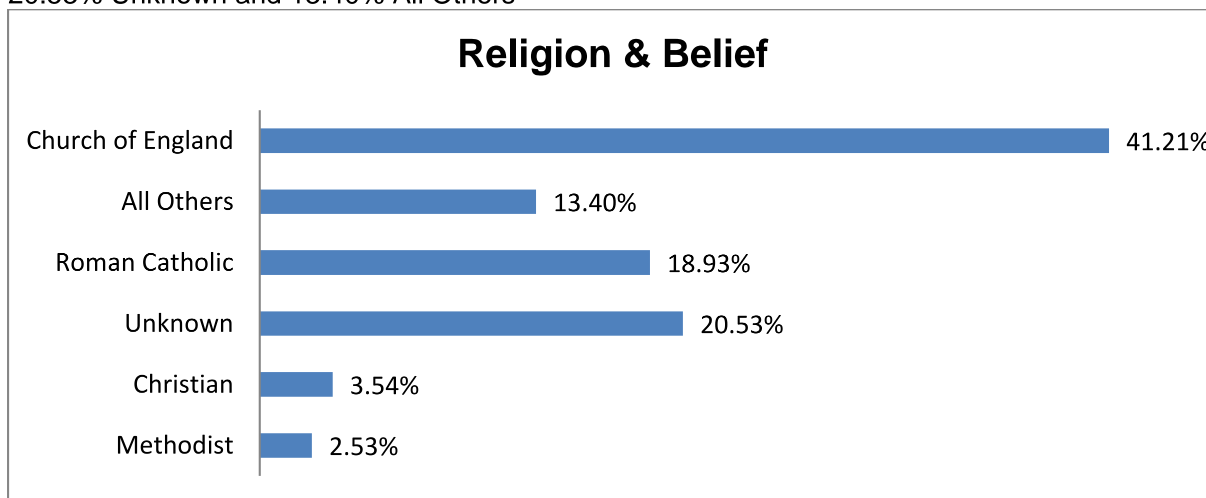
Age Band	Headcount Inpatients	Headcount Outpatients	Headcount Inpatients & Outpatients
<=18 Years	6,126	12,760	18,886
18-24	1,851	4,084	5,935
25-34	3,823	8,955	12,778
35-44	2,914	7,318	10,232
45-54	3,788	10,369	14,157
55-64	4,826	13,322	18,184
65-74	6,249	16,481	22,730
75 +	10,588	20,683	31,271
Total	**40,201**	**93,972**	**134,173**

Ethnicity: The ethnicity of patients accessing Trust services are 4.29% from Black Minority and Ethnic groups 89.32% White staff and 6.39% Not Specified.



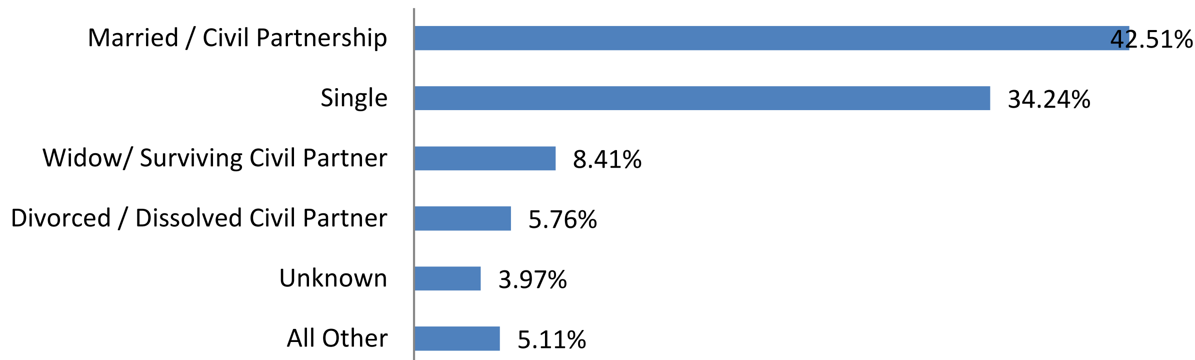
Ethnic Group	Headcount	Percentage %
White	119,851	89.32%
Not Specified	8,576	6.39%
BAME	5,746	4.29%
Total	**134,173**	**100%**

Religion & Belief: The 4 highest religions & beliefs for patients accessing Trust services are as follows 41.21% Church of England, 18.93% Roman Catholic, 3.54 %Christian, 2.39% Methodist, 20.53% Unknown and 13.40% All Others



Religious Belief	Headcount	Percentage %
Church of England	55,294	41.21%
Roman Catholic	25,405	18.93%
Christian	4,752	3.54%
Methodist	3,212	2.53%
Unknown	27,557	20.53%
Others	17,953	13.40%
Total	**134,173**	**100%**

Marital Status: 42.51% of patients are Married or in a Civil Partnership, 34.24% Single, 8.41% Widow / Surviving Civil Partnership, 5.76% Divorced/Dissolved Civil Partnership, 5.11% All Others, 3.97% Unknown



Marital Status	Headcount	Percentage %
Divorced/Dissolved Civil Partnership	7,727	5.76%
Married/Civil Partnership	57,039	42.51%
Not disclosed	49	0.03%
Not Set	5,739	4.28%
Separated	1,074	0.80%
Single	45,935	34.24%
Unknown	5,322	3.97%
Widow / Surviving Civil Partnership	11,288	8.41%
Grand Total	**134,173**	**100%**

9. OUR WORKFORCE

This report is published to ensure that Southport and Ormskirk Hospital NHS Trust has the information it needs to promote workforce equality and meet its public sector equality duty, as outlined in the Equality Act 2010.

The report details an analysis of the Southport and Ormskirk Hospital NHS Trust workforce for April 2018–March 2019. Southport and Ormskirk Hospital NHS Trust are pleased to say that the Trust workforce reasonably reflects the characteristics of the local population across the areas that Southport and Ormskirk Hospital NHS Trust serves. The challenges for the Trust in developing a diverse workforce is understanding the distinct differences in community make up across the area the Trust serves.

Staff Profile Highlights

Headlines: As of March 2019 Southport and Ormskirk Hospital NHS Trust employed 2986 people of which:

- **Gender:** 78.90% of the workforce are Female and 21.10% are Male
- **Age:** 24.54% of the workforce are aged 35yrs and under, 51.11% of staff are 36yrs to 55yrs of age and 24.35% are aged over 55 years of age
- **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.
- **Disability:** 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.
- **Sexual Orientation:** 81.69% of staff have disclosed their sexual orientation as Heterosexual or Straight, 1.07% as Lesbian, Gay, 0.26% Bisexual with the remainder Not stated (person asked but declined to provide a response) 7.91% and 9.07% Unspecified.

- **Religion & Belief**: 63.37% Christian, 7.77% Atheists the third biggest group is Islam 1.74% with Not Disclosed and Unspecified 21.56% and all other 5.56%
- **Employment Status:** the workforce consist of 55.52% Fulltime Staff and 46.48% Part time Staff .
- **Length of Service:** The highest proportion of the workforce have been employed by the Trust for between 1-5 years 27.33%, 12.99% of the workforce have been with the with the Trust for under 1 year and 3.88% of the Trust have been employed by the Trust for 30 years and above

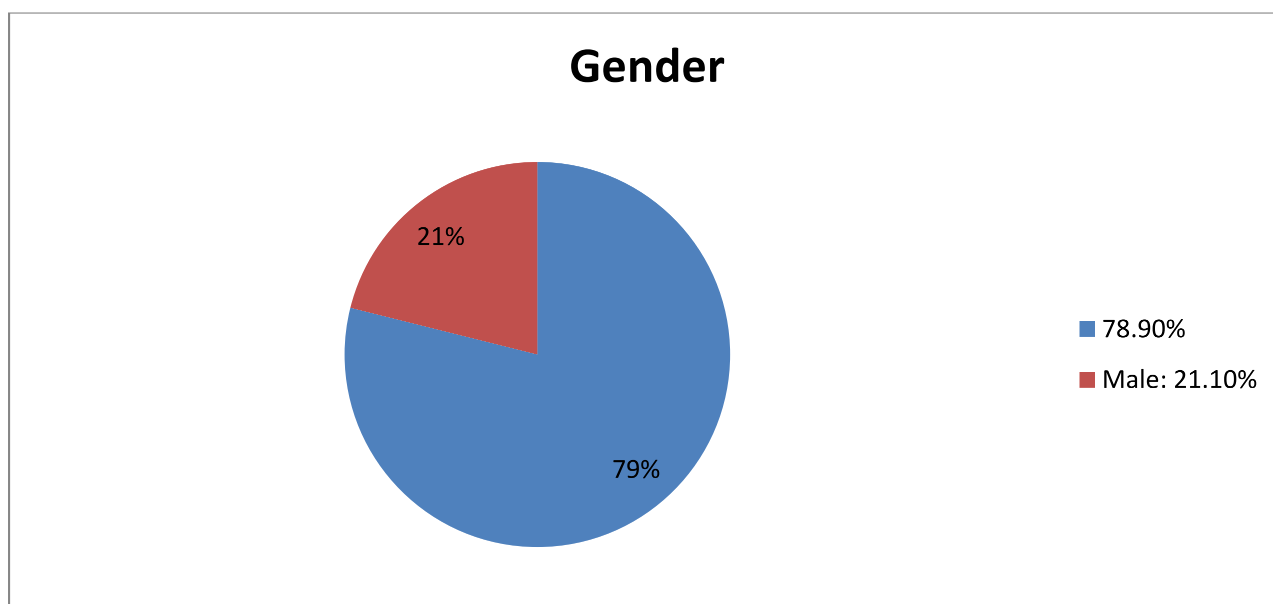
Workforce data below provides a general overview of staff ethnicity, gender, religion and belief, sexual orientation, disability employment status, length of service and recruitment.

Data figures in the various graphs are rounded up to the nearest point, the exact data figures are highlighted to the right of the graph.

Workforce pay banding and grades highlight by percentage White and BME staff in each band or grade, the data in Appendix A was compiled as part of the evidence submitted for the Workforce Race Equality Standard (WRES) 2018 -2019.

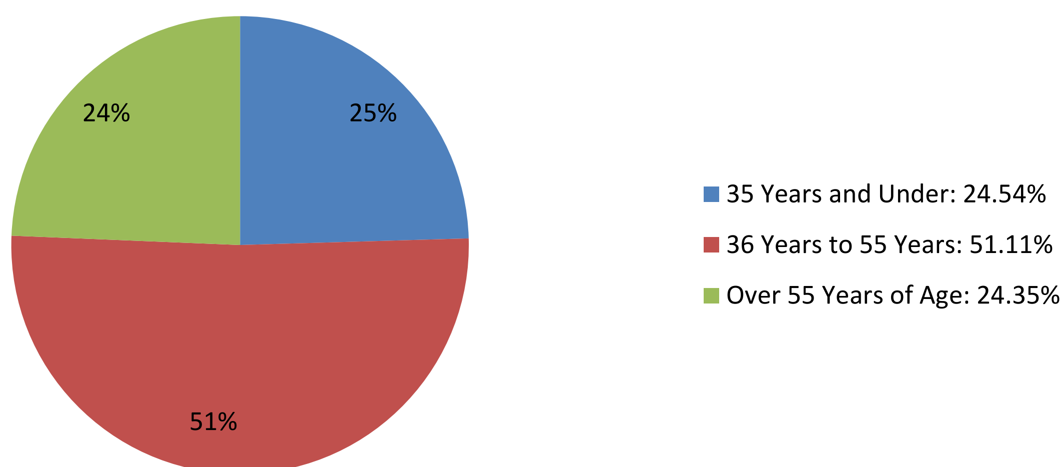
Consensus data for 2011 Appendix B highlights the ethnicity of residents in the Sefton and West Lancashire area, this data has been used as a comparator to cross reference the Trust workforce, The evidence highlights that the Trust is representative of the local regions

Gender: 78.90% of the workforce is Female and 21.10% are Male



Gender	Headcount	Percentage %
Female	2355	78.90%
Male	631	21.10%
Grand Total	**2986**	**100%**

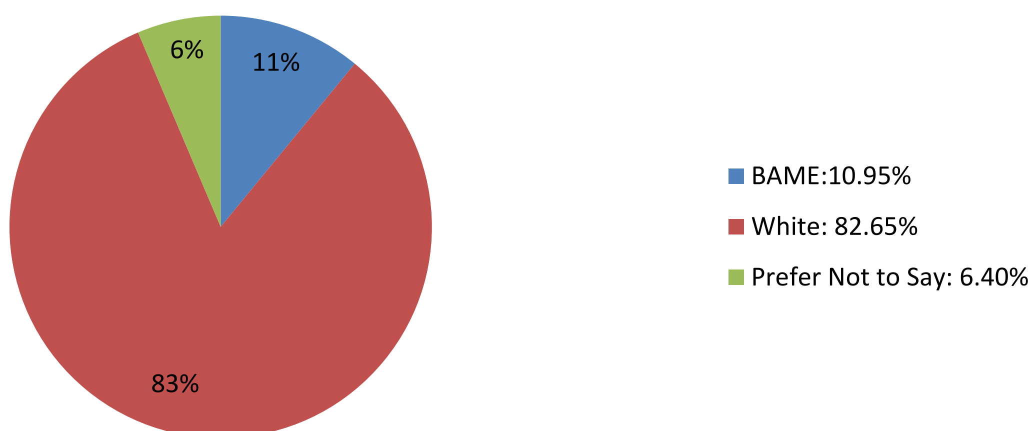
Age Profile: 24.54% of the workforce is aged 35yrs and under, 51.11% of staff are 36yrs to 55yrs of age and 24.35% are aged over 55 years of age



Age	Headcount	Percentage %
<=20 Years	9	24.54% of the workforce is aged 35yrs and under
21-25	164	
26-30	247	
31-35	313	
36-40	316	51.11% of staff are 36yrs to 55yrs of age
41-45	340	
46-50	388	
51-55	482	
56-60	409	24.35% are aged over 55 years of age
61-65	238	
66-70	69	
>=71 Years	11	
Grand Total	**2986**	**100%**

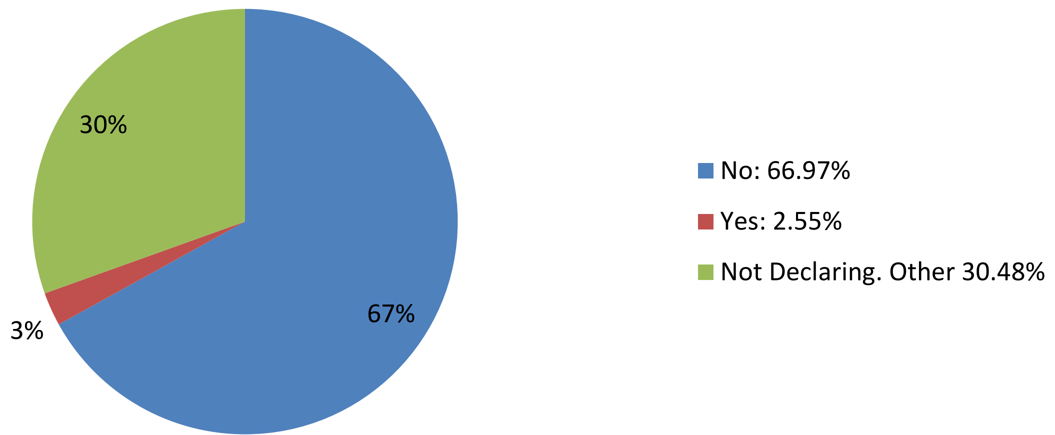
Ethnicity: The Trust workforce consists of 10.95% from Black Minority and Ethnic groups 82.65% White staff and 6.40% Not Stated or Unspecified.

Ethnicity



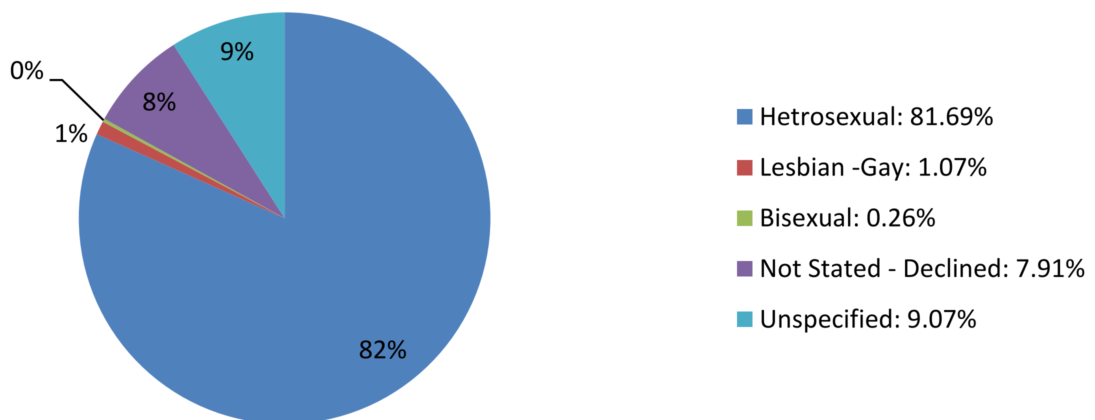
Ethnic Origin	Headcount	Percentage
A - White British	2445	82.65% White staff
B - White Irish	23	
C - Any Other White	83	10.95% from Black Minority and Ethnic groups
D - Mixed White/Black Caribbean	7	
E - Mixed White/Black African	5	
F - Mixed White/Asian	6	
G - Mixed Other	4	
H – Indian	79	
J – Pakistani	15	
K – Bangladeshi	1	
L - Other Asian	57	
M - Black Caribbean	2	
N - Black African	16	
P - Black Other	8	
R – Chinese	5	
S - Other Ethnic Group	39	
Unspecified	12	6.40% Not Stated or Unspecified
Z - Not Stated	179	
Grand Total	**2986**	**100%**

Disability: 2.55% of the Workforce informed the Trust 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%**

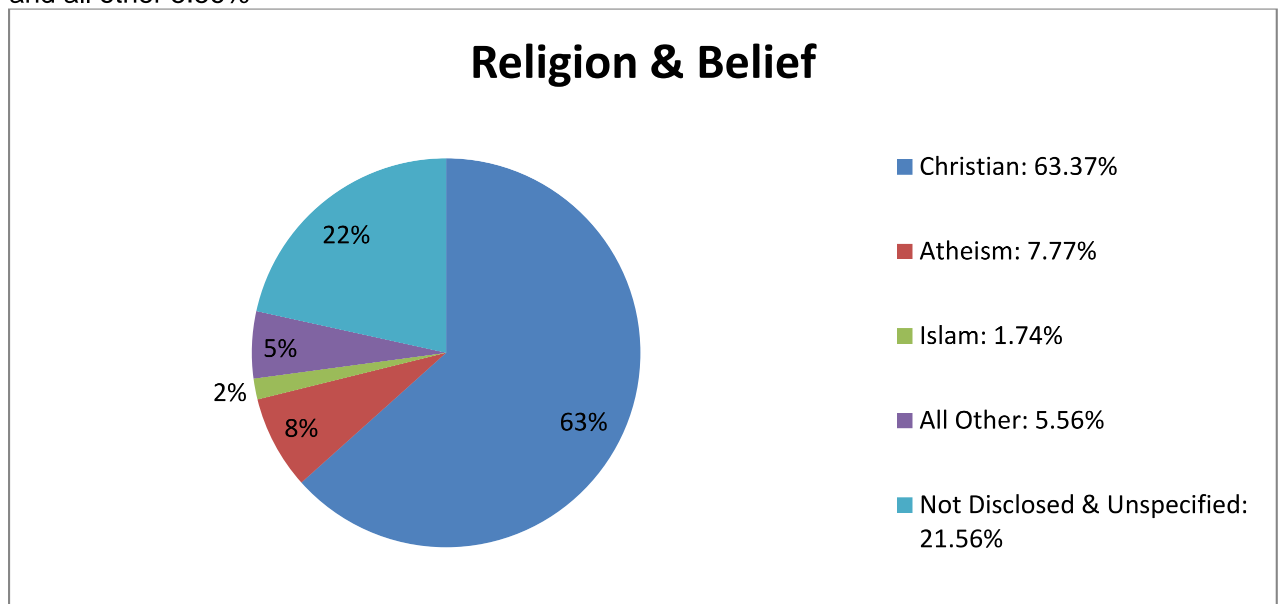
Sexual Orientation: 81.69% of staff have disclosed their sexual orientation as Heterosexual or Straight, 1.07% as Lesbian, Gay, 0.26% Bisexual with the remainder Not stated (person asked but declined to provide a response) 7.91% and 9.07% Unspecified.



Sexual Orientation	Headcount	Percentage %
Bisexual	8	0.26% Bisexual

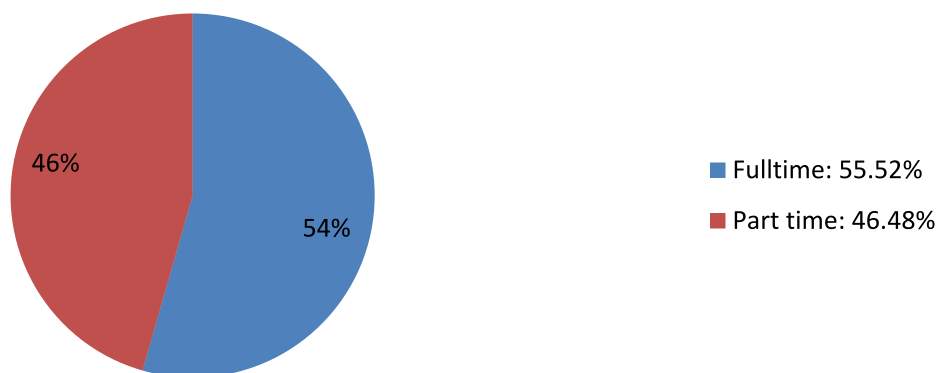
Gay or Lesbian	32	1.07% as Lesbian, Gay
Heterosexual or Straight	2439	81.69% of staff have disclosed their sexual orientation as Heterosexual
Not stated (person asked but declined to provide a response)	236	Not stated (person asked but declined to provide a response) 7.91%
Unspecified	271	9.07% Unspecified
Grand Total	**2986**	**100%**

Religion & Belief: the 3 highest religions & beliefs at the Trust are as follows 63.37% Christian, 7.77% Atheists the third biggest group is Islam 1.74% with Not Disclosed and Unspecified 21.56% and all other 5.56%



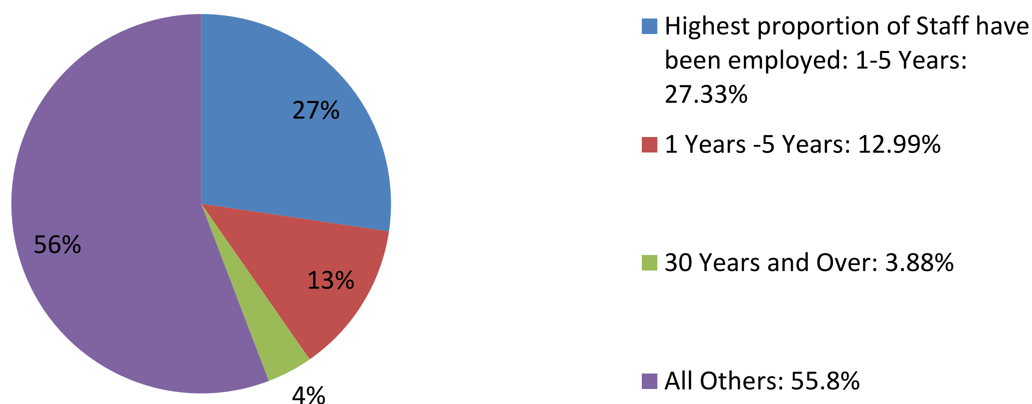
Religious Belief	Headcount	Percentage %
Atheism	232	7.77%
Christianity	1892	63.37%
Islam	52	1.74%
Other + Sikhism + Hinduism + Buddhism + Judaism	166	5.56%
I do not wish to disclose my religion/belief - Unspecified	644	21.56%
Grand Total	2986	100%

Employment Status: The workforce consist of 53.52% Fulltime Staff and 46.48% Part time Staff



Employee Category	Headcount	Percentage %
Fulltime	1,598	53.52%
Part Time	1,388	46.48%
Grand Total	**2,986**	**100%**

Length of service: The highest proportion of the workforce have been employed by the Trust for between 1-5 years 27.33%, 12.99% of the workforce have been with the with the Trust for under 1 year and 3.88% of the Trust have been employed by the Trust for 30 years and above



Length of Service	Headcount	Percentage %
<1 Year	388	12.99%
1<5 Years	816	27.33%
5<10 Years	575	19.26%
10<15 Years	376	12.59%
15<20 Years	424	14.20%
20<25 Years	173	5.79%
25<30 Years	118	3.95%
30+ Years	116	3.88%
Total	**2,986**	**100%**

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

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

10. GENDER PAY GAP

The Trust is passionate about creating a fulfilling, diverse and inclusive place to work, with equality and fairness at the heart of our values, policies and everyday practices. That is why we are committed to be an employer of choice and work hard to ensure that our staff have equality of access to jobs, promotion and training and why we highlight to all our staff strategies to overcome Unconscious Bias in all manner of decisions. This and other supportive policies are making SOHT a more inclusive place to work.

As from 30 March 2018 we must publish on our website and on a government website, the following:

mean gender pay gap
median gender pay gap
mean bonus gender pay gap
median bonus gender pay gap
proportion of males and females receiving a bonus payment
proportion of males and females in each pay quartile

The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website.

11. OTHER TRUST EQUALITY INFORMATION

NAVAJO Chartermark (LGBT+)

The NAVAJO Chartermark was first achieved in March 2015 the Trust was reassessed at the beginning of 2018 and was awarded the NAVAJO charter mark for another year. The NAVAJO Merseyside & Cheshire LGBT+ Charter Mark is an equality mark sponsored by In-Trust Merseyside & Sefton Embrace and supported by the LGBT+ Community networks across Merseyside– a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, transgender and other (LGBT+) people in Merseyside.

Disability Confident Employers Scheme

The Disability Confident scheme is an initiative which shows employers how to commit to recruiting, retaining and developing disabled people. Through Disability Confident, the Government aims to work with employers in the UK to: challenge attitudes towards disability; increase understanding of disability. The Trust signed up to the Scheme in 2017.

12. NEXT STEPS

Action Plan and Next Steps
It is acknowledged by Southport and Ormskirk NHS Trust that positive actions to support Equality, Diversity and Inclusion underpin the principles of positive staff engagement.

The Trust has developed an action plan to address the areas of shortfall identified. The Action Plan is attached as Appendix1 and is monitored through the Valuing Our People Group, HR Governance and Workforce Committee which is a subcommittee of the board of directors. The Trust has a separate WRES and WDES Action Plan which is monitored through the same governance structure.

NHS
Southport and Ormskirk Hospital
NHS Trust

Equality Objective Plan 2018 - 2020

Equality Objective Themes:

1. Improving our Intelligence
2. Developing our Staff
3. Working within our Communities

Southport & Ormskirk Hospital NHS Trust Equality Objectives 2018-2020

Southport & Ormskirk Hospital NHS Trust Values: SCOPE

Supportive Caring Open & Honest Professional Efficient

Improving our Intelligence		Developing our Staff		Working within our Communities
• Develop a Trust-wide approach to collecting equality information • Review current patients accessing Trust services data/information in order to address gaps in equality and diversity information reporting. • Develop in partnership with representatives of local community group processes and information sessions for improving staff collection of equality data / information • Work with patients and carer representatives who access the Trust to assist the Trust in developing its E&D objectives and action plan • Formalise relationship with Local Authority, third sector and other statutory bodies to enable greater sharing of data and intelligence information in relation to equality groups and health inequalities		• Provide training and development opportunities for all staff across the Trust and provide a summary of mandatory and non - mandatory training by ethnic groups providing data for the Trustwide Valuing Peoples Group • The Trust to develop a diverse workforce in the various bandings and attract minority staff across the range of job opportunities and in particular into senior roles. • Develop a range of successful community and staff engagement events and activities that highlight different communities and demonstrate the Trusts commitment to being a personal, fair and diverse organisation • Develop successful Staff Network Groups and a Equality Champions Network that plays a meaningful role within the Trust and local community		• Corporately and locally develop robust partnership working with third sector providers including the sharing of information and intelligence, partnership service delivery and shared training events • Develop leaflets with partnership organisations to ensure they are reflective and meet the needs of our targeted communities and ensure our website is truly reflective of our personal, fair and diverse services we deliver • Invite representatives from the various diverse community to present information and training sessions on issue relating to their specific group, • Support local community events across the Trusts footprint

Southport and Ormskirk Hospital NHS Trust

REPORTING TIMELINE FOR ANNUAL REPORT, ANNUAL ACCOUNTS AND QUALITY ACCOUNTS 2019/20

	January	February	March	April	May	June	July
Annual Report **Annual Governance Statement (AGS)** **Annual Accounts** **Quality Accounts**							
DRAFT VERSIONS							
Annual Report	**Structure- Audit Committee 15th**	**Structure – Board – 5th** **Structure- Mazars- External Auditors-14th**			**Board of Directors – 6 May**		
Unaudited Annual Accounts	Emailed to Audit Committee Members **for Virtual Approval** before 13 April and submitted to NHSI on 17 April						
Unaudited Annual Accounts	Emailed to External Auditors before 2nd May						
Quality Accounts			**ETM – 16** **HMB - 19** **Quality & Safety Committee - 23**	**Audit Committee - 15h**	**Board of Directors 6** **Mazars - 7**		

Southport and Ormskirk Hospital
NHS Trust

	January	February	March	April	May	June	July
Annual Governance Statement (AGS)				**Audit Committee- 15** **MAZARS – 17** **ETM - 6/9** **HMB – 16** **Quality & Safety Committee - 23rd** **Finance, Performance Committee – 23rd**			
FINAL VERSIONS							
Annual Report (incl. AGS) **Audited Annual Accounts**					**Approved at:** **Audit Committee and Board of Directors - 20** **Submit to NHSI-29**		**Publication of Annual Report/Annual Accounts - 31**
Audited Quality Accounts					**2019/20 Quality Accounts presented to Quality and Safety Cttee – 26** *[Quality Accounts approved via delegated authority from the Board]*	**2019/20 Quality Accounts** **Board - 4 Ratification of Approval by Q&S on 22**	**Publication of Quality Accounts - 31**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

5 February 2020

Agenda Item	**TB014/20**	**Report Title**	**Annual Report, Accounts and Quality Accounts Timelines and Responsibilities**
Executive Lead	Trish Armstrong-Child, Chief Executive		
Lead Officer	Sharon Katema, Interim Associate Director of Corporate Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Trust has a statutory responsibility to produce a number of documents that are submitted to the Regulator. These documents are:

- Annual Report
- Annual Governance Statement
- Annual Accounts
- Quality Accounts (QA)

A lot of preparatory work is needed to ensure that strict reporting timelines are adhered to, not only to the regulators, but also to the Board through the Assurance Committees. However, due to publishing timelines the Quality and Safety Committee may need to receive delegated powers from the Board to approve the final version of the Quality Accounts following input from external stakeholders such as Overview and Scrutiny Committee, Commissioners and Healthwatch.

Details for Annual Accounts and Quality Accounts timelines and distribution of responsibilities are being dealt with by the finance and nursing teams respectively.

Recommendation:
The Board of Directors is asked to **note** the report.

Strategic Objective(s) and Principal Risks(s)

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

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

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	*If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience.*
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	*If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted*
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	*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 ✓ 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)*	
All named leads and officers should ensure that submission dates are met.	
Previously Presented at:	
✓ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

ANNUAL REPORT 2019/20 OUTLINE STRUCTURE WITH RESPONSIBILITIES AND TIMELINES

Sections	Sub-Sections	ARA Ref.	Lead Executive	Lead Manager / Officer	Drafts	Final
THE PERFORMANCE REPORT	Overview As a minimum, the overview must include: • a short summary explaining the purpose of the overview section • a statement from the chief executive providing their perspective on the performance of the organisation over the period • a statement of the purpose and activities of the organisation, including a brief description of the business model and environment, organisational structure, objectives and strategies • the key issues and risks that could affect the entity in delivering its objectives • an explanation of the adoption of the going concern basis (see paragraphs 4.11-4.16 below) where this might be called into doubt (for example, by the issue of a report under Section 30 of the Local Audit and Accountability Act 201424 for a CCG or an NHS provider), and • a performance summary.	3.15	CEO / Associate Director of Corporate Governance	Marketing and Comms Manager	20 March	15 May
PERFORMANCE ANALYSIS	As a minimum, the performance analysis must include: • Information on how the entity measures performance i.e. what the entity sees as its key performance measures, how it checks performance against those measures, and narrative to explain the link between KPIs, risk and uncertainty. • A more detailed analysis and explanation of the development and performance of the entity during the year and an explanation of the relationships and linkages between different pieces of information. This analysis is required to utilise a wide range of data including key financial information from the financial statements section of the accounts.	3.17	Director of Finance	Deputy Director of Finance / Assistant Director of Finance	20 March	15 May

	• Non-financial information, including social matters, respect for human rights, anti-corruption and anti-bribery matters. • Information on environmental matters, including the impact of the entity’s business on the environment. Entities must also comply with mandatory sustainability reporting requirements25. Reporting entities are expected to report annually on sustainability matters. Mandatory reporting requirements can be met by following the standard reporting format for NHS bodies produced by the Sustainable Development Unit. It is envisaged that reporting entities will produce a report that will be integral, with reference throughout the annual report and accounts and not a separate standalone report. • Performance on other matters raised during the year (for example, in Treasury PES papers): DHSC will notify group bodies of such additional requirements in FAQs					
ACCOUNTABILITY REPORT	Auditors will review the Accountability Report for consistency with other information in the financial statements and will provide an opinion on the following disclosures which must clearly be identified as audited within the Accountability Report: • disclosures on Parliamentary accountability, as detailed in paragraph 3.61 • single total figure of remuneration for each director • CETV disclosures for each director • payments to past directors, if relevant • payments for loss of office, if relevant • “fair pay” (pay multiples) disclosures • exit packages, if relevant, and • analysis of staff numbers and costs	3.20	Director of HR and OD	Assistant Director of Finance	20 March	20 April
	The Accountability Report is required to have three sections: • a Corporate Governance Report • a Remuneration and Staff Report • a Parliamentary Accountability and Audit Report.	3.21	Director of Finance / Director of HR and OD	Associate Director of Corporate Governance /	20 March	15 May

				Assistant Director of Finance		
	Corporate Governance Report As a minimum, the Corporate Governance Report must include: • the directors' report • the statement of Accounting/Accountable Officer's responsibilities • the governance statement.	3.24	Chief Executive	Associate Director of Corporate Governance	20 March	15 May
	The directors' report The directors' report must include the following, unless disclosed elsewhere in the ARA, in which case a cross-reference may be provided: • the names of the chair and chief executive, and the names of any individuals who were directors of the entity at any point in the financial year and up to the date the ARA was approved • the composition of the board of directors (including advisory and non-executive members) having authority or responsibility for directing or controlling the major activities of the entity during the year • the names of the directors forming an audit committee or committees (recommended) • the details of company directorships and other significant interests held by members of the management board which may conflict with their management responsibilities (where a register of interests is available online, a web link may be provided instead of a detailed disclosure in the annual report) • information on personal data related incidents where these have been formally reported to the information commissioner's office • (NHS bodies) a statement to the effect that each director: knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.	3.25	Chief Executive	Associate Director of Corporate Governance	10 May	15 May

	Statement of Accounting/Accountable Officer's Responsibilities The Accounting/Accountable Officer must explain his/her responsibility for preparing the financial statements. The Accounting/Accountable Officer is required to confirm that, as far as he or she is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accounting Officer has taken all the steps that he or she ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. The Accounting/Accountable Officer is required to confirm that the ARA as a whole is fair, balanced and understandable and that he or she takes personal responsibility for the ARA and the judgments required for determining that it is fair, balanced and understandable.	3.26 3.27 3.28	Chief Executive	Associate Director of Corporate Governance	10 May	15 May
	Annual Governance Statement -AGS In preparing the statement, the Accounting/Accountable Officer should reflect the particular circumstances in which the entity operates. (NHS Trusts must follow guidance to be issued by NHS Improvement). • The purpose of the system of internal control - Associate Director of Corporate Governance • Capacity to handle risk- Associate Director of Corporate Governance • The risk and control framework - Director of Nursing/ Associate Director of Corporate Governance • Care Quality Commission Regulatory Requirements – Assistant Director of Nursing and Quality • Pension Schemes-brief statement on how it is managed – Assistant Director of Finance • Equality, Diversity and Human Rights – Equality and Diversity Lead • Internal and external stakeholders and service user and carer Involvement - Gill		Chief Executive	Associate Director of Corporate Governance	10 May	15 May

	Murphy
	• Quality Governance Framework - Deputy Director of Nursing (Quality) / Assistant Director of Nursing
	• Information Governance – Information Governance Manager
	  • Review of economy, efficiency and effectiveness of the use of resources- Company Secretary/Mark Wilson
	  • Work of the Board of Directors - Associate Director of Corporate Governance
	  • Work of the Audit Committee - Associate Director of Corporate Governance
	  • Work of the Finance, Performance and Investment Committee - Director of Finance
	  • CIP: Delivery Process/Governance Process/CIP Achievements in 2018/19/Success Factors/Next
	  • Steps-Turnaround Director
	  • Financial Plans - Director of Finance
	  • Annual Quality Report – Deputy Director of Nursing (Quality) / Assistant Director of Nursing
	  • Review of Effectiveness - Associate Director of Corporate Governance with help from Executive Team
	  • Director of Internal Audit Opinion - MIAA, Internal Auditors
	  • Independent Review of the AGS – Mazars, External Auditors					

	Modern Slavery Act 2015 – Transparency in Supply Chains The Modern Slavery Act 201530 establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.	3.30 3.31 3.32	Associate Director of Corporate Governance	Associate Director of Corporate Governance / Procurement and Commercial Service	20 March	15 May

	Income earned by NHS bodies from government sources, including CCGs and local authorities, is considered to be publicly funded and is therefore outside the scope of these reporting requirements. Where NHS bodies engage in profit-making activities, these may still be sufficient to trigger the reporting requirements. This is likely to be the case where income is earned from non-government sources, such as private patients, and where this income exceeds £36 million in total. It is ultimately for individual NHS bodies to consider whether they have activities that require them to be treated as a commercial organisation for the purpose of the Modern Slavery Act 2015, and to produce the required statement accordingly. The Home Office have produced a practical guide on applying the reporting requirements, Transparency in Supply Chains etc. a practical guide31. Note that, where a slavery and human trafficking statement is required, the Act specifies that entities must publish this on their website if they have one. It is not a mandatory requirement to include the statement in an entity's ARA, but DHSC group bodies may nevertheless choose to do so.			Manager		
	Relationship between the remuneration report and exit packages, severance payments and off-payroll **engagements disclosures** In many cases, individuals who fall to be named in the remuneration report will also be included, although not individually identified by name, in the exit packages, non-compulsory departures or off-payroll engagements disclosures. Where this is the case, the remuneration report must provide the details of those agreements or payments on an individual by individual basis in a way that permits the user to cross-reference remuneration report data to that in the wider notes to the accounts. **Remuneration policy** Entities must disclose their policy on the remuneration of directors for the current and future years	3.33 3.57	Director of HR and OD	Assistant Director of Finance	10 May	15 May

	Remuneration of Very Senior Managers (VSMs) – CCGs only 3.42. Where one or more senior managers of a CCG are paid more than £150,000 per annum, the remuneration report must explain (not necessarily on an individual basis) the steps the CCG has taken to satisfy itself that this remuneration is reasonable. Pay for a part time senior manager must be compared against a pro rata of £150,000. For this disclosure, 'pay' should be considered to be columns (a), (b), (c) and (d) of the 'single total figure table' in the remuneration report (see Chapter 3 Annex 2 - Salary and Pension disclosure tables: information subject to audit). 3.43. A similar disclosure applies to NHS foundation trusts, set out separately in the ARM 2018-19. **Remuneration Report Tables** The tables for use as part of the remuneration report (the Single Total Figure, and Pension Entitlement tables) are '*Table 1: Single total figure table' and 'Table 2: Pension Benefits', reproduced in Chapter 3 Annex 2 - Salary and* *Pension disclosure tables: information subject to audit.* The figures relate to all those individuals who hold or have held office as a senior manager of the DHSC group body (CCGs – member of the Governing Body) during the reporting year or in the prior period. If seconded into the organisation at no cost to the organisation, disclose the arrangement. It is irrelevant that: • an individual was not substantively appointed (holding office is sufficient, irrespective of defects in appointment), or an individual's title as senior manager included a prefix such as "temporary" or "alternate", or • an individual was engaged via a corporate body, such as an agency, and					

	payments were made to that corporate body rather than to the individual directly. In addition disclose: explanation of any significant awards made to past senior managers Calculations in the single total figure table (notably in column “e” – all pensions related benefits) may return negative values. Negative figures must not be shown in the table: a zero must be substituted. **Compensation on early retirement or for loss of office** If a payment for compensation on early retirement or for loss of office (paid or receivable) has been made under the terms of legislation or an approved Compensation Scheme, the fact that such a payment has been made must be disclosed, including a description of the compensation payment and details of the total amounts paid (the cost to be used must include any top-up to compensation provided by the employer to buy out the actuarial reduction on an individual’s pension). **Payments to past directors** DHSC group bodies must provide details of any payments made to any person who was not a director at the time the payment was made, but who had been a director of the entity previously, unless already disclosed within a previous directors’ remuneration report, the current year single total remuneration disclosure or within the disclosure of compensation for early retirement or loss of office. Only payments of regular pension benefits which commenced in previous years and payments in respect of employment for the entity other than as a director may be excluded **Fair Pay Disclosure**					

	Entities must disclose the following information together with prior year comparatives: • the median remuneration of the reporting entity's staff (based on annualised, full- time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date) • the range of staff remuneration • the ratio between the median staff remuneration and the mid-point of the banded remuneration of the highest paid director, and • an explanation for any significant changes in the ratio between the current and prior years. NHS organisations must include a narrative highlighting the reasons for any variance in year-on-year multiples. This is because: • it describes the purpose of including the ratios, and what they mean • it ensures transparency in executive remuneration • it allows the public to hold government to account for their use of public funds • it provides an opportunity for entities to monitor their own remuneration and note any adverse or anomalous trends. It must then be followed by a concise and factual explanation of the changes on either side of the ratio, taking into account where relevant: • adjustment to the number or composition of the general workforce (for example, through restructuring, downsizing and outsourcing) • a change to the remuneration of the most highly paid individual. Entities should note that this may not necessarily be an increase to base pay, but a change in taxable expenses or allowances. Where the allowance is temporary (for example, relocation allowance), entities must note this and its likely impact on the pay multiple • a change of the most highly paid individual (for example, a new appointment, or the previously					

	• highest paid post having been vacated and/or eliminated) • the impact of any pay freeze on the multiple (for example, senior pay freeze that does not affect the majority of staff.) **Staff report** The staff report must include the following information: a) Where applicable, the number of senior civil service staff (or senior managers) by band. b) Staff numbers and costs – entities must provide an analysis of staff numbers and costs, distinguishing between 'permanently employed' staff and 'other' staff, which must state that the figures are subject to audit (see paragraph3.20) **Permanently employed' refers to members of staff with a permanent (UK) employment contract directly with the entity** • 'Other' refers to any staff engaged on the objectives of the entity that does not have a permanent (UK) employment contract with the entity. This includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally. • In addition, DHSC only is expected to provide a further breakdown of benefits incurred under two additional categories (ministers and special advisors)					
	[The figures must exclude non-executive directors/ lay Governing Body Members but include executive board members/Governing Body Members and staff recharged by other DHSC group bodies. The analysis of staff costs must additionally report by the accounts headings set out in paragraph 5.34. The analysis of staff numbers must additionally report by the functional categories of employees defined in NHS Digital's NHS Occupation Code Manual 32					

	The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The “contracted hours” method of calculating whole time equivalent number must be used, that is, dividing the contracted hours of each employee by the standard working hours. To note: Staff on outward secondment must not be included in the average number of employees] c) Staff composition – Entities must provide an analysis of the number of persons of each sex who were directors, senior civil servants (or equivalent) and employees of the company. d) Sickness absence data - NHS bodies are also required to report on staff sickness. The information is also required on the summarisation schedules for consolidation purposes and will be issued by DHSC after draft accounts submission. e) Staff policies applied during the financial year: for giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities ○ for continuing the employment of, and for arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company ○ Other employee matters – other diversity issues and equal treatment in employment and occupation; employment issues including employee consultation and/or participation; health and safety at work; trade union relationships; and human capital management such as career management and employability, pay policy etc. g) Expenditure on consultancy (see Chapter 5 Annex 2: Consultancy definition) h)Off-payroll engagements – Treasury requires public sector bodies to report arrangements whereby individuals are paid through their own companies (and so					

	are responsible for their own tax and NI arrangements). i) Exit packages – The figures to be disclosed here relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts. The disclosure must state that the figures are subject to audit (see paragraph 3.20). **Parliamentary accountability and audit report** The Parliamentary accountability and audit report is required by those entities that report directly to Parliament. It is also required in the consolidated DHSC annual report. Entities that do not produce a Parliamentary accountability report must nevertheless include an audit certificate and report. DHSC group bodies that are not required to produce a Parliamentary accountability report may nevertheless include these disclosures within the annual report. Where an entity elects not to do this, it must include the disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges as notes within its financial statements There will be a need to collect data for the consolidated account via the summarisation schedules to assist the completion of this report. Therefore, regardless of applicability of this report, all DHSC group bodies must ensure the summarisation schedule is completed					