NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC

To be held at 0930 on Wednesday 4 March 2020
Ruffwood Suite, Clinical Education Centre, Ormskirk Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Time
PRELIMINARY BUSINESS			***09:30***
TB020/20 (V)	**Chair's welcome & note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	Chair	10 mins
TB021/20 (D)	**Declaration of Directors' Interests concerning agenda items** *Purpose: To record any Declarations of Interest relating to items on the agenda:*	Chair	
TB022/20 (D)	**Minutes of the previous meetings held on 5 February 2020** *Purpose: To receive the minutes for approval*	Chair	
TB023/20 (D)	**Matters Arising Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda and review outstanding and approve completed actions.*	Chair	
TB024/20 (V)	**Patients and Engagement Issues including:** • **NEDs & Executive Visits/Walkabouts:**	NEDs EDs	30 mins
(V)	• **Patient Story:** Detailing a patient's experience. *Purpose: To receive the Patient Story and note lessons learnt.*	Michelle Kitson	
STRATEGIC CONTEXT			**10:10**
TB025/20 (D)	**Chief Executive's Report** *Purpose: To receive an update on key issues from the Chief Executive*	CEO	10 mins

QUALITY AND SAFETY			
TB026/20 (D)	**Quality and Safety Reports:** a) Quality Priorities Programme Update b) Summary of Complaints & Compliments c) Learning from Deaths Report d) Safe Staffing: Monthly e) CQC Update Report *Purpose: To receive the Quality and Safety Reports for information and assurance*	DoN / MD	30 mins
COMFORT BREAK – 10 minutes			
PERFORMANCE & GOVERNANCE			**11:00**
TB027/20 (P/D)	**Integrated Performance Report (IPR)** *Purpose: To receive the IPR and consider any issues stemming from the report*	COO	15 mins
TB028/20 (D)	**Finance Report** *Purpose: To receive the finance report for information*	DoF	15 mins
TB029/20 (D)	**Segmental Reporting and Charitable Funds** *Purpose: To approve the recommendations detailed in the report*	DoF	10mins
TB030/20 (D)	**AAA Reports** • Quality and Safety Report • Finance, Performance and Investments Committee • Workforce Committee • Hospital Management Board *Purpose: To receive the reports for information and assurance and receive items of concern escalated to the Board*	Committee Chairs	15 mins
ITEMS FOR INFORMATION			**11.55**
TB031/20	**Freedom to Speak up** *Purpose: To receive the quarterly report*	DoN FTSUG	10mins
CONCLUDING BUSINESS			**12:05**
TB032/20 (V)	**Questions from Members of the Public** *Purpose: To respond to any questions from members of the public that had been received in writing in advance of the meeting.*	Public	10 mins

TB033/20 (V)	**Message from the Board** *Purpose: To approve the key messages from the Board for cascading throughout the organisation.*	Chair	5 mins
TB034/20 (V)	**Any Other Business** *Purpose: To receive any urgent business not included on the agenda*.	Chair	5 mins
TB035/20 (V)	**Date and time of next meeting:** **09:30, Wednesday 1 April 2020** Ruffwood Suite, Education Centre, Ormskirk Hospital	**Chair**	***12:30 close***
	RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC: **The Trust Board resolves that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.**	**Chair**	

Chair: Neil Masom

NHS
Southport and Ormskirk Hospital
NHS Trust

Register of Interests Declared by the Board of Directors 2019/20 AS AT 27 February 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**	**20 February 2020**
CHRISTIAN, Mr Steven	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**27 February 2020**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**

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
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**	**31 January 2020**
KATEMA Mrs Sharon	Interim Associate Director of Corporate Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**02 December 2019**
LEES Ms Bridget	Director of Nursing, Midwifery and Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Spouse employed as a Pharmacy Technician**	**Nil**	**Nil**	**7 February 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
MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB** **NDLM Ltd**	**CQC Holdings Ltd** (manufacturer of textile products) **JSSH Ltd**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 February 2020**
PATTEN, Ms Therese	Deputy Chief Executive/Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**Nil**	**Nil**	**Nil**	**4 February 2020**
ROYDS, Mrs Jane	Director of Human Resources& Organisational Development	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**24 February 2020**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Member of the Board of Trustees for Age Concern Central Lancashire**	Nil	**Nil**	**Nil**	**Trustee – Age Concern**	**5 February 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
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health** **Trustee of the Southport and District Medical Education Centre Fund** **Trustee of the Ormskirk and District Post Graduate Medical Trust.**	**Nil**	**Nil**	**Nil**	**19 February 2020**

Minutes of the Board of Directors' Meeting held in public
Wednesday, 5 February 2020
Seminar Room, Clinical Education Centre, Southport

(Subject to the approval of the Board on 4 March 2020)

Members Present

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

In Attendance

Mrs Pauline Gibson	Non-Executive Director Designate	
Mr Steven Christian	Chief Operating Officer	
Mrs Sharon Katema	Interim Associate Director of Corporate Governance	
Mrs Jane Royds	Director of Human Resources and Organisational Development	
Mrs Michelle Kitson	Matron for Patient Experience	*(item TB 005/20 only)*
Ms Elaine Deeming	Lead Cancer Nurse	*(item TB 005/20 only)*
Ms Cassandra Garner	Colorectal Support Worker	*(item TB 005/20 only)*
Mr Michael Bennett	Cancer Patient	*(item TB 005/20 only)*
Ms Josie Howard	Assistant to ADCG	

Apologies

Dr David Bricknell	Non-Executive Director

AGENDA ITEM		Action Lead
PRELIMINARY BUSINESS		
TB001/20	**Chair's Welcome and Note of Apologies**	

Mr Masom welcomed all in attendance and highlighted that this was Mrs Cosgrove's last Board meeting as the Director of Nursing, Midwifery and Therapies. On behalf of the Board, Mr Masom thanked Mrs Cosgrove for her hard work during her time with and commended her for setting strong passion for improving the Trust's CQC rating and unwavering commitment in ensuring there were safe staffing levels.

Mr Masom highlighted that following a robust selection process, the Remuneration Committee had appointed Bridget Lees as the new Director of Nursing, Midwifery and Therapies.

The Board noted apologies for absence from Dr Bricknell.

TB002/20 Declaration of Directors' Interests concerning agenda items

There were no declarations of interests in relation to the agenda items.

RESOLVED:
The Register of Directors' Interests was **approved.**

TB003/20 Minutes of the Meeting held on 4 December 2019.

The Minutes of the meeting held on 4 December 2019 were approved as an accurate record of proceedings.

TB004/20 Matters Arising Action Logs – Outstanding & Completed Actions

There were no outstanding actions.

TB005/20 Patients and Engagement issues

a) NEDs and Executive Visits/Walkabouts:
Ms Patten and Mrs Gibson had visited four departments at Ormskirk Hospital on 27 January. They outlined that the visit had showcased great examples of team working and leadership. An issue relating to a glitch with the digital screen in Outpatient that indicated a 30 minute delay, had been observed and would be looked into further.

Mrs Cosgrove advised that she had visited Ward 14b and spent half a day partnered with Charlene, from the Domestic team. She advised that this had been a positive experience that also received positive comments on the Trust's social media platforms.

Mr Birrell informed the Board that he had visited Ward 15b and his overall impression was that this was a safe environment with a good Ward Manager. He highlighted that the ward was quite noisy and suggested that background noise could help calm distressed patients.

b) Patient Story
Mrs Kitson outlined the Patient Story would be focused on a patient's experience of the Personalised Stratified Follow Up (PSFU) led by the Cancer Support Team and introduced Ms Garner and Ms Deeming to the Board.

Ms Garner provided background to the work undertaken by the cancer support team at the conclusion of a patient's cancer treatment which included attending self-care and remote focussed education sessions. The service worked with cancer patients for a period of five years as required by the clinical pathway. She highlighted that Southport was leading the way in giving patients the power to self-manage following cancer treatment. Ms Garner advised that the PSFU workstream had resulted in the Trust being heralded as exemplar within the region. Furthermore, the Trust was part of the advisory team for NHS England that was re-writing the "How to guide".

Whilst acknowledging the achievements made in the last three years, Ms Garner

outlined that the biggest challenge for the patients was that there was no capacity within the system to see these patients in the Outpatients Department. She highlighted that financial savings could be realised as there was a reduction in the frequency of follow up appointments for patients.

Ms Deeming introduced Mr Bennett who shared his experience of the Cancer Support service before the introduction of the PSFU, when he had his first cancer diagnosis forty years previously, and following the second diagnosis and treatment once PSFU had been introduced.

Mr Bennett informed the Board that Ms Garner acted as a link between the patient and the consultant. He added that as a patient, he received wide-ranging support from the service which included wellbeing support such as joining a walking group with other cancer patients as well as the provision of a support service by email or telephone. Mr Bennett advised that working with the Cancer Team and the support provided was invaluable as this was also extended to his family which was reassuring. In conclusion, Mr Bennett stated that he understood that the Trust needed to consider financial implications and highlighted that as a patient, the service was of utmost importance as it provided an alternative for patients with less demand on the consultant's time.

Mrs Gorry thanked the team for sharing the benefits and asked how the service was promoted and if there were alternative ways that patients could access the service. Ms Deeming responded that plans to promote the service on the website were in place. She advised that there were alternative means of contact for patients without access to the internet, as all information could be sent either by post or they could liaise over the phone.

In response to Mrs Gorry's question on intentions to broaden the service to other types of cancers, Ms Garner responded that the service was currently available for bowel cancer and that there were plans to broaden availability to those with prostate cancer. She added that the team currently consisted of Ms Deeming and Ms Garner who supported 200 patients.

The Chair thanked Mr Bennett for sharing his experience of the PSFU service provided by the Cancer Team and thanked the team for their hard work.

RESOLVED:

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

Mr Bennett, Mrs Kitson, Ms Deeming and Ms Garner left the meeting.

TB006/20 Chief Executive's Report

Mrs Armstrong-Child presented her first report to the Board which provided a summary of awards and staff recognition, reportable incidents as well as news and developments relating to the Trust. She outlined that awards such as 'Thanks a Bunch' had a pivotal role in ensuring the work undertaken by staff was

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appreciated.

RESOLVED:
The Board **received** the Chief Executive's report.

TB007/20 Quality & Safety Reports

The Medical Director and the Director of Nursing, Midwifery & Therapies delivered the Quality and Safety summary presentation.

Mrs Cosgrove advised that a total of 14 new staff had been recruited following a successful recruitment event that was held on 25 January with a further recruitment event planned for February. She advised that a business case would be brought to Board in March regarding international recruitment adding that it was worth noting that it would take time to fulfil.

Dr Hankin provided an update on Coronavirus explaining that one patient had presented at the Trust with similar symptoms and tested negative. It was noted that guidance from Public Health England was regularly shared with the staff as soon as it was available**.**

a) Quality Improvement Plan Update
Mrs Cosgrove advised that detailed discussions had taken place around infection control between the Trust and NHS Improvement.

Mr Masom advised that quality priorities were approved in 2019 and there was a need to endorse priorities for 2021. It was noted that the Quality Improvement Board meet on 6 February. Updates from there are to be fed through to the next Board.

ACTION: The Director of Nursing to provide an update on the quality priorities at the March meeting. **DoN**

b) Summary of Complaints & Compliments
Mrs Cosgrove advised that the total number of compliments received had increased to 98. She drew attention to a compliment received concerning the support given to a patient that had been admitted to hospital following an injury. The staff had supported the patient and enabled her to attend her husband's funeral.

There was a request that more information regarding complaints should be added to the website and that Lessons Learnt bulletins are shared more widely.

c) Learning from Deaths Report
Dr Hankin presented the Learning from Deaths Report which provided assurance on activity undertaken to reduce avoidable deaths. The report detailed national mortality ratios and local Hospital Summary Mortality Rates by condition.

The Chair highlighted that the report was now very comprehensive and this was to be commended**.**

d) Safe Staffing: Monthly

Mrs Cosgrove presented the report which detailed the current position of nursing staffing for November and December 2019. The Board noted some disparity on the figures outlined in the report and requested that this be considered further. Mr Masom advised that the same anomaly had been raised at the Shadow Board and requested clearer information as questions over the report were frequently raised.

e) CQC Update report

Mrs Cosgrove presented the CQC Update report which detailed the development and progress of the CQC Improvement Plan following the publication of the CQC Inspection Report. It was noted that some of the key themes from the inspection directly correlated to the four quality priorities which would continue to be monitored. The Board discussed the key actions arising from report and noted the assurance mechanisms.

f) 7 Day Service

Dr Hankin advised that the Trust was unable to provide 7 day service and that any improvement in the provision was unlikely whilst the staffing issues continued. He advised that the Trust was 15% compliant against a national compliance level of 23%.

RESOLVED:

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

TB008/20 Winter Plan

Mr Christian, the Chief Operating Officer, presented the Winter Plan which provided an overview of the highlighted points in the report noting that the Trust measured second best in North-west despite increases in pressures. He outlined that work with regulators and key external stakeholders were ongoing. The Trust was managing as best as it could though a tipping point has been reached and drastic action was needed before next winter taking into account local demographics.

The Board considered whether a formal complaint needed to be raised as system partners had not delivered what was promised. Mrs Armstrong-Child advised that the System Management Board were keen to highlight issues and the knock-on effects adding that there was more transparency this year than previously which was essential.

Mr Masom commended Mr Christian on the Trust's winter response and commended the efforts across the team with a stark difference between sites.

RESOLVED:

The Board **noted** progress and acknowledge risks outlined in the Winter Plan

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TB009/20 Integrated Performance Report

Mr Christian presented the report noting that December will meet 85%. Mr Christian confirmed that measuring the impact on patients was picked up with rigour through Datix and SERG. He advised the Board that there was a specific piece that the Finance Performance and Investment Committee were looking at regarding the reduction in GP referrals.

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

TB010/20 Financial Position 2019/20

Mr Shanahan presented the Finance report for Month 9 which indicated that the financial plan had not been achieved. The Trust was £1.8 million off plan and was working with system partners to recover the financial position. He outlined that the increase in temporary staffing had resulted in increased staffing costs

Mr Shanahan advised that the CIP programme has slipped further and there was a projected year end shortfall of £2.1 million. There would be an interest rate rise next year to 3.50%.

Mr Shanahan outlined that the Trust had received additional funding which would be used to address items from the Capital Plan that required immediate attention.

RESOLVED:
The Board **received** the Finance Report

TB011/20 Risk Management: Corporate Risk Register (CRR)

Mrs Cosgrove presented the Corporate Risk Register advising that two new risks had been added to the Register. A focus task and finish group has been set up through the Workforce Committee which would pick up on life support training.

The Board discussed concerns around that the Trust needs to ensure that there are the right levels of forums assessing risks and that all high level risks are included.

RESOLVED:
The Board **received** the Corporate Risk Register

TB012/20 Single Improvement Plan Update (SIP)

Ms Patten presented the Single Improvement Plan which detailed the improvement activities that were being conducted as well as the priorities, actions and timescales that the Trust needed to deliver in order to achieve its Vision.

It was noted that all priorities, with the exception of finance, were currently rated as Amber, whilst the finance risk had moved from amber to red, and with two additional risks scored as red.

RESOLVED:
The Board **noted** the Single Improvement Plan Update.

TB013/20 Equality, Diversity and Inclusion Annual Report

Mrs Royds presented the Equality, Diversity and Inclusion Annual Report which enabled the Trust to meet is contractual, legal and regulatory reporting requirements. It was noted that the report would be shared with commissioners as part of the equality section of the quality contract update and it would also be presented at the Workforce Committee for further scrutiny.

Mr Masom acknowledged that there was significant improvement and requested that Equality and Diversity reporting is brought in line with the annual reporting cycle.

RESOLVED:
The Board received the Equality Diversity and Inclusion Report for 2018/2019.

TB014/20 Annual Report, Accounts and Quality Accounts

The Board noted the Annual Report, Accounts and Quality Accounts report. It was noted that the report had been presented at the Audit Committee and there were issues to bring to the attention of the Board.

RESOLVED:
The Board received the Annual Report, Accounts and Quality Accounts.

TB015/20 Questions from Members of the Public

Questions:

1) Q: Is there any truth in the rumour that the water tank as Southport is at end of life which could mean the end for Southport Hospital?
   A: Several of the Board confirmed they were not aware, and it was not recorded on the maintenance log. Mr Masom explained that there are full maintenance reviews carried out recording back log maintenance.

2) Q: Concern raised around that fact that the Government has not relaxed the financial impact on Trusts that don't meet targets. 85% of Trusts fail to meet the target – including Southport. NHS has been underfunded for nine years.
   A: Mr Masom confirmed that the NHS penalty regime is around control total, which is tracked, and not about breaking even. Mr Christian advised that there were penalties for A & E which were waived. Mr Masom explained that in 2018/19 the Trust did incur penalties but this year is signed up to control total which the Trust met. Mr Masom also explained that there is no change in Government policy.

3) Q: a) There are very experienced people carrying out roles such as explained in the Patient's Story. How is the Trust taking care of staff and compassion fatigue?
   b) Is there somewhere the Trust can discharge patients to from acute care in order to free up beds?

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A: a) Ms Royds explained that there is health & wellbeing support for staff and staff are also encouraged to take appropriate leave, however Ms Royds will consider compassion fatigue further.
A: a) Ms Cosgrove acknowledged there is only so much the Trust can ask of staff but it has changed the way staff are on call, hours of work and do try to understand well-being. The experiences of Junior Doctors are also taken into account.
A: a) Dr Hankin highlighted the Mental Health Charter
A: a) Mr Masom referred to a HR report produced by Ms Royds in December explaining that the biggest risk to the Trust is not financial but workforce around recruitment and retention of which there is a particular problem in Southport.
A: b) Mr Masom also confirmed that the recruitment and retention issue also leads to issues on discharge and pressures on the hospital and community including integrated care and social care which the Board will progress in the next 12 months.

Mr Masom advised that for future meetings, all questions would need to be raised in advance of the meeting. All details would be posted on the website for members of the public to submit questions to the Company Secretary in advice of the Board meeting with questions.

TB016/20 Meeting Evaluation

Meeting evaluation forms were circulated, completed and collated.

TB017/20 Message from the Board

The Board agreed the key messages to be communicated to the rest of the organisation.

TB018/20 Any Other Business

Mr Masom thanked Ms Cosgrove for her time in post as the Director of Nursing, Midwifery and Therapies and wished her well in her new role.

There being no other business to attend to, Mr Masom thanked everyone for attending and brought the meeting to a close at 1340.

DATE, TIME AND VENUE OF THE NEXT MEETING

TB019/20 Wednesday 4 March 2020 09:30am
Ruffwood Suite, Education Centre, Ormskirk District General Hospital

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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	✓	✓	✓	✓		✓	✓	✓	✓	✓	A	
Ged Clarke	✓											
Juliette Cosgrove	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Bridget Lees												
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												

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Public Board Matters Arising Action Log
4 March 2020

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TBG007/20	5 February 2020	Quality Improvement Plan Update	The Director of Nursing to provide an update on the quality priorities at the March meeting.	**DoN**	4 March 2020	March 2020	**March 2020 –** A revised report on the Quality priorities programme is included on the agenda.	**GREEN**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	**TB025/20**	**Report Title**	**Chief Executive's Report**
Executive Lead	Trish Armstrong-Child, Chief Executive Officer		
Lead Officer	Sharon Katema, Interim Associate Director of Corporate Governance		
Action Required	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The Chief Executive's Report provides an overview of specific activity and issues that have occurred in the organisation since the last Trust Board meeting.

Recommendation:

The Board is asked to receive the report for information.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

Continue to monitor complaints and compliments.

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

Previously Presented at:

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

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

1.1 National Awards.
The Surgical Assessment Unit (SAU) team have been invited to the Valuing patients' time national conference in recognition of their work on same day emergency care.

1.2 Thanks a Bunch.
Sister Lindsey Potter and Staff Nurse Tina Adnitt, from the Stroke Unit were nominated for January's Thanks a Bunch Award for the exceptional care and compassion shown to a family during exceptional circumstances.

2. News and Developments

2.1 COVID-19 virus
The NHS and Public Health England (PHE) are extremely well prepared for outbreaks of new infectious diseases. Measures have been put in place to ensure the safety of all patients and NHS staff, while also ensuring services are available to the public as normal.

At the time of writing, PHE is reporting a further four patients in England who have tested positive bringing the total number of cases in the UK to 13.

The Trust continues to work closely with PHE colleagues to ensure we are fully compliant with all current guidance

We have developed our own isolation area at the Southport site which is now in operation. Signage is now in place across the site, providing directions to our coronavirus "pod" which is available by appointment only, for patients directed here for testing by NHS111.

2.2 System Pressures
The last few weeks have continued to prove challenging for the Trust. However, despite these challenges staff continue to work tirelessly, going above and beyond for our patients. Our national and regional ranking has improved considerably. For February to date, we are inside the top 5 best performing Trusts in the North West and stand 35th country-wide out of 132 trusts. Well done everyone and thank you. Particular recognition should be given to the teams overseeing Ambulatory Care Units (ACU, CDU, and SAU) who are seeing higher numbers than ever which means we can offer safe alternative pathways to our patients that avoid an unnecessarily prolonged hospital stay.

2.3 Trust News
More than 1,600 staff are now members of our staff Facebook page which continues to flourish as the forum for sharing news and celebrating achievements. The most popular Facebook post of the month was promotion of a recruitment open day on Ward 14A at Southport.

The appointment of Bridget Lees as Director of Nursing, Midwifery and Therapies was well-received on social media, receiving more than 8,000 impressions on Twitter.

The Annual Staff Survey Results were released last week. However, due to the timing of the publication of the results, the report will be presented at the Workforce Committee in March for consideration, prior to being received at Trust Board in April.

3. NHSI/E Meetings

3.1 The Southport systems assurance meeting, chaired by NHSI Regional Performance Director took place on the 6 February and was attended by all system partners. The Trust's work around our contribution to this year's system winter plan was noted.

3.2 The Southport and Ormskirk Improvement Board, chaired by NHSI Regional Medical Director took place on the 7 February and progress on our continued improvement journey was noted. It was formally announced the Caroline Griffiths NHSI Improvement Director, who has been working and supporting the Trust since November 2017, will be leaving the Trust on 27 February to move to her next assignment.

4. Reportable Issues Log

Issues occurring between 30/01/2020 and 26/02/2020

4.1 Serious Incidents and Never events

Three STEIS incidents were reported within this time.

- 2 falls resulting in harm.
- Potential reputational damage in relation to the recent adverse publicity regarding the orthopaedic review of historic cases.

4.2 Level Four and Five Complaints

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

4.3 Regulation 28 Reports

No concerns were detailed in HM Coroner reports.

4.4 Whistleblowing

None to report

5. Media Coverage

5.1 Dr Paula Briggs, Consultant in Sexual and Reproductive Health, was the expert guest on the second episode of The Echo's new podcast series, MenoPod: myths, misinformation and the menopause No concerns were detailed in HM Coroner reports.

5.2 ITV's Granada Reports and the local Champion free newspapers reported on the Trust's invitation to the Royal College of Surgeons to conduct a review of past practice in orthopaedics. The Trust is conducting an ongoing review of orthopaedic procedures that required revision surgery to identify any concerns relating to individual surgical practice.

5.3 The Trust continued to support the NHS North Mersey A&E Delivery Board with the promotion of alternatives to hospital care using the hashtag **#HelpUsToHelpYou** on our social media channels**.**

6. Risk Register and Board Assurance Framework

Work on the review of the current Board Assurance Framework (BAF) will be presented later at the meeting. There have been no significant changes to the current BAF.

Trish Armstrong-Child
Chief Executive
26 February 2020

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 MARCH 2020

Agenda Item	**TB026/20a**	**Report Title**	**Quality Priorities Programme Update**
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality Amanda Locke, Programme Manager		
Action Required	☐ To Approve X To Assure ☐ For Information		X To Note ☐ To Receive

Executive Summary

The purpose of this report is to provide the Board with assurance on the progress of delivery of the Trust's Quality Priorities. This report provides assurance on the delivery and a progress update against plan for each of the quality priorities to the end of January 2020.

Section three of the report provides a summary of the progress during January 2020 for each of the quality priorities:

- Medicines Management
- Recognition and Care of the Deteriorating Patient
- Care of Older People
- Infection Prevention Control

The delivery plans for the four priorities will be reviewed and streamlined to ensure they focussed and aligned to the outcomes we want to achieve this will enable more effective and robust reporting including the development of programme level improvement measures and risks which currently do not exist.

The report demonstrates performance and progress to date of each of the Quality Priorities. The Quality Priorities will continue to be monitored by Quality & Safety Committee and presented to Board on a monthly basis.

Recommendation

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

Strategic Objective(s) and Principal Risks(s)	
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 X Effective X Responsive X Safe ☐ Well Led	☐ Statutory Requirement ☐ Annual Business Plan Priority X Best Practice X Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
☐ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal X 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)*	
Not applicable.	

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

Southport and Ormskirk Hospital NHS Trust

Quality Improvement Programme Update February 2020

1. Purpose of Report

The purpose of this report is to provide the Trust Board with assurance on the progress of delivery of the Trust's Quality Priorities.

2. Quality Priorities

The Quality Improvement Programme (QIP) is an integral part of the Vision 2020. The QIP identifies four 'Quality Priorities'. An overview of the quality priorities is tabled below.

Quality Priority	Overarching Aim	Impact
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
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 Executive Lead: Dr T Hankin Programme Lead: A Chalmers	Prevent and reduce healthcare associated infections and to ensure that outbreaks are effectively and appropriately managed in line with Trust policy	Reduction in the number of hospital acquired infections 85% compliance with statutory and mandatory training

Throughout quarter four of 2019/20 each of the Quality Priorities will be reviewed and detailed delivery plans for 2020/21 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.

A summary of the progress during January 2020 for each of the quality priorities is set out in section three of this report.

3. Quality Priorities Summary Highlight Reports

Medicines Management

- Medicines Management Improvement Plan

  The Medicines Management three, six, nine month Improvement Plan has been fully incorporated into the Safe and Secure Handling of Medicines quality improvement workstream. This will ensure that the CQC recommendations are fully embedded in the Medicines Management Programme.

  The first of a series of process mapping sessions commenced at the end of January. The aim of the sessions is to clarify roles and responsibilities across a number of priority areas within Medicines Management. The outputs from the sessions will be used to inform the development of new standard operating procedures (SOPs) and guidelines which will enable sustained improvements at ward and Trust level.

- Internal Assurance

  Internal assurance on the current levels of compliance within Medicines Management is being provided through a dedicated Ward Audit, which is subject to peer review.

  Assurance on compliance and progress against the CQC 'Must Do's' and 'Should Do's' is being provided to a second Quality Impact Assurance Panel on 25th February.

  A detailed deep dive into the Medicines Management quality improvement programme is being undertaken and will be presented to SOIB on 6 March.

  Recruitment to Business Case is in progress. The full recruitment process is expected to take 6 months to complete. A detailed paper for enhanced weekend working was presented in January, and engagement sessions with staff have been scheduled throughout February in collaboration with the Trust's HR team and the unions.

- Electronic Prescribing and Medicines Administration (EPMA)

  A memorandum of understanding for EPMA has been signed. An IT project manager and EPMA Pharmacist are to be presented for approval in February.

- Controlled Drugs and Out of Date Medicines Compliance

  The controlled drugs workstream will be reviewed to ensure that all actions have been undertaken and are embedded and a plan for project closure developed by the end of April.

  The performance against the improvement metrics for controlled drugs and out of date medicines is measured by ward level internal audit.

Recognition and Care of the Deteriorating Patient

- Electronic Ward Boards

  Funding has been confirmed for phase one of the Electronic Ward Board. The Electronic Ward Board will provide a tool to document consultant review of patients outside of standard wards rounds, and will also allow the identification and review of escalation and resus status of patients. Roll out is planned in conjunction with the ward refurbishment schedule.

- Comorbidity Summary Record

  A trial has commenced on Ward 9a. The tool provides information on patients' previous in-hospital treatment for their conditions and informs clinicians of the patients known medical history. The trial will be evaluated at the end of February and a plan for roll out across further wards will be agreed by the end of March.

- Advancing Quality

  Advancing Quality has commenced a new quality improvement project focussing on hospital acquired pneumonia. A 'Clinical Expert Group' has been established and has agreed a draft set of quality indicators as part of the correct care pathways work.

- Structured Judgement Review (SJR)

  Performance against target for the completion of SJR within 30 days is lower than expected. The main factors leading to the delay are; an increased number of deaths over the winter period, a lack of clinical time for reviewers to undertake the SJRs and an increased trigger rate over the winter months exceeding 30% (expected level between 10%-20%). In mitigation, MOG has agreed to remove UTI from the trigger tool which will reduce the number of SJR referrals by around 10%. In addition, a further four ITU reviewers have been recruited and the lead is considering how additional reviewers from a range of clinical staff groups can be recruited and trained to undertake SJRs to increase capacity.

- Overall Performance Summary

	2018/19			2019/20									Target
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Rolling 12 Month HSMR	102.9	98.7	94.8	96.3	98.3	95.6	91.8	89.0	87.1				*100.0*
Monthly HSMR	84.7	81.5	82.8	121.0	102.1	64.8	73.0	63.0	74.0				*100.0*
SHMI			101.9	101.3	101.1	99.6	99.1	98.1					*100.0*
Local HSMR Bronchitis	133.0	118.4	105.9	116.2	115.8	114.1	102.2	108.6	90.0				*100.0*
Local HSMR LRTI	134.1	119.5	106.8	120.8	116.8	115.1	109.9	105.9	107.3				*100.0*
Local HSMR Pneumonia	112.6	104.8	103.7	110.2	108.3	104.2	98.6	101.1	93.5				*100.0*

Local HSMR Septicemia	81.1	79.1	80.0	79.5	75.6	75.6	73.1	71.6	69.8				*100.0*
Local HSMR Stroke	100.3	100.2	103.5	105.5	98.0	95.6	101.0	98.6	106.5				*100.0*
Local HSMR UTI	106.2	109.0	80.0	84.2	91.7	85.5	76.8	73.7	70.0				*100.0*
Local HSMR Acute Renal Failure	126.8	115.0	101.3	112.8	113.9	118.1	107.9	116.5	118.2				*100.0*
Mortality Screens - %	64.52 %	61.67 %	47.22 %	35.16 %	32.93 %	58.33 %	89.83 %	84.62 %	92.06 %	90.67 %	81.48 %	62.75 %	*90.00 %*
SJRs	4.0	5.0	9.0	5.0	2.0	6.0	4.0	8.0	22.0	13.0	8.0	6.0	*0.0*
2nd Review	0.0	0.0	0.0	0.0	3.0	0.0	2.0	1.0	1.0	1.0	0.0	0.0	*0.0*
In Hospital Deaths	94.0	60.0	72.0	91.0	82.0	48.0	60.0	52.0	63.0	75.0	80.0	103.0	*77.0*
In Hospital Deaths Crude Rate	26.0	18.6	24.6	29.2	22.0	18.2	14.8	18.2	23.8	20.6	21.8	31.3	*31.0*
LD Deaths	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	*1.0*
Sickness Absence Medics	2.22%	2.80%	3.32%	2.82%	2.08%	1.75%	2.11%	0.57%	0.92%	0.91%	2.71%	1.49%	*1.00%*

December has shown a significant increase in the number of deaths compared with previous years. This is reflected in a rise in the crude mortality rate, which has risen above the historical target by 0.3%. SJR data suggests that this is driven by respiratory infection; further information on this will be available with the publication of SMRs in 3 months, completion of mortality reviews and clinical evaluation of the winter period.

This rising crude mortality is associated with increased demand on the system, with impaired Accident and Emergency Department (AED) flow and increasing staff sickness. This supply / demand mismatch exacerbates the problem. Further investigation of the AED flow data and clinical evaluation is to be undertaken with the A&E department to understand the areas of work.

The SHMI remains within the expected range, accepting that this figure is accurate to August 2019.

The rolling HSMR for September (average over 12 months) is 87.1. This is within the expected range. Acute Kidney Injury (AKI) remains a cause for concern, and an internal clinical review of AKI as a condition presenting to hospital and developing in hospital has been commissioned.

The monthly HSMR for September is 74. This is within the expected range. Mortality indicators in this month were largely favorable, with the exception of low acuity deaths, which are being investigated to quality assure the data, and deaths within 30 days of elective surgery which has been evaluated and shown to be related to elective transfusion of blood products in hematological malignancy.

During February and March the following is being undertaken in the following areas to address the areas of underperformance:

I. Review of deaths related to long waits in AED
II. Report expected on deaths related to drop in patient acuity
III. Review AKI and Low risk presentations.

Care of Older People

- Get Up, Get Dressed, Keep Moving

  Roll out of Get up, Get dressed, Keep moving will be relaunched. The team continue to develop an activity planner and patient information leaflets.

- Nutrition and Hydration

Key Performance Indicator	Threshold	Trust Actual	BRAG
MUST Screening - MUST screening compliance within 24 hours of admission	75%	55.62%	Red
MUST repeat - Repeated MUST assessment within 7 days	75%	72.14%	Amber

Performance is below the Trust threshold for both MUST screening and repeat assessment. The Nutrition Policy and associated Care Plan will be reviewed at the Nutrition and Hydration Project Group in February and presented to the Policy Review Group in March for formal approval. Full roll out of the policy, care plan and education will commence once the policy has been approved. In the meantime, ward level performance is monitored monthly and targeted support is provided to improve performance.

- Mouth Care

  Following the launch, Mouth Care Matters has continued to be rolled out across the Trust throughout January. The Mouth Care Group is supporting the testing of the new assessment, education, care plan and product range.

- Dementia and Delirium

Key Performance Indicator	Threshold	Trust Actual	BRAG

Key Performance Indicator	Threshold	Trust Actual	BRAG
Delirium - ALOS Average length of stay for patients with delirium	17.0	21.0	Red
Dementia - ALOS Average length of stay for patients with dementia	7.0	9.0	Amber
Delirium Discharges to UPOR - % patients with delirium discharged to usual place of residence	90.0%	65.0%	Red
Dementia Discharges to UPOR - % patients with dementia discharged to usual place of residence	90.0%	80.33%	Red

Two members of the Dementia and Delirium Team are in post and have commenced supporting the roll out of the new risk assessment and car 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.

A dedicated piece of work that focusses on hospital discharge will be scoped during February and March. Actions that emerge from the scoping exercise will include a focus on reducing readmission rates and increasing the number of discharges to usual place of residence for patients with dementia and delirium.

- Continence

  The continence project has resulted in a new assessment, care plan and product bank being launched. These will be trialled on wards 7A and 7B from 6th January for 1 month before feedback and amendments are made, following which the full roll-out will be planned.

- HomeFirst

  West Lancashire HomeFirst pathway is regularly achieving its KPIs. Sefton HomeFirst Pathway commenced on 6 January 2020. The pathway is being reviewed monthly. Sefton care capacity remains an issue. A dashboard has been developed and is due to be published in March which will highlight the reason for delays in the pathway.

- Falls

Key Performance Indicator	Threshold	Trust Actual	BRAG
Falls risk assessments - % of patients having a falls risk assessment	95.0%	97.6%	Green

Falls Care plans - % of patients with a falls care plan in place	95.0%	97.6%	Green
Number of falls - Actual number of falls	71	76	Amber

Performance data shows that whilst the number of falls at 76 is slightly higher than the target of 71, the percentage of patients across the Trust who received a fall assessment and have a falls care plan in place is performing well at 97.6% against a target of 95%.

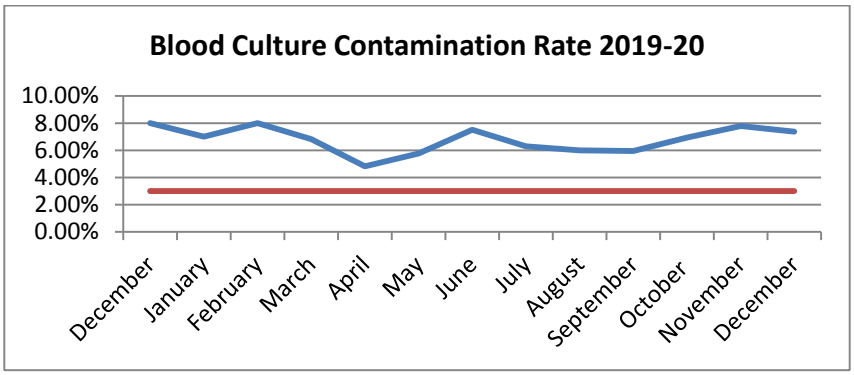
Performance issues are being addressed through the Falls Improvement Plan, which has now been approved and launched.

A new risk assessment and care bundle has been rolled out across the organisation and in addition, two sets of falls alarms and red walking frames have been trialled during January. Feedback has been collated and a recommendation will be made to the Falls Working Group in February, costs of implementation to be confirmed during March.

Infection Prevention and Control

Aseptic non-touch technique (ANTT)

In December, 733 blood cultures were collected and of these 54 were considered to be due to contaminants; this gives a blood culture contamination rate of 7% a decrease from 8% in November. The chart below shows the actual contamination rate against the Trust target of 3%, which is the upper limit of what should be achievable across the Trust as described by the Department of Health.



Contamination results are important to monitor and manage as a contaminated sample may lead to a patient being treated for an infection they do not have and thereby lead to an increased length of stay and avoidable treatment for our patients.

Implementing ANTT across all relevant staff groups will facilitate the organisation to reach its 3% target. A rolling programme of training is ongoing across the Trust and is also available as an e-learning package on the intranet site. In order to improve performance against target, ANTT training will be included as a core competency and part of the mandatory training programme for identified clinical staff. Numbers trained will be monitored over the coming months to ensure that all relevant staff members are trained.

- Hand Hygiene

In December the Trust's average hand hygiene compliance score was 97.6%; and 82% of audits were completed. Targeted training will be delivered on individual wards that consistently fail to achieve Trust standards for hand hygiene.

- Coronavirus

  During January there has been a focus on preparing for Coronavirus. A Coronavirus Policy was published on 31.01.2020 and posters are being displayed in the entrances to the hospitals. Daily meetings are being convened between emergency planning, IPC and Patient flow and work is ongoing with procurement to increase stock of PPE.

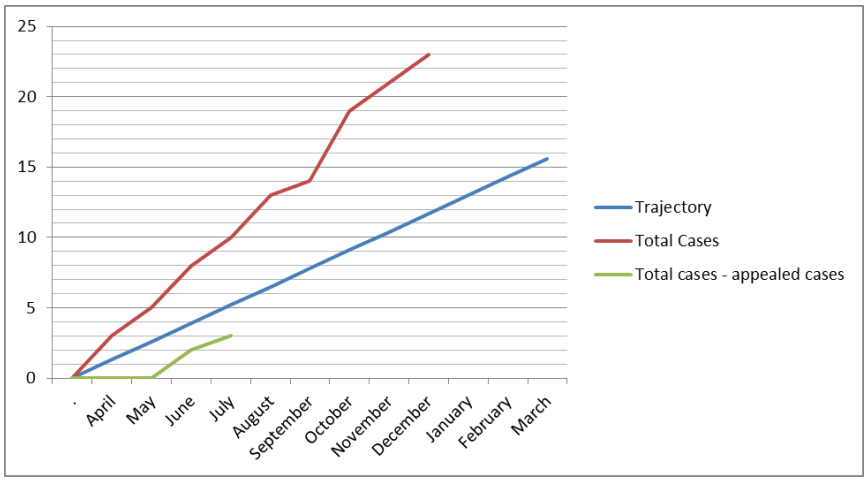
- Antibiotic Guidance

  Antibiotic Guidance on spinal has now been updated. Antibiotic Guidance for the rest of the Trust is being drafted currently and is looking to be completed by the end of March 2020, in preparation for the antibiotic app going live.

- C. diff. cases against trajectory 2019/20

  The Trust is currently exceeding its C.diff trajectory of 16 cases per year (Apr-Apr), however, there has been 6 successful appeals of those with the CCG, and a further 7 cases have been identified as being eligible for appeal. If all are successfully appealed the Trust we would be below the C.diff trajectory.

  In December the trust had one hospital attributed C diff case attributed to FESS and one COHA case attributed to 11A. Both of these cases identified no lapses in care when the RCA was completed and hence are eligible for appeal



The chart shows the yearly objective of 16 cases divided over 12 months; the actual cumulative totals are shown in red and exceed this target, however, after successfully appealing 7 "no lapse in care" cases and having a further 8 cases to appeal our performance will be below the trajectory line.

- Catheter Utilisation

  Catheter usage across the Trust continues to be higher than the national average at 19.99%, compared to 18.6%. However, this includes NWRSIC data, where out of necessity; catheter usage is higher than for the average user. When this data is extracted the Trust average drops to 15.92%, significantly below the national average.

4. Recommendation

The Board is asked to 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.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	**TB026/20b**	**Report Title**	**Complaints & Compliments**
Executive Lead	Bridget Lees, Director of Nursing, Midwifery & Therapies		
Lead Officer	Mandy Power, Associate Director of Integrated Governance		
Action Required	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This report provides a breakdown on the number of compliments, complaints, concerns received in January and actions taken.

Performance

- The trust target of written acknowledgement of a complaint within 3 working days has been maintained at 100% for January 2020 following 100% compliance in Quarter 3
- The number of complaints received in Jan 2020 is 10% less than Jan 19 and there has been an over-all reduction of 10% in year. There has been an continued increase of concerns raised.
- The trust target of completing complaint responses in 40 days has not been met. In Jan 20 there were 43 complaints that did not meet this criteria. The period of time of open complaints is ranging between 40 – 220 days

Next Steps

The review of the complaints process has been undertaken. A range of measures have been put in place in order to achieve compliance against complaint timescales, including enhanced monitoring and reporting arrangements. A Patient advice and liaison service (PALs) team will be introduced (Spring 2020) to enhance support and sign-posting for patients, families and the public. The expected impact will be an increase in concerns and queries reported and a reduction in the number of formal complaints which is nationally seen as a positive indicator of patient experience.

Recommendation

The Board is asked to **note** this report and actions to be taken to address the time that patients and families are waiting for a response to their complaint.

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

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

Impact

✓ 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

Continue to monitor complaints and compliments.

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

Previously Presented at:

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

Complaints & Compliments

January 2020

1.0 Introduction

This report provides an over-all position, a breakdown on the number of compliments, complaints and concerns received in the month of January 2020, it does not relate to care or experience received in Month. This report articulates next steps related to complaint response times and actions to be taken.

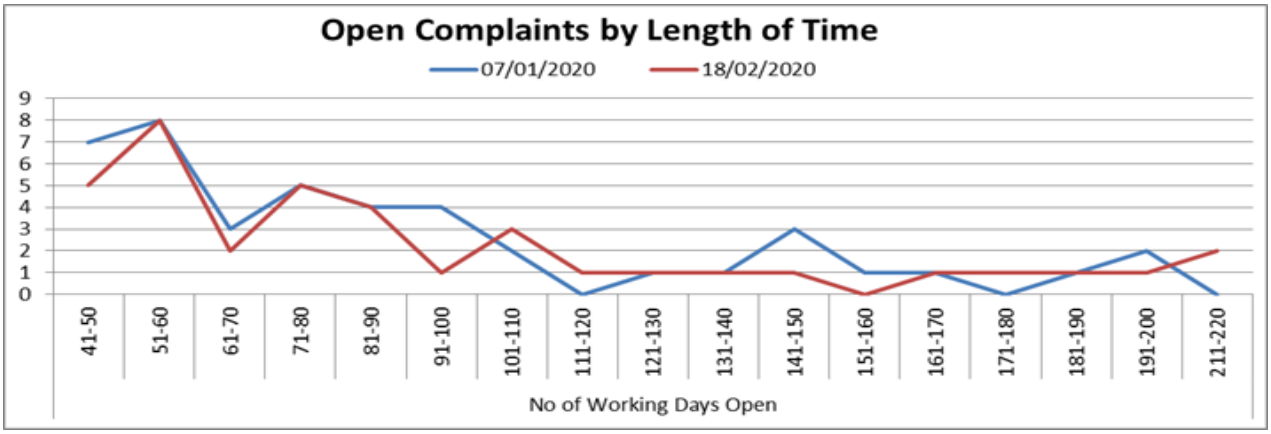
2.0 Complaints and Concerns

2.1 Complaints

- 27 complaints were received in Jan 20. These are attributable to Urgent Care (17), A&E (4), Specialist Services (3) and Planned Care (7)
- Themes included clinical treatment related to co-ordination of medical treatment, poor nursing care and alleged wrong diagnosis, staff attitude/behaviour communication and basic care
- The trust target of written acknowledgement of a complaint within 3 working days has been maintained at 100% for January 2020 following 100% compliance in Quarter 3
- The number of complaints received in Jan 2020 is 10% less than Jan 19.

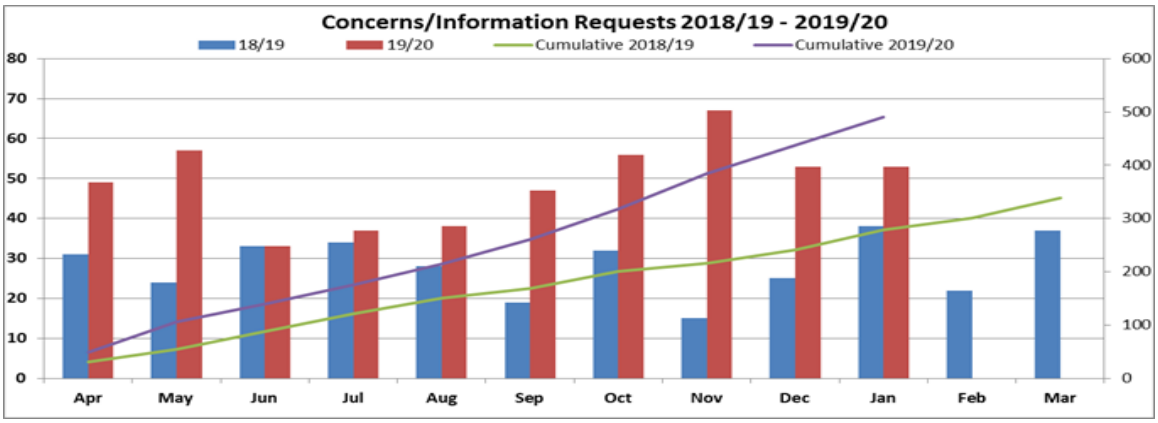
Performance

- 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 72 days
- In Jan 20 there were 43 complaints that did not meet this criteria. Importantly the graph below shows the period of time of open complaints with a range of 40 – 220 days that people are waiting to receive a response to their complaint and shows limited improvement meeting this measure



2.2 Concerns

- The trend and cumulative increase in the number of concerns and information requests compared to 2018/19 continues in Jan 2020
- The positive step change is in part attributable to the renewal of the public facing internet (in 2019) providing additional ways for the public to contact the Trust. The use of this is monitored via our communications team
- Additional staff training to support de-escalation and local resolution of concerns was also undertaken in November and December 2019



There have been a total number of 45 concerns raised in January. The themes are

- Communication (3)
- Patient discharges (5)
- Request for advice/information (8)
- Clinical treatment (4)
- Dates for appointments (9)
- Staff attitude/behaviour/competence (5)
- Patient lost property (4)
- Clinical care (6)
- Privacy & dignity (1)

Following a request by the Trust, Mersey Internal Audit Authority is currently reviewing the Trust policy and processes in relation to patient's property, in order to offer areas for improvement.

3.0 Compliments

Compliments received across the Trust related to the quality of care received by patients, communications with relatives & patients, staff behaviour, attitude, staff availability & competence, waiting times, cleanliness, also related to privacy & dignity.

- Planned Care Business Unit received the most compliments with 26 in total and HDU receiving 8.
- Urgent Care Business Unit received 12 Compliments, with the Wheelchair services Skelmersdale receiving the highest number (4), followed by the Physiotherapy Department (3).
- Women & Children's Business Unit received 7 compliments, of which 4 related to Maternity and 2 to Paediatric Ward & 1 to Paediatric A&E.

Compliments are put onto the Datix system by the Business units and are shared within the area. Compliments are also shared within Trust briefs out to staff by the Communication Department.

4.0 Next Steps and Actions related to Complaint Response Times

- The review of the complaints process has been undertaken. A weekly complaints update attended by the Director of Nursing is now in place to support achieving the complaint response time measure
- Complaint response times are monitored (Jan 2020) in Performance review Boards to support a accountability and action
- Complaint performance measures within the Integrated Performance report (IPR) will be reviewed and the additional metric of complaint response times and length will be included to support ward to board monitoring
- By reconfiguring resources in 2020, a Patient Advice and Liaison service (PALs) team will be introduced (Spring 2020) to further support and sign-post patients, families and the public. The expected impact will be an increase in concerns and queries reported and a reduction in the number of formal complaints
- Following review, the grading tool used for triaging concerns and complaints has been updated. The expected impact will be that any complaints meeting the threshold of serious concerns will be named as a “red complaint” and be reported at Trust Board rather than grade 4 and 5
- A trajectory to complete the 43 outstanding complaints be set by May 2020 and a further stretch target of complaint response times to be considered at 35 days in line with other organisations
- A recommendation following the complaints review is that the Director of Nursing will contact all appropriate patients who are awaiting a response offering an apology and offer to meet to discuss complaint findings with teams involved

5.0 Recommendations

- The board to note the position and actions to be taken to address excessive periods of time that patients and families are waiting for a response to their complaint

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	**TB026/20c**	**Report Title**	**Learning from Deaths Monthly Report**
Executive Lead	**Dr Terry Hankin,** Medical Director		
Lead Officer	**Dr Chris Goddard,** Associate Medical Director of Patient Safety		
Authors	**Rachel Flood-Jones,** Project Delivery Manager **Mike Lightfoot,** Head of Information		
Action Required	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

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

This is the monthly Learning from Deaths Report which gives assurance to the Committee 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 Committee 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.

Recommendation

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 August 2019
- Hospital Standardised Mortality Ratio (HSMR): Rolling 12 month and in month for September 2019 was
- Disease-Specific Mortality Ratios are reported for September 2019

3.0 Mortality Improvement Activity

Highlights of the new Recognition and Care of the Deteriorating Patient Programme as at February 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: February 2020
Appendix 2: Recognition and Care of the Deteriorating Patient Project Highlight Report February
2020
Appendix 3: Mortality Dashboard.(Dr Foster Mortality Data) February 2020
Appendix 4: Distribution Performance Graph, August and September 2019
Appendix 5: Mortality Indicators for September 2019

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

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

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

Impact

✓ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ✓ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment	☐ Policy ☐ Service Change ☐ Strategy

Next Steps

Previously Presented at:

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

1. Executive Summary

- Headline metrics remain in a satisfactory position.
- The SMR for AKI is rising, and this is being evaluated further on multiple fronts.
- The rise in deaths over the winter is being evaluated further. SJR data suggests respiratory infection is the leading issue; additional analysis by microbiology is being sought.
- UTI has shown continuous improvement and therefore is being removed as a independent SJR trigger.
- The responsibility for reporting-on-action for the external mortality review is to be from the responsible program or CBU from this report onwards to ensure those delivering the actions are reporting on that delivery.
- Further work on reporting from SJRs and reporting on learning is ongoing.

2. Mortality Indicators

2.1 Performance Indicator Chart: Key National and Local Mortality Indicators

	2018/19			2019/20									Target
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Rolling 12 Month HSMR	102.9	98.7	94.8	96.3	98.3	95.6	91.8	89.0	87.1				*100.0*
Monthly HSMR	84.7	81.5	82.8	121.0	102.1	64.8	73.0	63.0	74.0				*100.0*
SHMI			101.9	101.3	101.1	99.6	99.1	98.1					*100.0*
Local HSMR Bronchitis	133.0	118.4	105.9	116.2	115.8	114.1	102.2	108.6	90.0				*100.0*
Local HSMR LRTI	134.1	119.5	106.8	120.8	116.8	115.1	109.9	105.9	107.3				*100.0*
Local HSMR Pneumonia	112.6	104.8	103.7	110.2	108.3	104.2	98.6	101.1	93.5				*100.0*

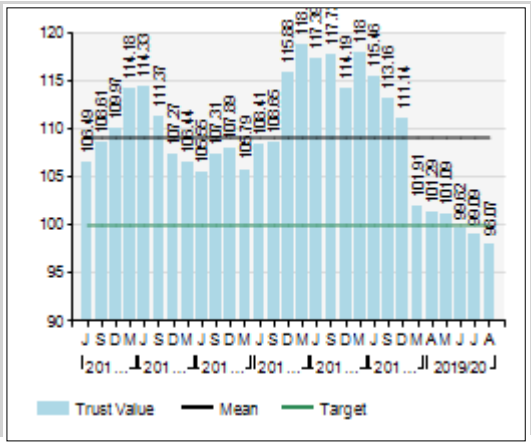
Local HSMR Septicemia	81.1	79.1	80.0	79.5	75.6	75.6	73.1	71.6	69.8				*100.0*
Local HSMR Stroke	100.3	100.2	103.5	105.5	98.0	95.6	101.0	98.6	106.5				*100.0*
Local HSMR UTI	106.2	109.0	80.0	84.2	91.7	85.5	76.8	73.7	70.0				*100.0*
Local HSMR Acute Renal Failure	126.8	115.0	101.3	112.8	113.9	118.1	107.9	116.5	118.2				*100.0*
Mortality Screens - %	64.52%	61.67%	47.22%	35.16%	32.93%	58.33%	89.83%	84.62%	92.06%	90.67%	81.48%	62.75%	*90.00%*
SJRs	4.0	5.0	9.0	5.0	2.0	6.0	4.0	8.0	22.0	13.0	8.0	6.0	*0.0*
2nd Review	0.0	0.0	0.0	0.0	3.0	0.0	2.0	1.0	1.0	1.0	0.0	0.0	*0.0*
In Hospital Deaths	94.0	60.0	72.0	91.0	82.0	48.0	60.0	52.0	63.0	75.0	80.0	103.0	*77.0*
In Hospital Deaths Crude Rate	26.0	18.6	24.6	29.2	22.0	18.2	14.8	18.2	23.8	20.6	21.8	31.3	*31.0*
LD Deaths	0.0	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	*1.0*
Sickness Absence Medics	2.22%	2.80%	3.32%	2.82%	2.08%	1.75%	2.11%	0.57%	0.92%	0.91%	2.71%	1.49%	*1.00%*

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

December has shown a significant increase in the number of deaths compared with previous years. This is reflected in a rise in the crude mortality rate, which has risen above the historical target by 0.3%. SJR data suggests that this is driven by respiratory infection, further information on this will be available with the publication of SMRs in 3 months, completion of mortality reviews and clinical evaluation of the winter period.

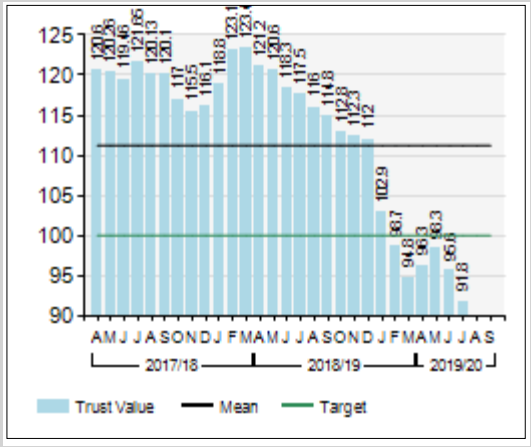
As previously reported, this rising crude mortality is associated with increased demand on the system, with impaired AED flow and increasing staff sickness. This supply / demand mismatch exacerbates the problem. Further investigation of the AED flow data and clinical evaluation is to be undertaken with the A&E department to understand the areas of work.

2.2 SHMI (to August 19)



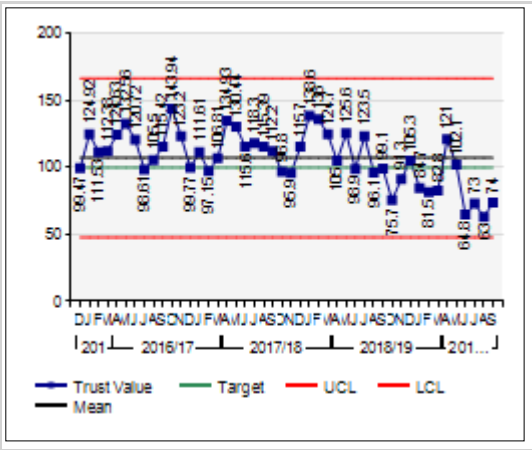
The SHMI remains within the expected range, accepting that this figure is accurate to August 2019.

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



The rolling HSMR for September (average over 12 months) is 87.1. This is within the expected range. There is an increasing recording of patient co-morbidity and identification of palliative care, which effects the observed and expected figures in HSMR (affects expected only in SHMI). Improvements in pneumonia, LRTI and UTI appear sustained. AKI remains a cause for concern, and a internal clinical review of AKI as a condition presenting to hospital and developing in hospital has been commissioned.

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



The HSMR for September is 74. This is within the expected range. Mortality indicators in this month were largely favourable, with the exception of low acuity deaths, which is being investigated to quality assure the data, and deaths within 30 days of elective surgery which has been evaluated and shown to be related to elective transfusion of blood products in haematological malignancy.

Areas of work:

1. Work has started to review deaths related to long waits in AED
2. Report expected on deaths related to drop in patient acuity
3. AKI and Low risk presentations. (see 2.5)

2.5 Diagnosis Groups

Ongoing work:

1. AKI. Two areas being reviewed:
   a. AKI on presentation – identification and treatment
   b. AKI as an inpatient – missed opportunities, risk assessment, identification and treatment
   c. Complemented by AQ QI program and MIAA review (ongoing)

2. Low risk diagnoses (LRTI / Bronchitis / UTI)
   a. Previous reviews demonstrate these are often secondary to multi-morbidity – process to ensure review of these cases to ensure correct diagnosis / identify patients dying from low risk conditions / identify other high risk diagnoses requiring management.

Results of these reviews will be presented in subsequent reports.

3. Mortality Improvement Activity

3.1 Update on Recognition and Care of the Deteriorating Patient Programme

Project within the RCDP Programme	Progress and achievements this month
1.Observations and Escalation	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.
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
3. Documentation & Coding	The Comorbidity Alerting Process trialled on Ward 9A (Short Stay Unit) has provided doctors with an overview of patient's comorbidities (in line with the information that the hospital has on the patient.) The Comorbidity Summary can support and expedite the decision making process regarding diagnostics, treatment and diagnosis. Further trials on a second medical ward will take place in March 2020.

4. Senior Ownership	Funding has been secured for Phase One of the Electronic Ward Board roll out (in line with the Ward Refurbishment Project at the Southport site.) PCs and screens will be purchased and installed on Wards: 7, 9, 10 and 11 A&B to deliver the new processes within the next financial year. The Electronic Ward Boards will provide a continuous, daily record of senior review (whether direct or remote) to ensure that support for junior doctors is documented. This solution has been created in response to junior doctor feedback to Health Education England. Recruitment for the replacement IT resource to undertake required IT fixes to complete the Electronic Ward Board are underway. It is estimated that it will take a further 3-6 months; in view of this an interim solution is being investigated.
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.
7. Maternity and Paediatrics	The requirement to incorporate Maternity and Paediatrics into the scope of the Programme has been identified through the Mortality Operational Group. The first session is being coordinated to ensure input from relevant senior clinicians the Risk and Governance Co-ordinator for Women's and Children's Division as well as the Trust's Bereavement Lead.

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

4.1 Screening

							Overall Assessment Rating per Month						
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***
Jan-19	94	60	63.8%	13	22%	12	92.3%	**1**	**3**	**4**	**1**	**1**	**2**
Feb-19	60	38	63.3%	4	11%	6	150%	1	1	1	1	0	2
Mar-19	72	32	44.4%	9	28%	9	100%	0	7	2	0	0	0
Apr-19	91	33	36.3%	6	18%	5	83%	1	4	0	0	0	0
May-19	82	25	30.5%	4	16%	6	150%	0	2	2	1	1	0
Jun-19	48	27	56.3%	11	41%	8	73%	1	3	2	2	0	0
Jul-19	59	52	88.1%	11	21%	10	91%	1	5	3	0	0	1
Aug-19	52	44	84.6%	13	30%	10	77%	0	4	4	1	0	1
Sep-19	63	57	90.5%	18	32%	13	72%	2	5	6	0	0	0
Oct-19	75	68	90.7%	19	28%	13	68%	1	9	1	2	0	0
Nov-19	81	66	81.5%	15	23%	10	67%	4	2	2	2	0	0
Dec-19	102	65	63.7%	24	37%	7	29%	1	3	3	0	0	0
Jan-20	96	63	65.6%	20	32%	1	5%	0	1	0	0	0	0

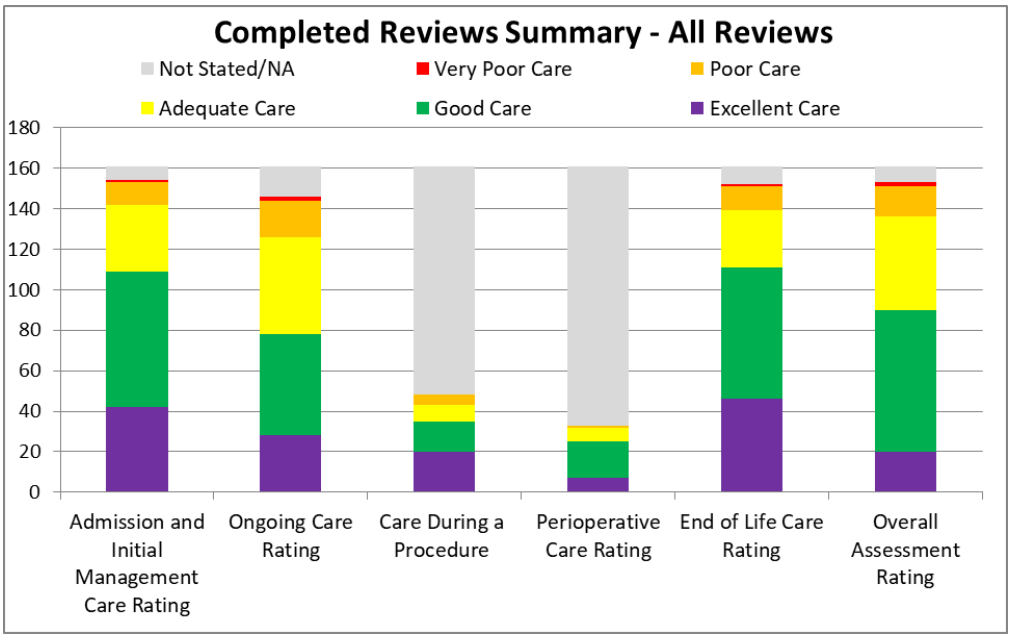
The screening rate is again static at 65%. The actual number of deaths screened (63) also remains static. The reduced screening rate is driven by the increased number of deaths in general, and is a function of the general increased medical workload. With the trigger rate running at around 30%, the reduced screening rate is off-set by a higher trigger rate, thus the number of referrals for SJR remains appropriate.
The ultimate fix for the screening rate will be the proposed introduction of Medical Examiners, ensuring all deaths are screened, until this point, further education of medical staff and re-enforcement by the bereavement team are the main mechanisms.

It was discussed and agreed at the February MOG that Urinary Tract Infection (UTI) would be removed as a trigger for SJR. Severe infection and death from UTI would still be reviewed under 'Sepsis', therefore reviewer time would be best served on these cases, which carry the highest likelihood of learning. It is hoped this will return the screening rate to the 10-20% target. Relative risk of death from UTI has also reduced to an acceptable position consistently for the past seven months.

4.2 First Structured Judgement Review

	2019												2020		Grand Total
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
General Medicine	1	1	3	2				2	5	3	1	2	4		**33**
Geriatric Medicine	1	3	2		1		1	1	3	1	1	1	5		**27**
Intensive Care/Coronary Care/High Dependency	1		3		1	2	1		2	1					**20**
Respiratory Medicine/Thoracic Medicine			2	2		1		2	3	1	2		2		**17**
Trauma & Orthopaedics							1		6	5			1		**16**
Cardiology						2	1	1	2			1	6	1	**17**
Stroke						1		1	1		2	2	1		**10**
A&E								1	1		2			1	**5**
Urgent Care								1			4				**5**
Gastroenterology	1			1						2		1			**5**
Urology		1				1	1		1						**4**
Endocrinology								1			1				**2**
Grand Total	**4**	**5**	**10**	**5**	**2**	**7**	**5**	**10**	**24**	**13**	**13**	**7**	**19**	**2**	**161**

22 further reviews have been completed in January and early February, this is the second highest monthly total on record thus far. Critical Care has seen a drop off in reviews due to processes issues in allocation to reviewers. A new process for this is being trialled and additional reviewers have been recruited (3) and trained (1 of 3 so far). This is anticipated to improve. It has been raised by reviewers that case notes are not being scanned to evolve in a timely fashion which is preventing reviews from occurring quickly. This will be reported on a case-by-case basis so that issues with the scanning system can be identified and remedied.



Similar to last month, the trust-wide SJR graph shows that Ongoing or ward-level care is the point in the patients' journey where care is most likely to be adequate, poor or very poor. Thus, this is the focus of many strands of quality improvement work. Without displaying specialty-specific graphs, this finding is replicated across all specialties, allowing for differences in numbers of deaths and the differing case-load.

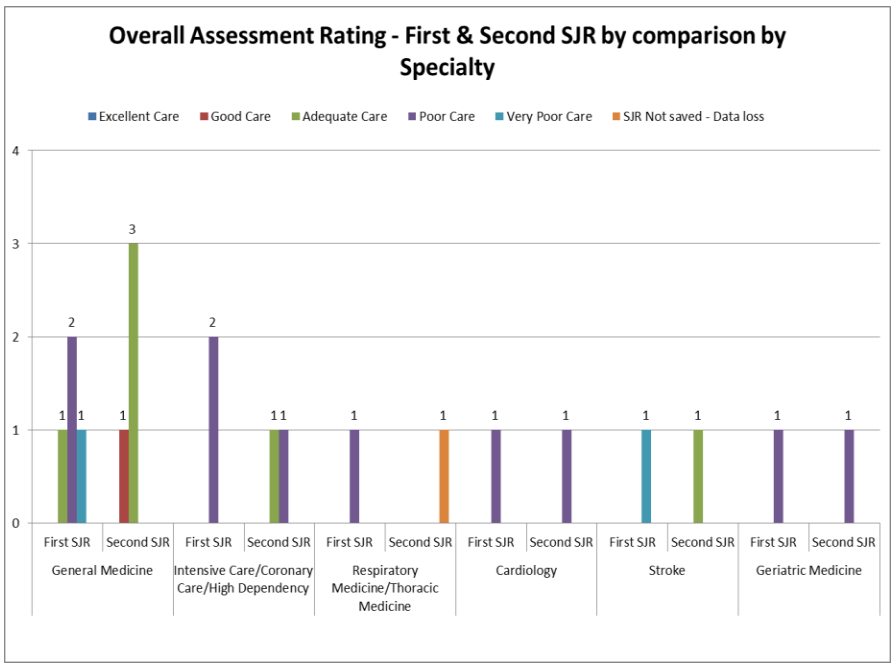
Planned thematic analysis remains:

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.

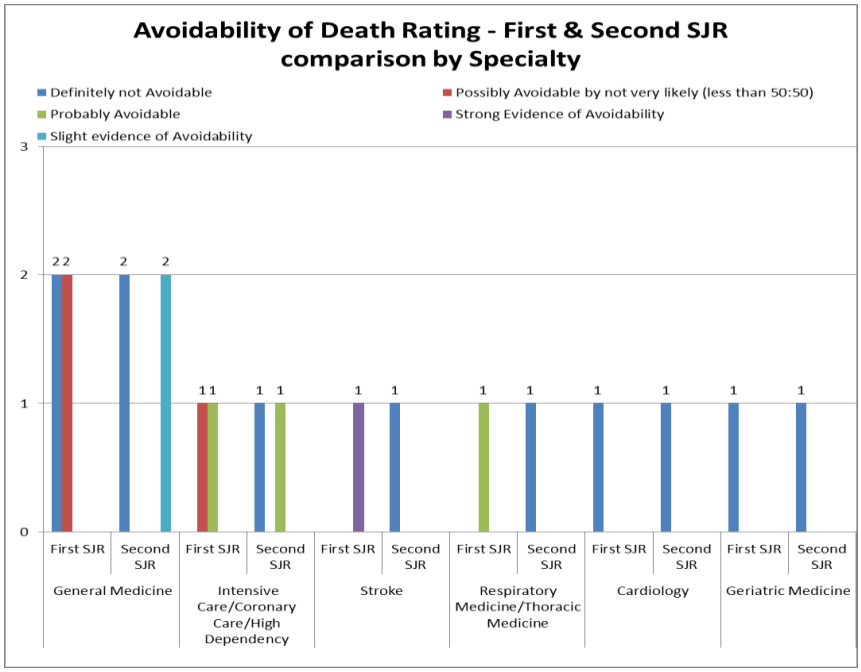
4.3 Second Structured Judgement Review

	Number of completed First SJR's	Number requiring a second SJR	Number of completed Second SJR's
General Medicine	33	6	4
Geriatric Medicine	27	1	1
Intensive Care/Coronary Care/High Dependency	20	3	2
Respiratory Medicine/Thoracic Medicine	18	1	1
Trauma & Orthopaedics	16	1	0
Cardiology	17	2	1
Stroke	10	1	1
A&E	5	0	0
Urgent Care	5	0	0
Gastroenterology	5	0	0
Urology	4	0	0
Endocrinology	2	0	0
Grand Total	162	15	10

There are 5 of 15 second reviews outstanding. Once completed these are reviewed by the Mortality Operational Group. This correlates to 9.3% poor or very poor overall care in the view of the first SJR reviewers.



Of the 10 second reviews completed thus far, three have had a finding of poor overall care upheld (1.8%) Of these, one case has been considered a serious incident and referred to SIRG.



So far, one death has been considered a serious incident as an avoidable death (0.6%) and this has gone through the trust and coronial governance process, with finding generated and changes to practice occurring. This case is illustrated below to describe the process.

4.4 Case Description of SJR learning process in avoidable mortality

The SJR process is a system for learning in order for pathways of care to be examined and continuously improved. Whilst it is not an investigative tool, there is a potential for critical incidents to be identified. This occurs in two ways:

1. Discrete incidents identified during the course of a review. Should a reviewer identify an incident during a review, this should be raised via Datix as a separate incident. In a mature system, any such incidents should already have been reported.
2. Avoidable mortality. By definition a serious incident and reportable as such. This is frequently a difficult and nuanced decision, thus this is made following two SJRs and a discussion of the case in MOG.

This case is an example of process 2.

Female patient, returned from recent holiday in Tenerife. She presented to hospital with a painful, red swollen knee after a fall from a taxi. Initial x-rays demonstrated arthritis of the knee, but no fracture. Inflammatory markers were raised, and there was a suspicion of septic arthritis.

Patient underwent aspiration of the knee joint, Staphylococcus Aureus (S.A.) was identified from the aspirate and from blood cultures. Appropriate antibiotics were started for this. It is worth noting that S.A. can be isolated if the sample is contaminated by the skin.

The patient was reviewed by orthopaedics, who felt that the clinical likelihood of septic arthritis was low. A second aspirate was attempted and no fluid was obtained. The patient was deemed to have a different source of sepsis and was referred to the medical team.

The medical team took over care and investigated for other sources (endocarditis, discitis). No other source was identified and the clinical suspicion from the medical team was that this was actually a septic arthritis. The patient deteriorated despite various anti-staphylococcal antibiotics, developing hypotension and Acute Kidney Injury. The patient was referred and admitted to critical care.

On critical care it was felt that the diagnosis was septic arthritis and further discussion with the orthopaedic team led to a decision to perform a surgical washout of the knee, which demonstrated pus in the joint and confirmed the diagnosis.

The patients' renal failure worsened post-op and due to the clinical situation and previous co-morbidity it was decided not to institute dialysis. Symptom control was maintained and the patient died.

The process is defined below:

1. The death was reviewed and screened in the bereavement office, signalling the need for an SJR. The case was discussed with the coroners' office.
2. The coroner opened and closed an inquest, recording a natural causes (accidental) death.
3. SJR1 was completed by a specialty doctor in anaesthesia. This was graded as poor care overall and a probably avoidable death due to delayed source control in sepsis.
4. SJR 2 was completed by a consultant anaesthetist, upholding the findings in SJR 1.

5. The case was discussed in MOG. MOG agreed that this death was probably avoidable and the case was referred to SIRG.
6. SIRG defined the case as a serious incident and an RCA was commissioned by the clinical director of orthopaedics.
7. Duty of candour was observed and the family kept fully informed of the situation and progress of the investigation.
8. The RCA identified areas for improvement, these included:
    a. Second review of potential septic arthritis cases by a second consultant to defeat confirmation bias.
    b. Routine use of ultrasound scanning of joints when a 'dry' aspirate occurs (unable to get sample from the joint) to identify any fluid.
    c. Follow-up of such patients using the consultant of the week model to review clinical progress.
9. The RCA concluded that death was avoidable in this instance with prompt treatment.
10. These findings were included in the RCA which was shared with the patient's family and the Sefton Coroner.
11. The patients' family are satisfied with the trusts approach, investigation and the improvements to practice described in the report.
12. The case and learning was discussed in the joint audit meeting of the orthopaedic and anaesthetic departments, with clinical discussion led by the clinical director of orthopaedics. This discussion is documented by the audit clerk in attendance.

5. Conclusions

Again, the supply / demand mismatch situation that reduces the effectiveness and safety of patient care remains relevant. Discussions have occurred with AED and Information as to how best examine the association between time spent in AED and mortality. AED deaths are now reported monthly to MOG.

Analysis is being sought from the Microbiology department of this winters' respiratory pathogens to see if this accounts for the rise in mortality.

Analysis of AKI deaths is progressing with two cohorts – AKI on arrival and AKI as an inpatient.

The drop in patient acuity reported on previously has been analysed by Information, and this is due to the dilution by observations from non-acute areas such as outpatient endoscopy coming on-line. This will reverse when AED adopts vitalpac.

Urinary tract infection data is improving, this will be removed as an independent SJR trigger, thus reducing the overall trigger rate to target. Process changes to improve the timeliness of SJRs are ongoing based on systemic experience.

The capturing and reporting of learning is not where it could be, and further work is needed to demonstrate this. Work has begun on this with the Datix team and forms part of the ongoing deteriorating patient project.

6. Recommendations

6.1 Standing Recommendations

Ensure 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

Review the deaths of ward outlying patients.

Improve SJR reporting to demonstrate changes in objective findings over time.

Examine and define the output from a departmental mortality meeting.

Devise a system for reporting themes from the subjective data in completed SJR reviews, both upwards and to the shop floor.

7.0 Appendices

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

The activities delivering the External Mortality Review Action are all delivered through the Deteriorating Patient Programme or Trust Programmes. Updates on activity have been provided to the Board over the last year in the form of the report below. This month will be the last month that this report is provided; assurance will be given through the routes indicated in the 'Update' column going forward

EMBAR

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

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

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 14th February 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	Continuous improvement is being delivered through the Trust's Patient Flow Improvement Programme, which has been in place since November 2018 and which will continue to drive the required activity. The Patient Flow Improvement Programme is accountable to the Patient Flow Improvement Board which in turn reports into the Hospital Improvement Board and the Hospital Management Board. This is the route through which continued assurance of performance and progress will be given.
		a. Alternative to admission	Avoidable admissions with turnaround at front door or within 12 hours under care of specialist teams		
		b. Criteria led discharge	Early discharge planning for admitted patients with agreed permissions for nurse and Allied Health Professionals (AHP) led discharging.		
		c. Proactive escalation planning	Comprehensive treatment plans detailing escalation and ceilings of care including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.		
		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.		
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	Deteriorating Patient Project: 'Correct Pathways of Care'	Workstream 2 of the Recognition and Care of the Deteriorating Patient (RCDP) Programme; Correct Pathways of Care (for key causes of clinical deterioration) will continue to drive the work required to ensure that pathways of care for key causes of clinical deterioration are; up to date, available, clear and used across the organisation.
	EMR Action 2	**Improve compliance with Sepsis 6 Guidelines / Monitor Compliance with Sepsis Pathway**	Improve awareness of Sepsis 6 guidelines and monitor adherence.		
	EMR Action 3	**Establish Pneumonia Pathway**	Review and/or establish a pneumonia pathway to ensure that it meets national guidelines.	Deteriorating Patient Project	

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 14th February 2020
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')	Workstream 4 of the RCDP Programme 'Senior Ownership' will continue to deliver these requirements. The aim of the workstream is for "a consultant to be clearly allocated to each patient. Clear processes to support teams to access senior owner & consistent documentation of senior review."
	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		
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	Documentation' Project Deteriorating Patient Project ('Observations & Documentation')	Documentation and Observations actions are to be delivered through the Trust's 'Documentation' Programme which was relaunched on 7th January, led by the Deputy Director of Nursing for Workforce. 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.
	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		
	EMR Action 6	**Review Nursing and AHP Documentation**	Review nursing and AHP documentation to ensure that it is fit for purpose in focusing and promoting essential care, particularly fluid balance and nutritional needs.		
	EMR Action 7	**Ensure Prescribing is legible, clearly signed and in line with national existing**	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.		
	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.		Workstream 1 of the RCDP Programme is 'Observations and Escalation' which has the aim of "To ensure that observations are taken in line with protocol so that every patient who deteriorates is recognised at the first possible opportunity and is reviewed and treated as quickly as possible in line with documented protocol (in the most appropriate manner for the patient's conditions and comorbidities.)"

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 14th February 2020
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')	Workstream 1 of the RCDP Programme is 'Observations and Escalation' which has the aim of "To ensure that observations are taken in line with protocol so that every patient who deteriorates is recognised at the first possible opportunity and is reviewed and treated as quickly as possible in line with documented protocol (in the most appropriate manner for the patient's conditions and comorbidities.)"
	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		
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.		Workstream 6 of the RCDP Programme; Cross Setting Anticipatory Clinical Management Plan (ACMP) will link into the Older Peoples Care Programme to develop processes and training in order to ensure that individual end of life care plans are commenced promptly and that the care plans are well documented including preferred place of care.
	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')	Workstream 5 of the RCDP Programme; Learning from Deaths will continue to deliver a robust mortality review process with central reporting with a focus of disemination of learning from deaths.
	RCA Action 6	**Mortality & Morbidity Reviews must occur in departments with evidence produced of agreed actions and improvement projects**	Mortality and Morbidity review must occur in departments with evidence produced of agreed actions and improvement projects, as defined by the cases presented. These improvements, generated by clinical teams, must have evidence of review by CBU and senior management to demonstrate openly how change is supported.		

	Origin	Area Requiring Improvement	Recommendation Detail	Programme	Update: 14th February 2020
Specialist Services	RCA Action 7	**Management of Diabetes**	Review and update the trusts policy and approach to the management of inpatient diabetes. Ensure available, clear guidance exists for the management of diabetic emergencies and that appropriate patients are identified and referred to the inpatient diabetic service. Resource and support this service to provide the necessary support to clinical teams	Independent Work	A review of diabetes service for the Trust has now been commissioned with Dr. Kevin Hardy, Endocronologist and ead of Undergraduate Medicine at Edge Hill. The Trust now has a dedicated Diabeties Nurse and two new consultants.
	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	Acute pain management guidance has been produced and is being circulated at ward level. There is no dedicated acute pain service in the Trust.

7.2 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

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	Southport & Ormskirk Improvement Board
Report Date	February 2020

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

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

The RCDP Programme builds on the success of the Trust's Reducing Avoidable Mortality Project (2018/19) which delivered the reduction in 'avoidable mortality'. NHS Digital's Summary Hospital Mortality Indicator (SHMI) in December 2017 was 111.1; by August 2019 this had reduced to 98.07. Dr Foster's Rolling 12 Month Hospital Summary Mortality Indicator for December 2017 for the Trust was 112; by August 2019 it had fallen to 88.3.

The RCDP Programme moves the focus from the reduction of avoidable mortality to proactive recognition and effective care of deteriorating patients, incorporating; National Early Warning Signs (NEWS) within the performance reporting to ensure a focus on recognition and subsequent proactive management of deteriorating patients, and development of a 'Cross Setting Anticipatory Care Management Plan' which will feed into the Older Peoples Care Programme.

Progress during January and early February is summarised below:
- Funding has been confirmed for phase one of the Electronic Ward Boards (EWB). The EWB will provide a tool to document the consultant review of patients outside of standard wards rounds, and will also allow the identification and review of escalation and resus status of patients. Roll out is planned in conjunction with the ward refurbishment schedule.
- A trial of the 'Co-morbidity Summary Record' has commenced on Ward 9a. The tool provides information on patients' previous in-hospital treatment for their conditions and informs clinicians of the patients known medical history. The trial will be evaluated at the end of February and a plan for roll out across further wards will be agreed by the end of March.
- Advancing Quality has commenced a new quality improvement project focussing on hospital acquired pneumonia. A 'Clinical Expert Group' has been established and has agreed a draft set of quality indicators, as part of the correct care pathways work.
- Performance against target for the completion of SJR within 30 days is lower than expected. The main factors leading to the delay are; an increased number of deaths over the winter period, a lack of clinical time for reviewers to undertake the SJRs and an increased trigger rate over the winter months exceeding 30% (expected level between 10%-20%). In mitigation, MOG has agreed to remove UTI from the trigger tool which will reduce the number of SJR referrals by around 10%. In addition a further four ITU reviewers have been recruited, to date one has been trained. The programme lead is also considering how additional reviewers from a range of clinical staff groups can be recruited and trained to undertake SJRs to increase capacity.

Aim and Objectives
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)

Integrated Performance Report KPI's:	Target	Actual	Year to Date Actual	RAG	Trend	Trajectory RAG	Comments
Pneumonia - chest x-ray within 4 hours	100%	80%	86.40%	●	⮟	●	Integrated Performance Report January 2020 (Quality and Safety Committee Dashboard)
Pneumonia - Initial antibiotic therapy	100%	80%	76.90%	●	⮟	●	
Sepsis - timely identification	75%	100%	98.40%	●	⮝	●	
Sepsis - timely treatment	75%	82.80%	78.60%	●	⮝	●	
Percentage fractured NOF operated on within 36 hours of admission	90%	80.80%	74.40%	●	⮟	○	
Venus thromboembolism (VTE) risk assessment all inpatients	95%	96.90%	97.9	●	⮟	●	
Proportion of stroke patients who have 90% of hospital stay on stroke ward	80%	78.80%	72.90%	●	⮝	●	
Percentage of deaths screened	100%	62.70%	66.80%	●	⮟	○	
Summary hospital-level mortality indicator (SHMI)	100	98.1	99.8	●	⮟	○	
Rolling 12 month hospital standardised mortality rate (HSMR)	100	87.1	87.1	●	⮟	○	

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	Metrics from the Integrated Performance Report aligned to the programme. Work stream KPIs are being updated to reflect Q&S Group recommendations.
Timely Observations & Observations Compliance - Ward 9a	01.08.19	29.02.20	A Westwood	10%	Red	Meeting held with Ward 9a and 14b to understand the work that has been undertaken to date and the factors that have contributed towards improvement made being / not being sustained. First process mapping session to be rescheduled from 30/01 (Wuhan Flu Emergency Planning.) Process mapping will be subject to further PDSA ahead of roll out across the wards. (Phasing factored into Programme plan.)
Correct Pathways of Care	01.12.19	30.03.21	C Goddard	Ongoing	Amber	Correct Pathways of Care is the second Project within the programme and continues on from the work undertaken by the Reducing Avoidable Mortality Project. Pneumonia and AKI are current focus with the other key conditions to be phased over the life of the project. The project group was represented on 23rd January at the quarterly AQUA Mortality Community Improvement Event to ensure continued learning and the adoption of best practice. AQ data (compliance to best practice activity by condition) is reported into the Monthly Learning from Death Board Report and will be included in this report going forward.
Coding and Documentation - Comorbidity Alerting Process	01.12.19	29.02.20	R Kinney	10%	Amber	Process evaluation with consultants 07/02 to evaluate comorbidity alerting process on the Short-stay Unit. Best practice to be confirmed and rolled out onto second ward as part of PDSA cycle.

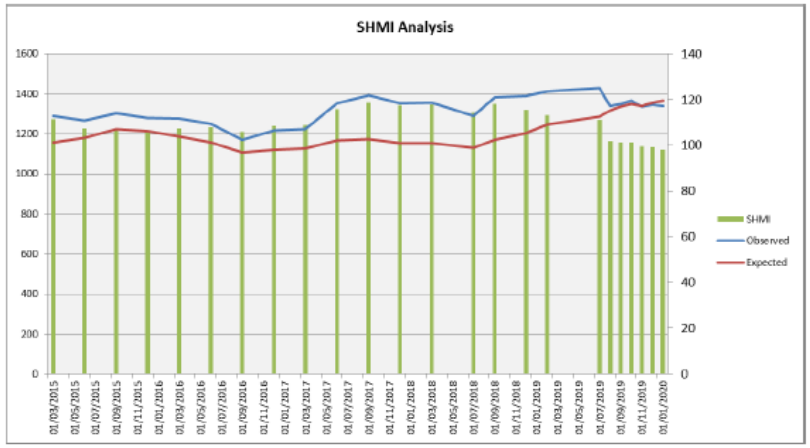
Risks				
Risk	RAG	Mitigating Actions	RAG	Comments
Electronic Ward Boards - IT Development There is a risk that a lack of capacity in the IT department will cause further delays to the roll out of the Electronic Ward Boards	Red	Meeting held in January with the IT Implementation Lead. Confirmed that post has been recruited to, awaiting confirmation of start date.	Amber	Recruitment underway. Work will progress but will be delayed. Delay expected to be between 3 and 6 months. This is being reviewed and further mitigations are booing considered.

Issues			
Issue	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	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
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 developed by the end of February

7.3 Appendix 3: Mortality Monthly Data Report

Analysis

The SHMI, reporting for the period September 2018 to August 2019 is 98.07, this is the lowest the Trust has had in nearly 5 years of reporting and represents a significant drop from a high of 118.69 in Apr-16 to Mar-17 which was reported in September 2017.

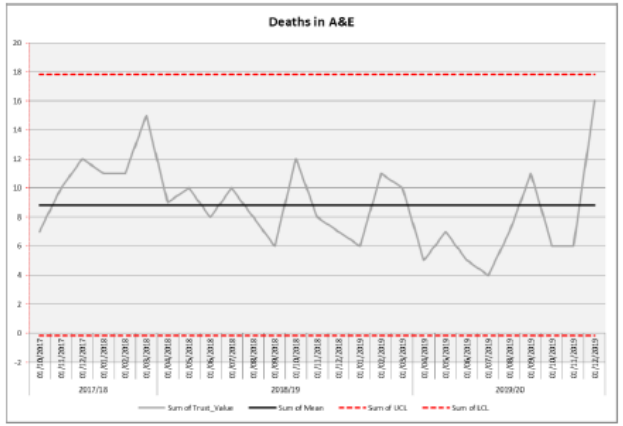


For the first time in reporting there is a significant gap between the number of observed and expected deaths, hence the favourable SHMI position currently being recorded.

The main reporting month is December during which there were 103 in hospital deaths, 16 deaths in A&E and 55 deaths within 30 days of discharge. This is a significant increase to the previous month (174 vs 122). Please note that there may be crossover between A&E deaths and deaths within 30 days of discharge if the patient had a related inpatient spell.

Diagnosis level HSMR shows Acute Renal Failure still showing poor performance with trajectory rising. Although LRTI and Stroke also remain over 100 they are showing a positive declining trend.

Despite an increase in actual number of deaths the crude rate remains around average which is a reflection of the increase in admissions during this time.



Demand on A&E is evident in increasing poor performance for waiting times, there is also a spike in deaths recorded in the department as can be seen on the chart to the left.

December also saw an increase in deaths post discharge following emergency surgery and also with laparotomy. There were 52 deaths with a primary procedure recorded, the most common procedures recorded were diagnostic procedures with most common diagnoses sepsis and pneumonia.

There were 15 emergency FNOF procedures recorded in month, with 2 deaths – both patients were elderly (80+) with comorbidities and died more than a week after discharge.

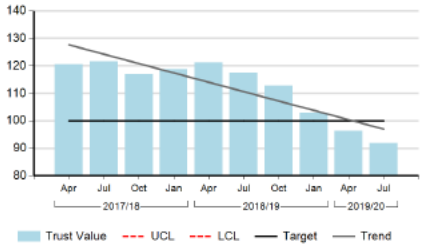
Notable quality indicators show increased sickness rates for nursing and a drop in safe staffing levels in month.

Southport & Ormskirk NHS Trust Deteriorating Patient Dashboard February 2020

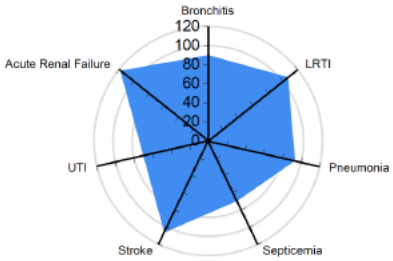
Southport & Ormskirk Hospital NHS Trust

Dr Foster National Mortality Statistics

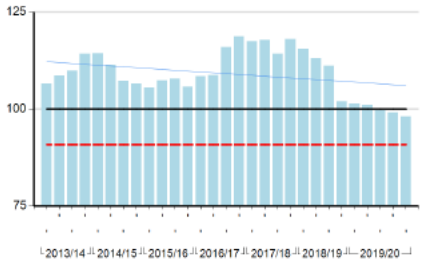
Rolling 12 Month HSMR



Local HSMR September 2019/20

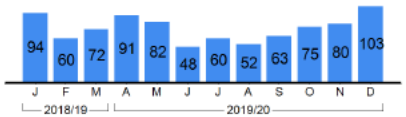


SHMI



Trust Mortality Statistics

In Hospital Deaths



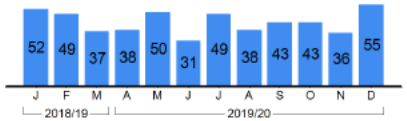
YTD Deaths of Patients with Learning Difficulties: 4

0.61% ▲

YTD Deaths of Patients with GSF Alert: 104

15.9% ▼

Deaths Post Discharge - 30 Days

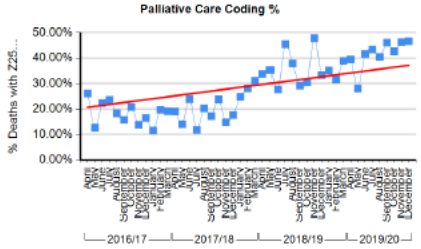


Avg Spell LOS whilst admitted: **15.2**

Avg Days to death post discharge: **11.4**

YTD Deaths of Patients with GSF Alert: 118 **30.8%** ▼

Palliative Care Coding %



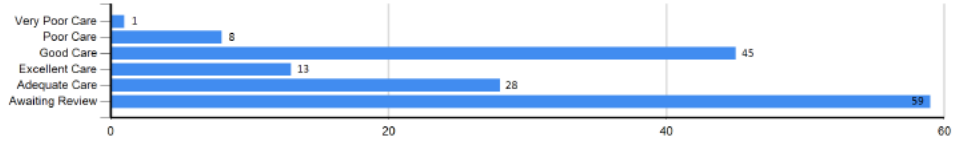
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Sepsis, unspecified	21	▲
Pneumonitis due to food and vomit	9	▼
Lobar pneumonia, unspecified	8	▼
Pneumonia, unspecified	5	▲
Acute renal failure, unspecified	4	▲

Mortality Reviews

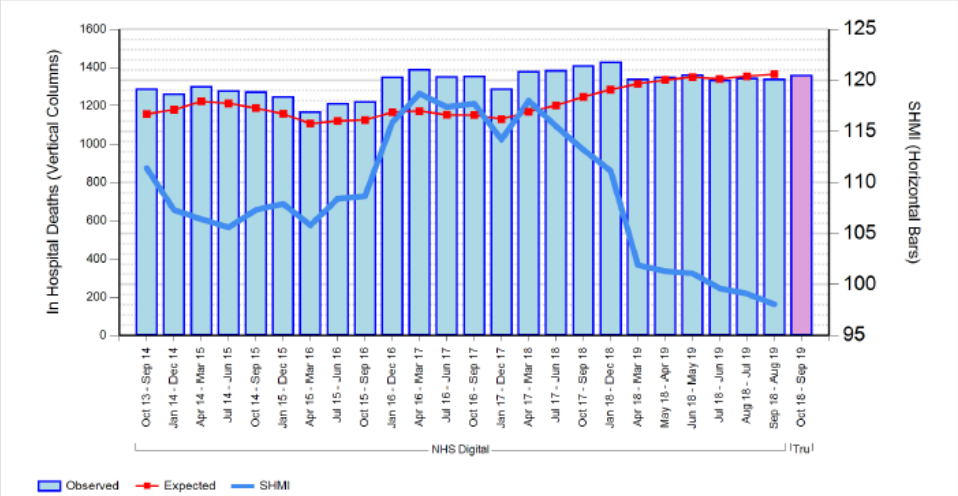
	2018/19			2019/20								
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Screens Completed	60	37	34	32	27	28	53	44	58	68	66	64
Screens %	63.8%	61.7%	47.2%	35.2%	32.9%	58.3%	88.3%	84.6%	92.1%	90.7%	82.5%	62.1%

Overall Assessment Rating Outcomes - Last 12 Months



SHMI Breakdown

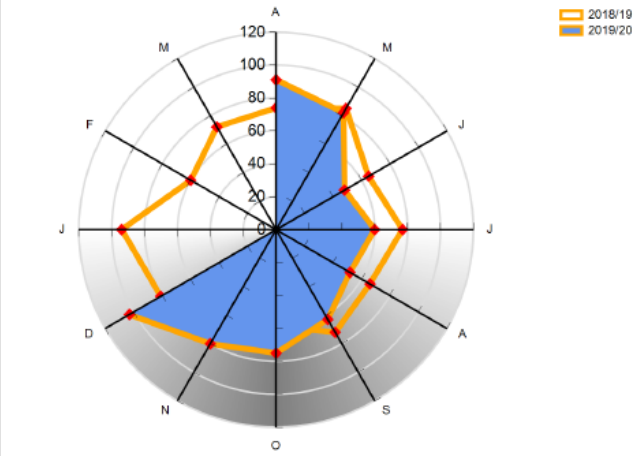
Southport & Ormskirk Hospital NHS Trust



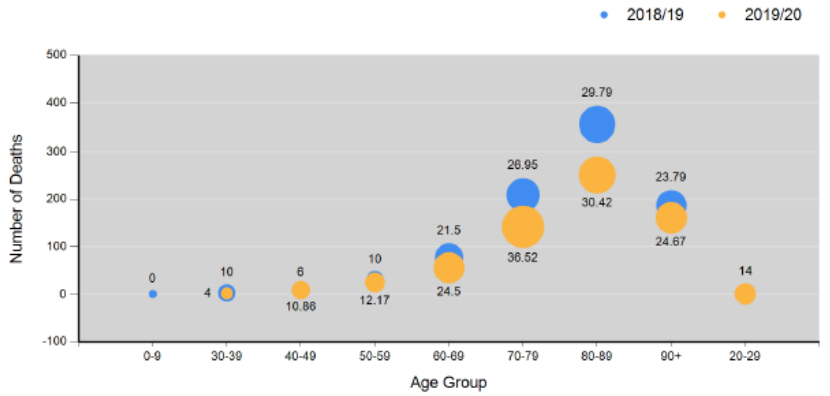
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

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

In Hospital Deaths Seasonality Distribution



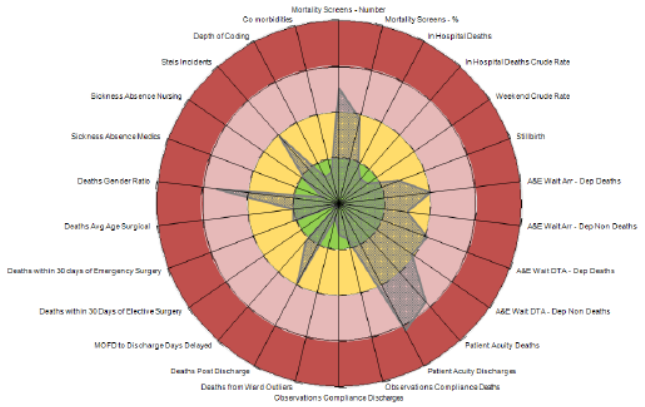
In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



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

7.4 Appendix 4: Peformance Distribution for August and September 2019

Performance Distribution for August 2019/20
HSMR Value in Month: 60.8



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

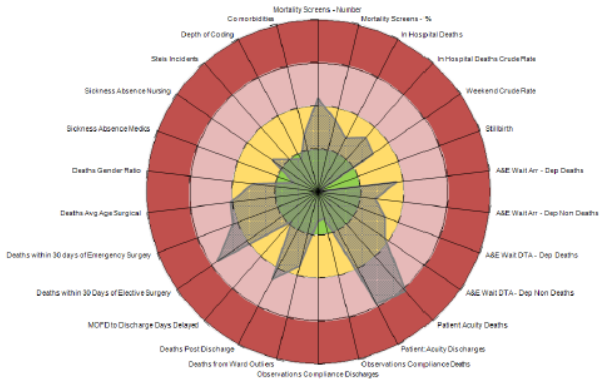
Patient acuity were the most significant indicators this month which are showing a decrease for both those patients who died and those who did not.

The in month HSMR in September was 74 with 63 in hospital deaths, this is 21% more than the previous month.

The most notable factors again this month are the continued drop in acuity which has been linked to an increase in recording—thus lowering the average.

There is also an increase in the number of deaths following elective and emergency surgery however these will not impact the HSMR, only the SHMI.

Performance Distribution for September 2019/20
HSMR Value in Month: 74



Performance Measuring

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

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	**TB026/20d**	**Report Title**	Monthly Safe Nurse & Midwifery Staffing Report- January 2020
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Claire Harrington - Deputy Director of Nursing Carol Fowler- Assistant Director of Nursing Workforce		
Action Required	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

This report presents the safer staffing data for the month of January 2020. 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.

Position:

- For the month of January 2020 the Trust reports safe staffing against the national average (90%) at 90.52% showing an improvement in overall fill rate of 2.01% from December 2019
- Care Hours per Patient Day (CHpPD) reports at 8.1 for January 2020, a slight increase from last month and is above the national average of 7.0
- HCA band 2/3 vacancy for inpatient ward areas is currently 36.20 wte
- Registered Nurse band 5 vacancy trustwide128.17 wte, a decrease from last month
- No harm events are recorded to have occurred to our patients due to staffing levels
- Off framework agency use continues to reduce to minimal levels
- Due to variation in Nurse Fill Rates and CHpDD (Appendix 1) a validation exercise of roster templates is required

Next Steps:

- Recruitment events are planned in for 2020. There are 26.87 wte HCAs and 10.61 wte RNs in the recruitment pipeline for February and March 2020. Some individual ward areas are running additional recruitment campaigns to attract candidates
- A paper to be presented at FP&I and Trust Board proposing an International Nurse Recruitment programme with an aim to reduce high cost agency spend
- A review of nursing establishments is underway with additional focus on roster governance
- The process of authorisation of off framework agency use is currently being reviewed
- A further validation and sign-off process will be introduced to as an assurance process

Recommendations:

- Trust Board to be advised that work is being undertaken to understand the variance in the data between some of the ward areas CHpPD levels and temporary staffing use. It is expected that the format of this report will change as a result of this

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

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

Impact

✓ Compliance	☐ Legal
✓ Engagement and Communication	✓ Quality & Safety
✓ Equality	✓ Risk
✓ Finance	✓ Workforce
Equality Impact Assessment	☐ Policy
	☐ Service Change
	☐ Strategy

Next Steps

Previously Presented at:

☐ Audit Committee	☐ Quality & Safety Committee

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

1. Introduction

This report provides an overview of the staffing levels for January 2020. The report provides assurance that the trust had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nurse staffing.

2. Fill Rate

Definition : The purpose of the nurse staffing fill rate collection and publication is to monitor at a ward and trust board level, the extent to which rota hours are being filled by registered nurses and midwives and unregistered care staff. The key purpose of the collection is to obtain assurance that wards are being safely staffed.

The Trust overall fill rate for January 2020 was **90.52%**
When broken down by shift and role the fill rates are:

- 90.73% Registered Nurses/Midwives (RN/RM) on days
- 84.59% Registered Nurses/Midwives (RN/RM) on nights
- 97.73% Health Care Assistants (HCA) on days
- 89.91% Health Care Assistants (HCA) on nights

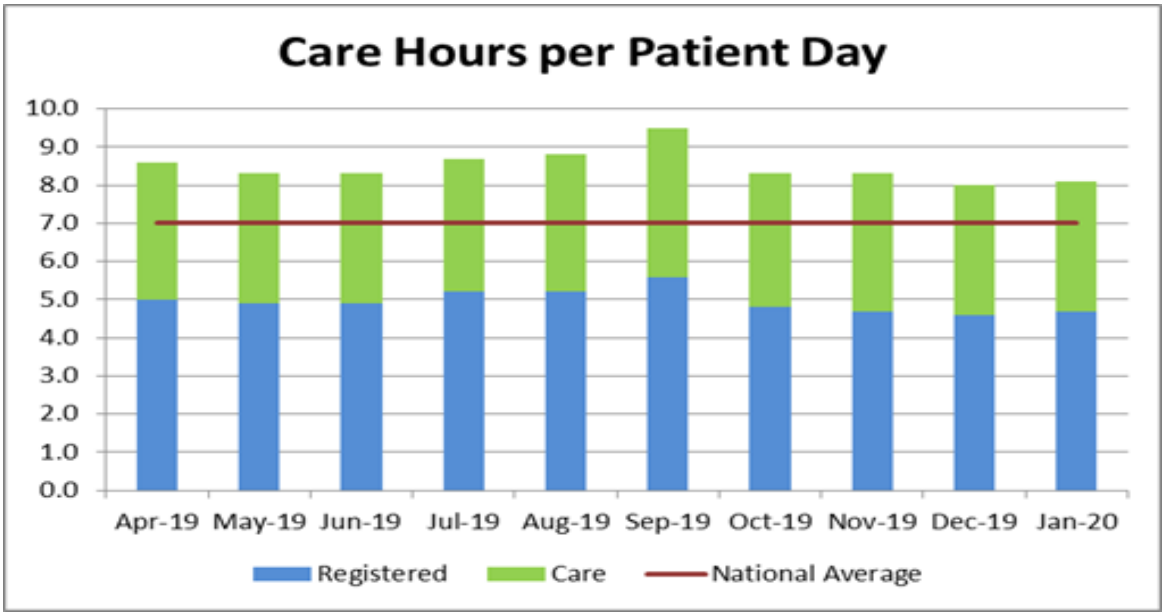
This demonstrates lower fill rates of both RN/RM and HCA on nights however, the overall percentage fill remains within the safe staffing levels of >80% and includes the additional beds opened at Ormskirk. Where area shortfalls in staffing occur, the Heads of Nursing at the staffing huddles held twice daily and the late shift Matron, move staff according to need to ensure a safe level of staffing in each area balanced with patient acuity and skill mix of staff.

3. Care Hours Per Patient Day (CHPPD)

Definition : Care hours per patient day are calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available for each patient on the ward or unit and is used as a benchmark.

Table 2 reports the Trusts Care Hours per Patient Day (CHpPD) at 8.1 for January 2020 remaining slightly above the national average of 7.0. Further individual ward/department CHpPD reporting can be viewed for January 2020 in appendix 1. The Trusts current reporting for CHpPD includes RN/RM and HCA's for all inpatient wards and departments including Critical Care. It is noted that there is a degree of variation between some of the ward areas CHpPD and work is underway to understand the reason for this and findings will be reported next month.

Table 2: *Data excludes AED, ACU & Paediatric AED, includes E ward ODGH from January 2020.*



4. Registered Nurse/Midwife and Health Care Assistant vacancies

Tables 3a/b below report the trusts whole time equivalent (wte) funded establishment versus contracted for January 2020 reported through the finance ledger.

HCA (band2/3) vacancies

The current balance of HCA (band 2 and 3) vacancies Trust wide in January 2020 is 54.88, of which 36.20 vacancies are in ward based areas. There is a pipeline of 26.87 HCAs (band 2 and 3) to commence in Q4 2020 which will result in a balance of 9.33 vacancies. Recruitment activity will continue to fill the remaining gaps and match turnover. The increase of 9.96wte in funded posts in Jan 2020, are due to additional beds opening on H Ward and 2 posts being funded within Paediatrics.

Table 3a- Trust wide band 2/3 HCA vacancies

Band 2/3	Funded wte	Contracted wte	Vacancy
Dec 19	391.09	340.91	50.18
Jan 20	402.01	347.13	54.88

Registered Nurse/Midwife (band 5) Vacancy

The current number of band 5 RN vacancies is 128.17 wte The Board is advised of 10.16 RNs in the pipeline to commence in post in February and March 2020.

Table 3b - Band 5 Registered Nurse vacancy

Band 5	Funded wte	Contracted wte	Vacancy
Dec 19	509.09	375.80	133.29

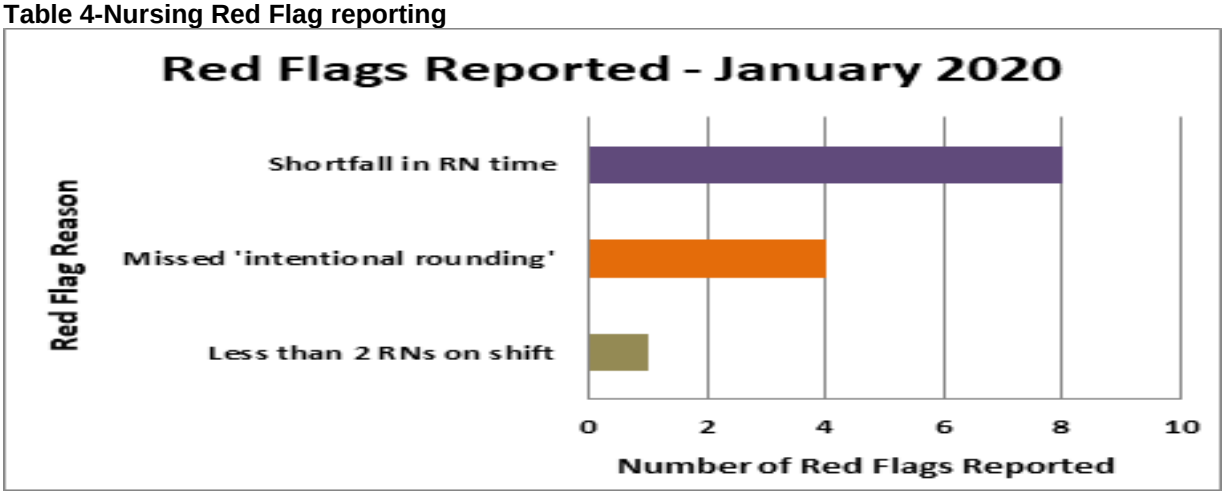
Jan 20	507.53	379.36	128.17

Workforce data demonstrates that since April 2019 – January 2020 there have been an average of 5.17 band 5 starters per month and 4.66 leavers per month. A recruitment event is booked for Saturday 14th March followed by a further event in April 2020. Discussions are underway to consider raising the number of nursing students in training at the Trust with focus on local students in order to increase the future pipeline potential. A business case to roll out International Nursing recruitment has been agreed in principle (Paper to go to Board in March 2020) with the potential of 70 International Nurses coming into the trust over the following 12 months.

5. Red Flag reporting

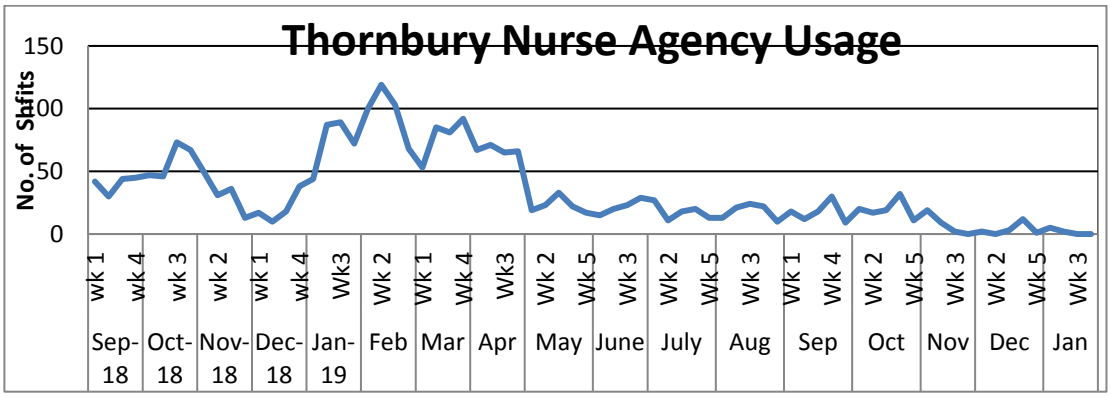
The committee is advised of the 13 red flags reported in January through Safecare and all have been appropriately escalated and managed.

Table 4-Nursing Red Flag reporting



21 incidents related to staffing were reported in January 2020. 12 of these incidents highlight insufficient nurses/midwives or nurse shortfalls. Two of these incidents related to Ward 11B, 2 to Neonatal and none of these incidents resulted in harm to patients

6. 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 further x 3 Tier 1 agencies have be added to the flexible workforce cascade via NHSP in 2020.

Off framework agency use in January 2020 is related to additional escalated bed capacity (x4 night shifts and 2 day shifts). A further 2 night shift requests were to support increase in patient acuity in urgent care. Off framework agency booked in January 2020 totals 81hrs at a cost to date of £7,431.49.

There remains a continued focus to align agency 'block booked' registered nurses to high vacancy areas within general ward areas to further support reducing non framework usage and provide continuity of care for patients. This is further aligned with ongoing review of ward rosters to support improved utilisation of our temporary workforce.

7. Recommendations

The Board is asked to receive this paper and support the on-going plans to achieve and sustain compliance against Safe Staffing Plan.
Trust Board are to be made aware that work is being undertaken to understand the variance in the data between some of the ward areas CHpPD levels and temporary staffing use. It is recommended that the format of this report should change as a result of this.

Carol Fowler
Assistant Director of Nursing – Workforce

Appendix 1: Care Hours per Patient Day (CHPPD) – January 2020

Ward name	Specialty	Registered nurses-Day		Care Staff-Day		Registered nurses-Night		Care Staff-Night		Patients at 23:59 each day	Day		Night		CHPPD	CHPPD	CHPPD
		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 (%)	Registered nurses	Care Staff	Overall
Ward 7A-SDGH	300 - GENERAL MEDICINE	1,470.50	1,434.00	1,566.75	1,247.50	1,090.00	1,217.50	1,246.50	941.50	842	97.52%	79.62%	111.70%	75.53%	3.1	2.6	5.7
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	732.00	731.50	349.00	394.50	729.50	754.50	362.50	326.50	259	99.93%	113.04%	103.43%	90.07%	5.7	2.8	8.5
10A - E A U	300 - GENERAL MEDICINE	1,710.75	1,662.00	1,460.00	1,311.50	1,091.50	1,150.00	1,091.50	1,142.50	577	97.15%	89.83%	105.36%	104.67%	4.9	4.3	9.1
9B - FESS Ward	300 - GENERAL MEDICINE	1,583.05	1,334.38	2,077.50	1,619.00	1,088.50	1,166.50	853.00	797.25	849	84.29%	77.93%	107.17%	93.46%	2.9	2.8	5.8
Ward 11B-SDGH	300 - GENERAL MEDICINE	1,479.25	1,449.06	1,432.00	1,335.73	1,096.50	1,247.00	1,115.00	1,055.00	807	97.96%	93.28%	113.73%	94.62%	3.3	3.0	6.3
Ward 14B-SDGH	300 - GENERAL MEDICINE	1,880.25	1,844.50	1,627.25	1,436.75	1,508.50	1,720.00	1,122.00	859.00	929	98.10%	88.29%	114.02%	76.56%	3.8	2.5	6.3
9A - Short Stay Unit	300 - GENERAL MEDICINE	1,509.73	1,435.71	1,747.00	1,577.00	1,087.00	1,090.50	1,233.00	968.00	877	95.10%	90.27%	100.32%	78.51%	2.9	2.9	5.8
Ward 15a General Med	300 - GENERAL MEDICINE	1,574.25	1,334.42	1,737.75	1,697.08	1,093.50	1,132.00	1,099.00	1,147.50	743	84.77%	97.66%	103.52%	104.41%	3.3	3.8	7.1
15B - Stroke Ward	300 - GENERAL MEDICINE	1,270.25	1,329.75	1,567.00	1,339.25	1,090.00	1,119.50	738.50	727.00	579	104.68%	85.47%	102.71%	98.44%	4.2	3.6	7.8
7B - Rehab	314 - REHABILITATION	1,586.75	1,493.65	1,993.25	2,115.50	1,091.50	1,154.50	1,083.50	1,077.50	823	94.13%	106.13%	105.77%	99.45%	3.2	3.9	7.1
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	1,977.22	1,755.22	2,497.25	2,092.50	1,114.17	1,142.67	1,511.00	1,391.50	890	88.77%	83.79%	102.56%	92.09%	3.3	3.9	7.2
10B - Short Stay Surgical Unit	100 - GENERAL SURGERY	1,239.25	1,174.00	1,501.50	1,219.00	748.50	751.00	368.50	369.50	447	94.73%	81.19%	100.33%	100.27%	4.3	3.6	7.9
Ward H	110 - TRAUMA & ORTHOPAEDICS	1,080.00	836.75	1,109.00	632.50	739.00	584.00	755.50	544.50	297	77.48%	57.03%	79.03%	72.07%	4.8	4.0	8.7
11A - Surgical Ward	100 - GENERAL SURGERY	1,136.00	1,058.75	1,143.00	993.00	741.50	791.00	365.50	449.00	521	93.20%	86.88%	106.68%	122.85%	3.6	2.8	6.3
Spinal Injuries Unit	400 - NEUROLOGY	3,524.58	3,149.42	3,500.67	3,176.58	2,905.75	2,668.25	1,493.00	1,413.50	1,091	89.36%	90.74%	91.83%	94.68%	5.3	4.2	9.5
Ward G	100 - GENERAL SURGERY	740.00	466.50	743.50	291.00	742.50	541.50	34.50	164.00	87	63.04%	39.14%	72.93%	475.36%	11.6	5.2	16.8
Ward E	502 - GYNAECOLOGY	1,028.00	832.50	1,076.50	711.00	737.50	773.50	369.00	357.00	177	80.98%	66.05%	104.88%	96.75%	9.1	6.0	15.1
ITU/CCU	192 - CRITICAL CARE MEDICINE	3,829.23	3,040.57	1,156.50	1,036.50	3,712.00	3,005.00	1,109.50	509.50	387	79.40%	89.62%	80.95%	45.92%	15.6	4.0	19.6
Maternity Ward	501 - OBSTETRICS	3,692.25	3,387.00	1,354.00	961.00	637.75	630.75	1,106.50	1,071.50	520	91.73%	70.97%	98.90%	96.84%	7.7	3.9	11.6
Neonatal Ward - ODGH	420 - PAEDIATRICS	1,109.25	1,129.50	360.00	234.75	1,148.25	1,126.25	12.00	12.00	229	101.83%	65.21%	98.08%	100.00%	9.9	1.1	10.9
Paediatric Unit	420 - PAEDIATRICS	1,574.00	1,536.00	789.00	622.50	1,487.00	1,332.50	587.50	551.50	381	97.59%	78.90%	89.61%	93.87%	7.5	3.1	10.6
TOTAL		**35,726.57**	**32,415.18**	**30,788.42**	**26,044.15**	**25,680.42**	**25,098.42**	**17,657.00**	**15,875.25**	**12,312**	**90.73%**	**84.59%**	**97.73%**	**89.91%**	**4.7**	**3.4**	**8.1**

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
		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		4,247.98	4,604.23	2,644.00	1,927.25	3,646.50	3,842.33	1,107.50	760.00	0	108.39%	72.89%	105.37%	68.62%			
Ambulatory Care Unit		740.50	396.50	723.25	491.17	0.00	360.00	0.00	49.00	119	53.54%	67.91%	0.00%	0.00%			
Paediatric A&E		985.50	1,135.75	0.00	0.00	1,028.00	1,040.00	0.00	0.00	0	115.25%	0.00%	101.17%	0.00%			
TOTAL		**5,973.98**	**6,136.48**	**3,367.25**	**2,418.42**	**4,674.50**	**5,242.33**	**1,107.50**	**809.00**	**119**	**102.72%**	**71.82%**	**112.15%**	**73.05%**	**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
		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 (%)			
PLANNED		14,554.28	12,313.71	12,727.92	10,152.08	11,440.92	10,256.92	6,006.50	5,198.50	3,897	84.61%	79.76%	89.65%	86.55%	5.8	3.9	9.7
URGENT		14,796.78	14,048.97	15,557.50	14,073.81	10,966.50	11,752.00	9,944.50	9,041.75	7285	94.95%	90.46%	107.16%	90.92%	3.5	3.2	6.7
W&C		6,375.50	6,052.50	2,503.00	1,818.25	3,273.00	3,089.50	1,706.00	1,635.00	1,130	94.93%	72.64%	94.39%	95.84%	8.1	3.1	11.1
TRUST TOTALS		**35,726.57**	**32,415.18**	**30,788.42**	**26,044.15**	**25,680.42**	**25,098.42**	**17,657.00**	**15,875.25**	**12,312**	**90.73%**	**84.59%**	**97.73%**	**89.91%**	**4.7**	**3.4**	**8.1**

Green- 80% and above
Red- Under 80%

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 MARCH 2020

Agenda Item	**TB026/20e**	**Report Title**	**CQC UPDATE**
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ 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.

Of the 31 'Must Do' regulatory actions, four have been completed (Green), 25 are on track to deliver (Amber) and two are not progressing to plan (Red). The report outlines the measures being taken to deliver the actions and how the Trust will demonstrate the changes have been embedded and sustained and for the actions not progressing to plan, what mitigation has been put in place to ensure patient safety.

The CQC Improvement Plan at Appendix A outlines actions to be taken, measures / evidence and timescales for delivery for each 'Must Do' action, Appendix B describes the assurance and monitoring arrangements for the improvement plan, along with a 2020 schedule for Quality Assurance Panels and SO Proud Visits.

Progress against the 'Should Do's' will be reported to Board on a quarterly basis, the first report will be presented to Board in April 2020 and will follow the same assurance. Monitoring and reporting process.

Recommendation

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)

	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

✓ 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

The Board are 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 March 2020

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 and was rated as Required Improvement (RI).This report also outlines the assurance processes going forward to ensure a continuous cycle of sustainable improvement.

2. EXECUTIVE SUMMARY

There were 31 identified 'must do' actions relating to beaches of regulation and 92 actions the CQC recommend we 'should do' as considerations to further support compliance. Appendix A includes the latest Must Do action plan and detail to date. Progress against the full action plan including the Should Do's will be reported to Board on a quarterly basis, the first report will be presented to Board in April 2020. Appendix B provides an overview of the assurance and monitoring arrangements for the CQC Quality Improvement Plan.

Trust Must Do BRAG ratings

Rating	Must Do
Delivered and Sustained	0
Action Completed	4
On Track to Deliver	25
No Progress / Not Progressing to Plan	2
Total	31

There were a total of 9 "must do" actions that were due for completion in entirety in February 2020. Of these 4 have been completed and signed off which are:

Action Completed

- 03(2019) - **The Trust must ensure that resuscitation trolleys contain the right equipment, which is in date and checked thoroughly and regularly according to trust policy:** The new electronic checklist 'My Kit Check' includes missed checks, missing items and expired items, since December 2019 overall compliance is over 90% any non-compliance or missed checks are actioned immediately on the day taking overall compliance back to 100%

- 49(2019) - **The Trust must ensure that substances that are hazardous to health are locked away safely. It must ensure it acts on patient safety alerts to securely store superabsorbent polymer gel granules:** COSHH cupboards in place for every ward and clinical area across both sites, monthly spot checks by the Health and Safety Team across the Trust to ensure COSHH related substances are being stored securely and are not accessible to vulnerable patients. The last audit was completed January 2020 showing varying compliance the Health & Safety Manager is providing refresher training as part of the Health & Safety programme.
- 51(2019) - **The Trust must ensure that all staff use appropriate infection prevention and control measures, in line with trust policy, especially when providing care and treatment to patients with identified infections in side rooms:** New IPC signage has been installed across both sites, monthly compliance audits are in place, the last audit demonstrated continued improvement in compliance - 47 of the side rooms were appropriately used with door closed and right sign in place, however two were not and 41 were not applicable, this is a 95.6% compliance rate.
- 51(2019) - **The Trust must ensure that all safety checks are completed in theatre in line with national guidance:** WHO Checklist January 2020- Compliance with the WHO observational audit is 100%. The documentation audit compliance is 93% at SDGH and 96% at ODGH (95% overall).

Of the remaining six actions, four are on track for completion end of February 2020. These are:

On Track to Deliver

- 41 & 87 (2019) - **The Trust must ensure patient records are stored securely in all areas (Medicine and Trust wide)** – Order placed for new locks and trolleys for non-compliant wards and clinical areas. Integrated Governance (IG) Team continue to complete monthly compliance audits, the January 2020 audits have demonstrated a small improvement primarily due to ward refurbishment and medical records being held in the Multi Disciplinary Team (MDT) rooms. The IG Team continue to work with staff in the wards and clinical areas to promote the importance of IG compliance. IG mandatory training compliance is green at 89%, all three CBUs are above target IG training compliance.
- 111 (2019) - **The Trust must ensure that emergency equipment is checked regularly, recorded accurately and replaced appropriately, in line with trust policy. (Accident and Emergency).** Electronic resuscitation checks are in place and compliant, but is being extended to other trolleys in ED so will be signed off once complete.
- 39 (2019) - **The Trust must ensure that patients' privacy and dignity is maintained at all times (Medicine).** A "SO Proud" visit in relation to 'privacy and dignity' is taking place in March 2020 for all Medicine Core Service wards and clinical areas. Six out of the 11 wards and clinical areas have had their SONNAS reviews. In person centred care (Care standard 11) related to privacy and dignity, all wards have scored silver or higher with the exception of ward 9b. There have not been any complaints in relation to privacy and dignity within the medicine core service.

The two actions overdue for original completion in January 2020, relate to the core service of Children's and Young people. Timeframes are in discussion in the Trust related to these must do actions as whilst there is assurance in place regarding an audit programme to mitigate risk, further plans need to be considered against the long-term plans for Paediatric medical staffing. Therefore these will not be delivered against the original timescale. These are:

Not Progressing to Plan

- 01 (2019) - **The Trust must ensure that every child is seen by a consultant paediatrician within 14 hours.**
- 07 (2019) - **The Trust must ensure that there are enough medical staff to meet the needs of the service, particularly at consultant level.**

The Core Service is still awaiting feedback on whether approval has been given to progress with a Statement of Case for additional consultant paediatricians. An audit of any children not seen within 14 hrs has been completed and has found no harms have occurred. No Serious Incidents (SIs) have been reported in January or February 2020.

Compliance Actions Due February – April 2020 and Confidence against Plans

The final action-plan submitted to regulatory bodies has been BRAG rated and reviewed January 2020. Within this all ongoing actions have demonstrated assurance and progress against plan; however three must do regulatory actions for completion dates have been modified.

The first is related Oxygen administration audit which is due to a delay in the audit programme which is planned for March 2020 rather than February 2020. The further two regulatory actions where dates have been modified relate to Mental Capacity assessments and training. An initial review of work to be undertaken has established that original timescales set in December 2019 were unrealistic.

3. RECOMMENDATIONS & NEXT STEPS

The Board are 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

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Lead
01 (2019)	Children & Young People	Regulation 12(2)(a)	Must Do	Safe	The trust must ensure that every child is seen by a consultant paediatrician within 14 hours	●Review supporting workforce to understand options regarding service delivery, report findings to inform business planning cycle ●Monthly audit of clinical records to assure children not seen in timeframe are not compromised ●Review number of incidents	●Statement of case completed including QIA ●Annual business cycle ●Monthly Audit completed and presented at CBU Governance forums ●Reduction in number of incidents	● Feb 2020		MD
03 (2019)	Children & Young People	Regulations 12(1)(2)(e); 17(2)(b)	Must Do	Safe	The trust must ensure that resuscitation trolleys contain the right equipment, which is in date and checked thoroughly and regularly according to trust policy	● Electronic resus trolley checks in place and can be accessed at any time and audited monthly, results discussed at daily huddle	● Compliance reports and alerts from electronic checklist ● Monthly audits	●Jan-20 - completed		DON
11 (2019)	Children & Young People	Regulation 18(2)(a)	Must Do	Safe	The trust must ensure that all staff members attend mandatory training, and that compliance for resuscitation training is improved, particularly for medical staff.	● Ascertain compliance for both medical and nursing staff in individual areas - targeting levels of low compliance immediately ● Set trajectories with key leads to improve compliance ●TNAs to be reviewed to ensure staff are aligned to the correct level of training (to be completed by the resuscitation team). ● Additional training dates to be made available for Jan / Feb-20.	●Mandatory Training Compliance targets achieved ● Reports showing compliance against all levels of resuscitation training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance. ● Discussed through appraisal meetings	●Apr-20		HROD
16 (2019)	Children & Young People	Regulation 18(1)	Must Do	Safe	The trust must ensure that there are enough medical staff to meet the needs of the service, particularly at consultant level.	●Recruit into Consultant Paediatrician for Community ● Review supporting workforce to understand options regarding service delivery, report findings to inform business planning cycle ● Monthly audit of clinical records to assure children not seen in timeframe are not compromised ● Review number of incidents	● Undertaken review of SLA ● Recruitment for Consultant Paediatrician for Community underway - discuss in April panel ● Statement of case completed including QIA ● Annual business cycle	● Feb-20 ● Feb-20		MD
39 (2019)	Medicine	Regulation 10 (2)(a)	Must Do	Caring	The trust must ensure that patients' privacy and dignity is maintained at all times.	● Immediate Action taken at the time as outlined in Letter Dated 3rd September 2019 Ongoing Assurance measures ● Rollout SONAAS accreditation Scheme across all adult inpatient areas ● SONAAS action plans to be implemented and monitored. ● Peer review of Patient experience at the organisation to evaluate level of corroboration of intelligence to demonstrate continual improvement ●Related ongoing National and Local survey results to be actioned. ●#endpjparalysis education to patients and families to provide patients own clothes.	Over-all Measure of Success Intelligence will be corroborated and reported from a number of sources (e.g. below) to evaluate Privacy and Dignity as part of Patient Experience Strategy for the Trust ● complaints and themes ● PLACE Audit ● Inpatient Survey Results ● Friends and Family Test	● SONAAS Accreditation Rollout by Mar-20 ● NHS Leadership Patient Experience Lead 1 day a week commencing Jan-20 ● Evaluation of Patient Experience at the Trust Feb-20 ● Go see visits to be agreed and		DON
41 (2019)	Medicine	Regulation 17 (2)(C.)	Must Do	Safe	The trust must ensure patient records are stored securely in all areas.	● Complete audit of Record trolleys in all clinical areas ● Action any findings through procurement to replace any records trolleys that are not fit for purpose ● Ongoing Audit programme to provide assurance ● SOP to be created in conjunction with medical records, ward staff and matrons concerning the correct use and storage of patient information.	● Audit completion of records trolleys ● Develop business case for any replacement trolleys ● Audit of Compliance reported to information Governance	● Dec 19 audit completed ● Feb 20 ● Order Feb 20 ● Audits reported bi-monthly to Information Governance Steering Group - next due Feb - 20		DF
42 (2019)	Medicine	Regulation 17 (2)(C.)	Must Do	Effective	The trust must ensure care and treatment of patients is provided with their consent. They must ensure when patients lack capacity to consent staff complete a capacity assessment in line with legislation, especially when using do not attempt resuscitation orders.	●Safeguarding training to be delivered to all AHP/Nurses/doctors regarding capacity. ●Review TNA ensure all identified staff complete the blended learning mental capacity training (MCA) ●CBUs to monitor their (MCA) training compliance at Governance meetings ● If compliance not achieved the CBU provides assurance of improving compliance and a trajectory to the Safeguarding Assurance Board ●Safeguarding team to ensure that mental capacity training is included in other relevant training programmes ●Awareness sessions regarding DNACPR and capacity to be undertaken for medics	●Achievement and sustaining the 90% compliance for MCA training ● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees	●Apr-20 for training actions		DON / MD
44 (2019)	Medicine	Regulation 17 (2)(a)	Must Do	Well Led	The trust must ensure local governance process address areas of poor practice.	● Complaints to be completed within the 40 day timescale ● RCA's will be completed within the 60 day timescale ● Learning from complaints and RCA's will be shared with areas ● Audits to measure changes in practice will be implemented ● RCA's to be completed within 60 day deadline ● Review of governance structure and accountability within CBU	● Complaint Timescales reporting ● Evidence of Audit reporting and actions within CBU Governance Arrangements ● RCA's with timescales reporting delivered within 60 day timescale ● Governance restructure options in place underpinned by an accountability framework	● Complaint 40 day timescale June-20 ● RCAs compliant by June-20 ●Learning from complaints(to follow straight after complaint response) June-20		DON

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Lead
45 (2019)	Medicine	Regulation 17 (2)(a)(b)	Must Do	Well Led	The trust must ensure it has effective systems to manage risk and performance. It must ensure actions are taken to mitigate against known risks and audits of service performance are consistent and provide relevant information to improve services.	● Put additional support in place to streamline processes to ensure there are effective governance systems in place relating to :- * risk registers (mitigation of risks, gaps in controls) * weekly patient safety meetings to discuss Incidents, complaints * Review of daily, weekly and monthly ward checklists * Improve the performance management system in relation to the ward checklists *Improve attendance at Mortality and Morbidity meetings ● Appraise the market for real-time audit and performance checklists to improve consistency and	● Additional Resource will be in place ● Metrics related to risk and performance will reach the required standard included in Must do related to complaints. In addition :- * risk registers (mitigation of risks, gaps in controls) * weekly patient safety meetings to discuss Incidents, complaints * Review of daily, weekly and monthly ward checklists	● Additional Support Feb-20 ● Metrics Mar-20 ● Effective Systems Mar-20		DON
49 (2019)	Medicine	Regulation 12 (2)(b)	Must Do	Safe	The trust must ensure that substances that are hazardous to health are locked away safely. It must ensure it acts on patient safety alerts to securely store superabsorbent polymer gel granules.	● COSHH cupboards ordered and fitted in all wards and clinical areas ● COSHH files including alerts to be held in wards and clinical areas ● Re-circulation of PSA 2017 003 related to ingestion of Polymar gel granules ● COSHH assessors in place for each ward ● Provide bespoke training for COSHH assessors ● Audit programme of COSHH Inspections by designated H&S Officer ● Complete risk assessment for all wards and clinical areas ● Produce a Trust Wide COSHH database with Manufacturers Safety Data Sheets (SDS) and completed	● COSHH cupboard in place ● Files availability assessed a part of H&S monthly audit ● Circulation evidenced via communication tools used ● Assessors named for each ward/department ● Audit results presented as part of audit cycle ● Completed Risk assessments evaluated by designated trust H&S lead	● Nov 2019 - complete ● Feb 20 ● Dec 19 - complete ● Jan 20 - complete		DCEO
51 (2019)	Medicine	Regulation 12 (2)(h)	Must Do	Safe	The trust must ensure that all staff use appropriate infection prevention and control measures, in line with trust policy, especially when providing care and treatment to patients with identified infections in side rooms.	● Immediate actions taken (see letter dated 3rd September 2019) ●Signage to be bought for Southport Site ●Three monthly audits in place - reported as part of the IPC monthly report ● Audit reporting to be embedded into IPC governance process ● Signage to be bought for Ormskirk Site	●Signage in place ●Audits in place and being reported monthly ●IPC and audit programme ●Signage in place	● Sep 19 - complete ● Jul 19 - complete ● Dec 19 - complete ● Feb 20 ● Feb 20		MD
53 (2019)	Medicine	Regulation 13 (6)(d)(7)(b)	Must Do	Effective	The trust must ensure staff complete a capacity assessment before depriving patients of their liberty and ensure they do not restrict patient's liberty of movement without legal authority.	● Safeguarding training to be delivered to all eligible AHP/Nurses/doctors regarding capacity and DoLs ● All relevant staff, as per the trusts TNA, to complete the blended learning mental capacity training ● Each CBU to monitor their training compliance ● When compliance not achieved the CBU provides assurance of improving compliance and a trajectory at the Safeguarding Assurance Board	● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees	● Feb 20 ● Apr 20 ● Feb 20		DON
62 (2019)	Medicine	Regulation 18 (2)(C.)	Must Do	Safe	The trust must deploy sufficient nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.	● Daily staffing to be reviewed by HoN and matrons to ensure staffing is safe ● Weekend staffing review to be undertaken on Friday matron cover over the weekend to support safe staffing ● Corporate nursing to complete 6 monthly staffing review of areas to ensure patient dependency matches the establishment ● Staff to compete datix where short falls in staffing are happening ● Develop a long term nursing workforce plan (including overseas and Home Grown initiatives)	● Staffing templates to be completed weekend matron rota ● Safer Nursing Care Tool review six months	● Aug-19 ● May-20		DON
72 (2019)	Surgery	Regulation 12	Must Do	Effective	The trust must ensure that all safety checks are completed in theatre in line with national guidance.	●Continue to review WHO audit compliance ●Identify areas for improvement, share good practice ● Relevant action from the audits to be embedded in practice.	●Increase WHO audit compliance to 100% ● Spot checks to be conducted by Matron	● Mar 20		DON
75 (2019)	Surgery	Regulation 17(2)(C.)	Must Do	Effective	The trust must ensure that all staff can complete documentation for Mental Capacity Act Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately.	●Safeguarding training to be delivered to all AHP/Nurses/doctors regarding capacity. ●Review TNA ensure all identified staff complete the blended learning mental capacity training (MCA) ●CBUs to monitor their (MCA) training compliance at Governance meetings ● If compliance not achieved the CBU provides assurance of improving compliance and a trajectory to the Safeguarding Assurance Board ●Safeguarding team to ensure that mental capacity training is included in other relevant training programmes ●Awareness sessions regarding DNACPR and capacity to be undertaken for medics	● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees	●Apr-20 for training actions		DON
78 (2019)	Surgery	Regulation 12(2)(C.)	Must Do	Safe	The trust must ensure that all staff completes mandatory training requirements.	● Ascertain compliance for all staff in individual areas - targeting levels of low compliance immediately ● Set trajectories with key leads to improve compliance ●TNAs to be reviewed to ensure staff are aligned to the correct level of training.	●Mandatory Training Compliance targets achieved ● Reports showing compliance against all levels of Mandatory Training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance.	●Apr-20		HROD

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Lead
79 (2019)	Surgery	Regulation 12(2)(C.)	Must Do	Safe	The trust must ensure that theatre staff, supporting the urgent and emergency department are trained to support paediatric patients.	● TNA to be completed ●Training dates to be circulated and all staff to be booked on the training based on their individual TNA. ●Trajectory for staff to be trained in Paediatric Life Support.	●Training Compliance targets achieved ● Reports showing compliance against paediatric levels of resuscitation training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance.	●Apr-20		DON
81 (2019)	Surgery	Regulation 12 (2)(g)	Must Do	Safe	The trust must ensure that oxygen is prescribed and administered appropriately.	● Oxygen Audit to be completed and action plan to be developed and reported to Clinical Audit Group and incorporated into Medicines Management Quality Improvement Plan	● All Oxygen unless given in an emergency is prescribed on the prescription charts. ● All Oxygen is administered correctly as assessed by??	●Mar-20 - Audit to be completed ●Jun -20 -Re Audit / improvement		MD
86 (2019)	Trust Wide	Regulation 17(2)(C.)	Must Do	Effective	The trust must improve its record keeping in relation to 'Do Not Attempt Cardio-pulmonary Resuscitation' orders and capacity assessments.	●Review TNA ensure all identified staff complete the blended learning mental capacity training (MCA) ●CBUs to monitor their (MCA) training compliance at Governance meetings ●Awareness sessions regarding DNACPR and capacity to be undertaken for medics	●Achievement and sustaining the 90% compliance for MCA training ● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees	●Feb-20 ●Feb- 20		MD
87 (2019)	Trust Wide	Regulation 17(2)(d)	Must Do	Safe	The trust must ensure that records are securely stored.	● Audit completion of records trolleys ● Develop business case for any replacement parts eg locks so that kit is fit for purpose ● Audit of Compliance reported to information Governance	● Completed Audit ● Completion of business case for replacement parts eg locks so that kit is fit for purpose ●Improved compliance with bi-monthly trolley audits	● Dec 19 audit completed ● Feb 20 ● Order Feb 20 ● Audits reported bi-monthly to Information Governance Steering Group - next due Feb - 20		DF
90 (2019)	Trust Wide	Regulation 17(2)(a)	Must Do	Effective	The trust must ensure that all policies are reviewed in a timely way.	● A change of process is underway which will include transferring policy management to the Associate Director of Corporate Governance (ADCG) ● Undertake a review of the: a. Policy ratification process b. PRG composition and ToRs c. Overall management of policies ● Develop new reporting process by the Assistant to the ADCG who start with the Trust in mid Jan 20.	● Robust monitoring assurance process in relation to policies ● No out of date policies	●Apr-20		COSEC
96 (2019)	Trust Wide	Regulations 17(2)(d);18(2)(a)	Must Do	Safe	The trust must ensure that staff are competent for their roles and that competency records are maintained for staff.	● Developed a robust system and process to monitor and report staff competencies ● Establish mandatory training task and finish group ● Ascertain compliance for all staff in individual areas - targeting levels of low compliance immediately ● Set trajectories with key leads to improve compliance ●TNAs to be reviewed to ensure staff are aligned to the correct level of training.	● Effective monitoring process in place for staff competencies ●Mandatory Training Compliance targets achieved ● Reports showing compliance against all levels of Mandatory Training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance.	●Jun-20		HROD
110 (2019)	Urgent & Emergency Care	Regulation 12 (2)(b)	Must Do	Safe	The trust must ensure that the risks to the health and safety of service users are assessed and that all is done to mitigate any such risks.	● Audit of patient risk assessment documentation ● Staff training and awareness sessions regarding completing risk assessments	● Completion of monthly audits ● Spotchecks by Matron ● Staff awareness sessions / training at daily huddles ● Review of current documentation	● Jan 20 (monthly) ● Mar 20 ● Apr 20		DON
111 (2019)	Urgent & Emergency Care	Regulation 12 (2)	Must Do	Safe	The trust must ensure that emergency equipment is checked regularly, recorded accurately and replaced appropriately, in line with trust policy.	● Electronic resus trolley checks in place and can be accessed at any time and audited monthly ● Results discussed at daily huddle ● New lockable equipment trolleys at bedside in resus bays, each has a daily checklist which will be made electronic going forward	● Compliance reports and alerts from electronic checklist ● Monthly audits	● Feb 20		DON

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Lead
56 (2019) 80 (2019) 82 (2019) 98 (2019) 99 (2019) 100(2019) 101 (2019)	● Medicine ● Surgery ● Surgery ● Trust Wide ● Trust Wide ● Trust Wide ● Trust Wide	●Regulation 12 (2)(g)	Must Do	Safe Well Led	**Must Do's in relation to Medicines Management** ● The trust must ensure the proper and safe management of medicines. The trust must ensure all medications are within their expiry dates. They must ensure controlled drugs are prescribed and supplied to patients in adherence with the legal requirements. ●The trust must ensure that medicines, including controlled drugs, are stored, prescribed, administered, recorded and disposed of according to national guidance. ●The trust must ensure staff respond appropriately to fridge and environmental temperatures outside of accepted safe ranges. ●The trust must address the Hospital Pharmacy Transformation Plan (HPTP) in a timely way. ●The trust must become compliant with the Falsification of Medicines Directive (FMD) ●The trust must ensure the correct processes are followed for the management of controlled drugs. ●The trust must produce a clearer vision for medicines optimisation across the trust and resolve immediate medicines optimisation issues identified during our inspection.	**Delivery of the Medicines Management Quality Priority which include** ● **Safe and Secure Medicines:** To ensure the safe and secured management of medicines in order to deliver patient requirements and meet legislation. ●**Controlled Drugs:** To ensure the safe and secure Management of Controlled Drugs in order to deliver patient requirements and meet **legislation.** ●**Workforce:** To develop a structured and empowered team with clear roles and responsibilities who deliver patient and legislative requirements seven days a week. ●**Governance & Leadership:** To develop a robust governance and leadership framework to ensure the effective and efficient delivery of medicines management. ●**Governance & Leadership:** To develop a robust governance and leadership framework to ensure the effective and efficient delivery of medicines management. ●**CQC Assurance**: To provide the required assurance through reporting that all CQC recommendations are being acted upon and to ensure that they are delivered as a priority as part of the programme schedule. (CQC Must Do and Should Do requirements fall across the 8 Project areas of the Programme.) ●**Electronic Prescribing and Medicines Administration System (EPMA):** To modernise the Pharmacy Service through information technology to improve medicines management and patient care. ●**Automated Ward Drugs Storage Systems** To modernise medicines optimisation at ward level reducing risk of medicines administration errors, reduce missed doses of medicines and increase accountability of stock. ●**Automated Pharmacy System to support the delivery of the Falsification of Medicines Directive** To replace and maintain the standards of dispensing practice by replacing old technology with more advanced solutions that also provide compliance with FMD. ●**Centralised Temperature Monitoring System** To modernise clinical area storage and provide assurance that medicines in clinical areas are stored correctly to provide optimised care for our patients.	●Various KPIs and outcome measures are included as part of the Medicines Management Priority ● Develop sustainability plan to over see embedding of improvements	● Immediate Action Plan Complete - Jul-19 ● 30 Day Action Plan Complete - Aug-19 ● 3 month Action Plan - completed Oct-19 ● 9 month Action Plan - April-20 ● Develop sustainability Plan - Sept 20		MD

ASSURANCE AND MONITORING ARRANGEMENTS FOR CQC QUALITY IMPROVEMENT PLAN

A twelve month programme of work has commenced in the Trust to provide assurance and compliance on regulatory actions required, and also demonstrates improvements at both core service (e.g. Medicine and themed subjects (e.g. Medicine Management). The programme is multi-faceted and has been designed with the purpose of providing assurance against the July 2019 Inspection findings, but importantly outlining a framework going forward of the Trust position against regulatory compliance. These include:

Quality Assurance Panels

Assurance panels have commenced, chaired by the Director of Nursing with MDT panel representation. The purpose of the panel is for the responsible lead and team present a position and evidence against regulatory breaches and concerns raised in the report (named as must and should do's). These are set up in order of priority with Medicine core service and Medicines Management prioritised for Q1.

Southport and Ormskirk 'So Proud' Programme

A programme of core service reviews have been planned for Q1 onwards to provide a "go See" element to continuous cycle of improvement underpinned by the Health and Social Care Act methodology. These will be undertaken by a range of staff in order to promote a learning culture, ensure continual improvement, but importantly share learning and celebrate excellence. In Q2 this will be further supported by a Peer review.

Audit and Monitoring Arrangements

Audit and monitoring have been built into the programme, however from initial assessment it has been identified that monitoring arrangements need to be more robust to support key performance indicator measurement at ward level. Therefore support for implementation of "Perfect ward" has been sought which will support both the key quality priorities and also delivery of the CQC improvement plan and provide the Trust with real-time performance on a range of key priorities. This will strengthen ward to Board visibility.

Ongoing monitoring arrangements will be undertaken through Performance Review Boards however, a clear accountability framework needs to be produced and wrapped around this. The agenda should be structured with equal amount of time to Quality and Safety, Performance, Workforce and Finance. Performance information should be generated centrally by the BI Team, available in a timely manner to ensure the CBU Management Team

Appendix B

The table below provides an overview of the timetable for the Quality Assurance programme for 2020.

Quality Improvement Plan - Assurance Process	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Medicines Management												
Quality Assurance Panel	x	x	x		x		x		x		x	
"So Proud" Programme				x				x				x
External Peer Review						x						
Medicine												
Quality Assurance Panel	-	-	x		x		x		x		x	
"So Proud" Programme				x								
External Peer Review						x						
Urgent & Emergency Care												
Quality Assurance Panel				x		x		x		x		x
"So Proud" Programme					x		x		x		x	
Children & Young People												
Quality Assurance Panel					x			x			x	
"So Proud" Programme				x			x			x		
Sexual Health												
Quality Assurance Panel						x						
"So Proud" Programme							x					x
Outpatients												
Quality Assurance Panel						x			x			
"So Proud" Programme								x				
Surgery												
Quality Assurance Panel				x			x			x		
"So Proud" Programme						x			x			
Critical Care												
Quality Assurance Panel					x		x		x		x	
"So Proud" Programme				x				x				x
External Peer Review								x				
End of Life												
Quality Assurance Panel				x			x				x	
"So Proud" Programme					x				x			
Trust Wide												
Quality Assurance Panel												
"So Proud" Programme							TBC					
Well Led												
Quality Assurance Panel												
"So Proud" Programme							TBC					

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	TB027/20	Report Title	Integrated Performance Report (IPR)
Executive Lead	Steve Christian, Chief Operating Officer		
Lead Officer	Mike Lightfoot, Head of Information		
Action Required	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ 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 January along with the Executive Summary complimenting 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	
CQC KLOEs	**GOVERNANCE**
✓ Caring ✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	☐ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change
Impact	
☐ Compliance ☐ Engagement and Communication ☐ Equality ✓ Finance	☐ Legal ✓ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment	☐ Policy ☐ Service Change ☐ Strategy
Next Steps	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ✓ Finance, Performance & Investment Committee	✓ Quality & Safety Committee ☐ Remuneration & Nominations Committee ✓ Workforce Committee

Integrated Performance Report Executive Summary

January 2020, Steve Christian (Chief Operating Officer)

Governance Framework

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Executive Summary

Domain	High Level Summary (priority KPIs by exemption)
Responsive & Efficiency Exec Lead: Steve Christian	**Urgent and Emergency Care (UEC)** 4 hour performance has improved by 1.6% in January to 84.4% compared to December however slightly down on last year. 13 patients breached the 12 hour DTA standard. 10 of those were during or immediately following a weekend. Medically Optimised for Discharge (MOfD) rate remained consistent with December at 71 patients per day a significant increase from 58 in January 2018. The number of general and acute beds per day was significantly higher than January 2019 – 419 compared with 376 however the number of escalation beds per day was less than half of what was utilised last year – 15 as compared to 32. **Cancer** The 62 day standard was 92.1% against the 85% constitutional requirement. This is an excellent result and the first time since October 2018. Endoscopy continues to appoint at the 14 day point. Haematology and Head & Neck services under intense pressures due to workforce constraints (both services have historical SLAs in place with other providers that are not performing). Tumour Group Meeting continue with issues to be escalated through to the COO as part of the Operation and Performance Improvement Group Meeting – to be held on a monthly basis. Formal discussions are underway with other providers regarding

	Haematology and Head & Neck services. **18 Week RTT Performance** January 18-week RTT performance was 92.6%. Predictions for February show performance will continue to be above the 92% threshold. Performance has been impacted by closure to new referrals for haematology due to clinical workforce issues. **Diagnostics** Performance for January dropped by 0.8% against December to 1.5%. This is still significantly below previous year. Major performer is radiology with performance under 1%. Cystoscopy continues to be an issue however the Trust has now appointed a locum Urologist whilst recruiting to the substantive role. Arrival is expected in mid-March. The delays seen in colonoscopy are due to the prescription issues. These have now been resolved. Majority of breaches have dates in February. **Outpatient Utilisation** Outpatient Utilisation has increased in January 2020 compared with December 2019. Session Utilisation has increased by 2.68% to 92.64%. With Slot Utilisation improving by 3.23% to 89.5%. DNA rate has decreased by over 1%. This may have attributed to the increase in Outpatients seen despite the first two weeks of January having clinics numbers being highly controlled due to Safer Start. OP numbers increased by 2,830 on December's numbers. Phase II of the Improvement Programme has commenced with the recently appointed DM of Access focussing on drilling into individual clinic performance. Performance meetings are held with individual DMs and OSMs to review utilisation. Deep dives into DNA rates will commence into February and beyond. **Theatre Utilisation** January saw a 2.53% improvement in utilisation against December figures. Mainly due to decreased elective cancellations in January due to Safer Start and the start of the 48 hour TCI call. Phase II of the Improvement Programme has commenced. DMs and OSMs of the specialties to have increased knowledge and ownership of the performance within theatres. A new DM started in February who will also have Theatres and Anaesthetics as two of their main portfolios. This will assist Matron in driving change. Consistent underruns are now being seen and outliers to be challenged around additional cases or flexible staffing.
Well Led Exec Lead: Steve Shanahan / Jane Royds	Workforce: Staff turnover increased by 0.79% in January compared with December 0.63% however the rolling 12 month decreased for the second consecutive month to 12.32% in January. January's sickness rate has decreased from 5.68% in December to 4.32% in January 2020 also significantly below January 2019 at 6.39%. Nursing and Medical vacancy rates have improved slightly in January with a comparative drop in agency staff cost however agency utilisation is high due to winter and the opening of escalation areas.
Safe	Falls – Performance is static against December with 3 falls at moderate / severe harm. Currently testing new falls alarms and

Exec Lead: Terry Hankin	red walking frames to improve monitoring of patients and safe use of mobility aids. Walkabouts have commenced to educate staff how to assess, plan care to reduce falls risk and manage patients who fall. FNOF – Performance dropped slightly against December. However there is a continued focus on achieving all aspects of best practice. Continuing focus on the Golden Patient and time to surgery. The Trust continues to demonstrate improving FNOF mortality rates and is no longer an outlier. Orthopaedic Rehab ward open at Ormskirk. Highly positive feedback from all involved re patient experience. Review underway of LOS. Safe Staffing – Improvement of over 2% against December. Pleasing given winter pressures. Maintained safe staffing whilst opening up Orthopaedic Rehab Ward at Ormskirk and escalation areas in response to Winter Pressures.
Effective Exec Lead: Terry Hankin	90% Stay on Stroke Ward – performance improved in January to 87.9% Sepsis – improvements in both timely identification and treatment Screening Deaths – a decrease in performance compared with last month to 62.75%. This was due to an increased number of deaths in Q3 v previous quarter.
Caring Exec Lead: Juliette Cosgrove	Performance has improved on December to 93.7% yet slightly below the 94% target. There has been an improvement in response rates due to ENVOY system – 20.09%. Number of written complaints has increased in January to 27 compared to 16 in December. An increase in 7 in Urgent Care and 5 in Planned Care. There is however a pleasing result in a decrease in complaint turnaround to 63 days. Still outside the 40 day working target. 43% of complaints closed in January were completed within the 40 days.

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - January 2020

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
MRSA	1	0	1	0			
C-Diff	1.33	1	24	1			
Never Events	0	0	1	0			
VTE Prophylaxis Assessments	95%	96.9%	97.9%	140			
Harm Free (Safety Thermometer)	95%	97.4%	98%	10			
Falls - Moderate/Severe/Death	1	3	18	3			
Patient Safety Incidents - Low, Near Miss or No Harm		982	8266	982			
Safe Staffing	90%	90.5%	91.5%	N/A			
Fractured Neck of Femur	90%	80.8%	74.4%	21			
Hospital Pressure Ulcers - Grade 2	2	8	62	N/A			
Hospital Pressure Ulcers - Grades 3 & 4	1	2	12	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%	87.9%	73.8%	4			
Sepsis - Timely Identification	75%	100%	98.4%	N/A			
Sepsis - Timely Treatment	75%	82.8%	78.6%	N/A			
Percentage of Deaths Screened	100%	62.7%	66.8%	38			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	14	183	14			
Written Complaints	35	27	215	27			
Complaints Average Turnaround Time	40	63	786.7	N/A			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	93.7%	92.2%	116			

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Accident & Emergency - 4 Hour compliance	94.99%	84.4%	85.5%	1605			
Accident & Emergency - 12+ Hour trolley waits	1	13	112	13			
Ambulance Handovers <=15 Mins	99%	51.8%	51.9%	724			
Diagnostic waits	1.01%	1.5%	3%	40			
14 day GP referral to Outpatients	93%	95.6%	94.9%	34			
31 day treatment	96%	97.9%	97.7%	1			
31 day treatment (Surgery)	94%	100%	100%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day pathway Analysis	85%	92.1%	80%	3			
62 day GP referral to treatment	85%	92.1%	79%	3			
Referral to treatment: on-going	92%	92.6%	93.3%	831			
Bed Occupancy - SDGH	93%	93.3%	92.2%	N/A			
Bed Occupancy - ODGH	60%	48.8%	48.9%	N/A			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	Traj RAG
Duty of Candour - Evidence of Discussion	100%	100%	97.6%	0			
Duty of Candour - Evidence of Letter	100%	100%	97.6%	0			
I&E surplus or deficit/total revenue	-4.21%	-11.7%	-11.7%	N/A			
Liquidity	-106	-142	-142	N/A			
Distance from Control Total	0%	6.8%	6.8%	N/A			
Capital Service Capacity	0.21	-0.862	-0.862	N/A			
% Agency Staff (cost)	5.45%	10.2%	9%	N/A			
Use of Resources (Finance) Score	3	4	3	N/A			
Distance from Agency Spend Cap	0%	163%	163%	N/A			
Staff Turnover	0.76%	0.8%	6.8%	N/A			
Staff Turnover (Rolling)	10%	12.3%		N/A			
Vacancy Rate - Medical	5%	14.8%		N/A			
Vacancy Rate - Nursing	8%	17%		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%	69.3%	70.9%	N/A			
Mandatory Training	85%	89.1%	87.6%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.1	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	6.7	7	N/A			
DTOC - Number of Beds lost per month		276		276			
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	71	66	71			
Stranded Patients (>6 Days LOS)	170	185	1794	185			
Super Stranded Patients (>20 Days LOS)	58	68	693	68			
New:Follow Up	2.64	2.7	2.5	N/A			
DNA (Did Not Attend) rate	8%	6.8%	7.1%	1644			
Theatre Utilisation - SDGH	80%	72.1%	62%	N/A			
Theatre Utilisation - ODGH	90%	68.9%	70.1%	N/A			
Cancelled Operations	0.61%	0.1%	0.3%	2			
Southport A&E Conversion Rate	20%	22.8%		1090			

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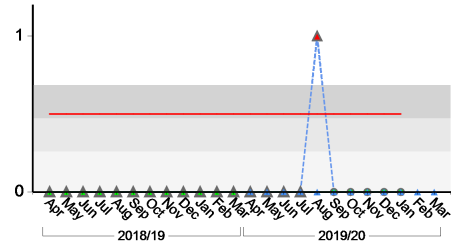
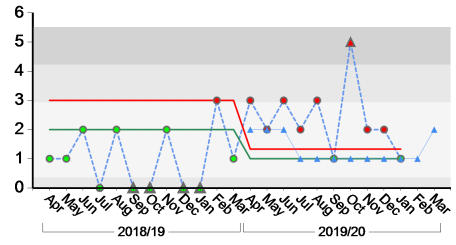
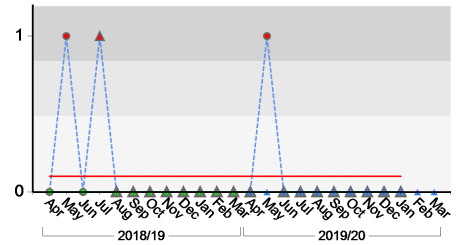
NHS
Southport and Ormskirk Hospital
NHS Trust

Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	No further cases of MRSA bacteraemia since August 2019 - Year to date there has been one MRSA bacteraemia which was in August 2019; no further causes since that time. The IPC team continue to include in mandatory training the learning from this last incident and in addition verify that patients who are MRSA positive are prescribed suppression treatment. The Consultant Microbiologist has also arranged an audit of antimicrobial prescribing of patients known to be MRSA positive.	
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.	Single case of C diff in January in ITU - Total C diff year to date is 24 cases attributed to the trust, however 7 of these cases have been successfully appealed and there are a further 8 cases that are eligible and being prepared for appeal. Hence our total C diff cases minus appealed cases stands at 17 with a potential additional 8 that are likely to be appealed as there were no lapses in care identified. The January case hasn't been through an RCA process yet, however due to a delay in treatment this may not be appealable. It has been identified that Cephalosporin antibiotics may be a factor in C diff acquisition, hence the Consultant Microbiologist and the Antimicrobial Pharmacist are reviewing the Trust Antimicrobial guidelines.	
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death.	There were 0 Never Events in January - There were 0 Never Events reported in January	

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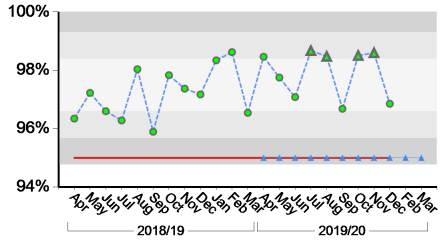
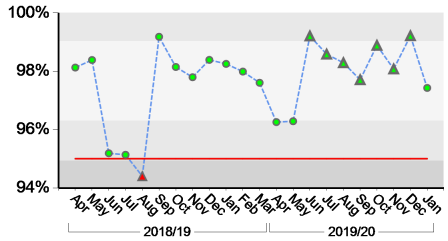
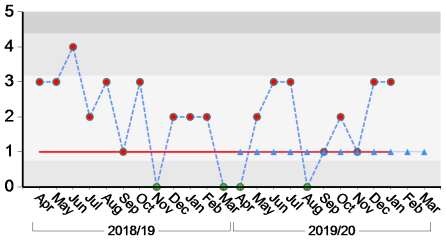
Southport and Ormskirk Hospital NHS Trust

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.	No change in performance. - Performance remains compliant and consistent and within limits of natural variation.	
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance remains above target - In December the Trust reported 4 Harms during the monthly census. The harms consisted of 1 x CAUTI on NWRSIU, 1 x DVT on 9a, and 2 x PE's on 15B and 11A. Any follow on action and/or further investigation is the responsibility of the relevant CBU.	
Falls - Moderate/Severe/Death	The total number of falls within the Trust were the severity of the harm was either moderate, severe or resulted in death. Threshold:0	Performance static at 3 falls with moderate/severe harm in December and a static total number of falls - The number of falls with harm has remained static at 3 in the month of January with a static total number of falls across the Urgent and Planned Care CBUs. The performance is above the target and is due to challenges with identifying risk, care planning and implementing the care actions. The new risk assessments and care plans have been rolled out across the organisation, however the high use of agency staff is contributing to the lack of completion in addition to the challenges of providing enhanced levels of care/supervision. To improve the current state we are testing two different sets of falls alarms and red walking frames to improve monitoring of patients and safe use of mobility aids as well as having prioritised and commenced walk abouts to teach staff how to assess, plan care to reduce falls risk and manage patients who fall. Staff are being trained on the Older People's Care Training Programme and the Trust Falls Group are testing the ESR Falls modules. Education is being planned for Doctors which has been a challenge to getting the clinician available to teach regarding the post-falls assessment and the Falls Group are planning a falls bag to be taken when a patient does fall to ensure appropriate management as a new emerging piece of work to support staff when a fall does occur.	

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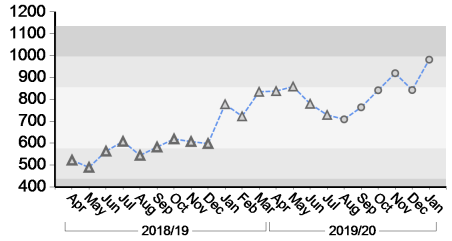
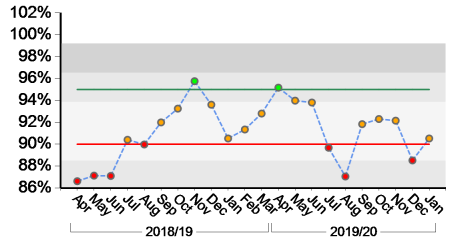
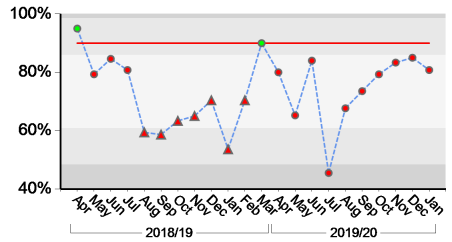
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Patient Safety Incidents - Low, Near Miss or No Harm	The number of incidents relating to patients where the severity was Low, Near Miss or No Harm caused. A higher number is good.	There were 973 lower level incident reported in January an increase from 843 - There were 973 lower level incident reported in January an increase from 843 in December this shows a good reporting culture throughout the Trust . (from the original 975 , 2 incidents were upgraded to moderate harm) The highest category of incident reported was Safeguarding, which are not incidents reported against the Trust. The second highest category was Bed Management, due to the delayed transfers from Critical Care to wards and lost to follow up due to the on going work with Urology and ophthalmology	
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%.	Overall Trust performance reports within the NQB recommended parameters (90-110%) - Variances within the registered nurse and healthcare percentage reporting within the CBU's are being explored to ensure reporting reflects current needs.	
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Peformance stable, with increase in Fracture neck of femur admissions - Orthopaedic rehab ward now open at Ormskirk, so patient flow improved. More patients now admitted on DOAC's meaning a delay in surgery is necessary for patient safety.	

Board Report - January 2020

NHS
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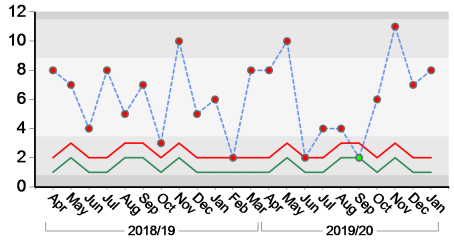
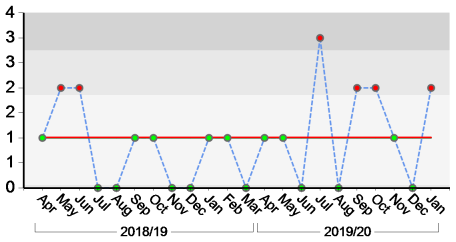
NHS Trust

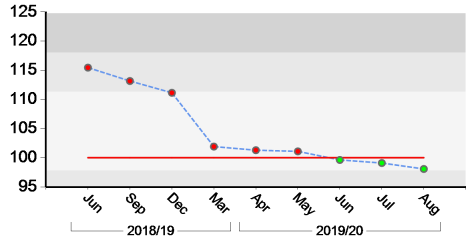
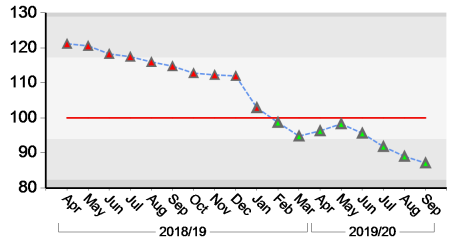
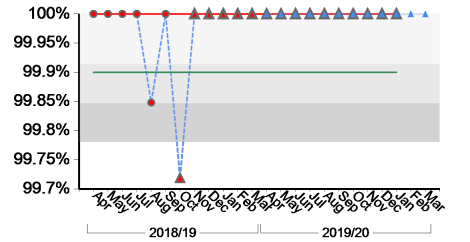
Safe

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Hospital Pressure Ulcers - Grade 2	Number of Patients with Hospital Acquired Grade 2 Pressure Ulcers.	- Resource folders for all wards are in process, to improve prevention, diagnosis and classification, to reduce the number of non pressure wounds e.g. moisture lesions/trauma wounds/friction injuries being inaccurately diagnosed as pressure ulcers.	
Hospital Pressure Ulcers - Grades 3 & 4	Number of reported Trust acquired pressure ulcers graded between 3 and 4.	- Both incidents occurred in urgent care CBU, to be reviewed at Harm Free Care Panel with Root Cause Analysis, and lessons learned will be shared across the organisation in fortnightly Lessons Learned article.	

Board Report - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly (rolling 12 months) and is 6 months behind due to when Dr Foster publish the data.	SHMI continues to improve, now sustained postive performance. - Work continues through the mortality operational group to track all aspects of mortality relating to SHMI so positive performance can be understood and sustained.	
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.	8th consecutive month of compliance demonstrating sustained good performance. - Continuing work with the re-scoping of the Deteriorating Patient Project and realignment of workstreams	
WHO Checklist	WHO Checklist.	WHO Checklist - Compliance with the checklist performance is 100%. Documentation completion is 93% at SDGH and 96% at ODGH (95% overall)	

Board Report - January 2020

NHS
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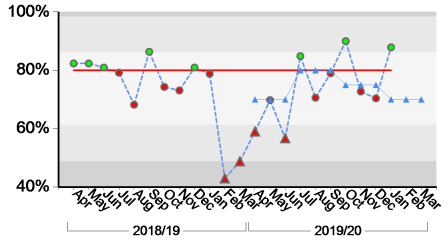
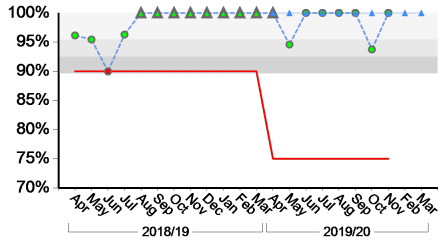
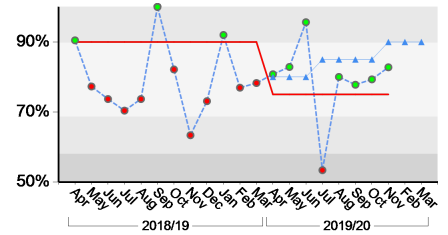
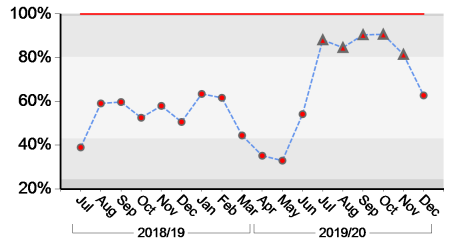
Effective

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.	Improvment - Target Achieved above 80% - 4 Patients breached 90% Stroke Unit stay during month 1 x Patient - Bed Capacity and no beds on Stroke Unit at time of admission - when bed available patient on ICP and not appropriate to move wards 1 x Patient admitted to Stroke Bed on admission but transferred to alternative ward to await discharge due to bed pressures in Trust which caused breach (85% Time spent on ASU) 1 x Bed Capacity Breach - No beds on ASU on admission. Patient fit for discharge when bed available 1 x Atypical presentation - initially treated as TIA but diagnosed CVA on CT Head and transferred to ASU following diagnosis.	
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 consistently performs well on this A&E measure - The total number of attendances in November 2019 was 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	
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 remains above our advancing quality target for antibiotic administration. - The total number of attendances in November 2019 was 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	

Board Report - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

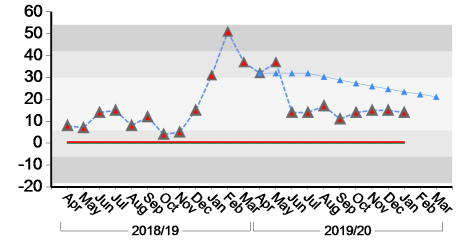
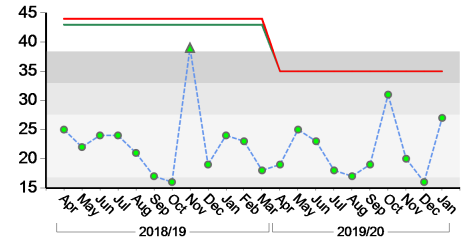
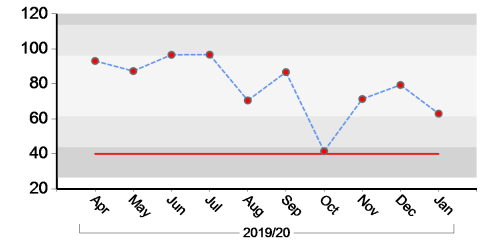
Effective

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Percentage of Deaths Screened	Percentage of Deaths Screened - DATIX	Drop in performance to 62.75% in December. - This is a result of an increase in the number of deaths seen in Q3 (258) vs the previous quarter (175).	

Board Report - January 2020

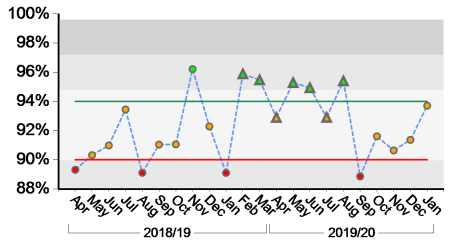
Southport and Ormskirk Hospital NHS Trust

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	
Written Complaints	The total number of complaints received. A lower number is good.	Increase in complaints In January - The number of complaints received has increased from 16 in December to 27 in January. This increase is attributable to Urgent Care whose complaint numbers have increased from 10 to 17 and Planned Care who have increased from 2 complaints to 7 in January. This increase is not due to A&E where complaint numbers have remained consistent (4). The highest number of complaints within Urgent Care related to Short Stay Unit where complaints related to discharge, poor communication and lost property and Ward 14B where the complaints related to clinical treatment, communication and alleged poor nursing care. The Outpatient department within Planned Care received the highest number of complaints for this CBU, with complaints relating to clinical treatment and staff attitude/behaviour.	
Complaints Average Turnaround Time	The average time in days from a complaint being received to closure.	Reduction in complaints turnaround time in January - The average complaints turnaround time reduced to 63 days for all complaints closed in January. Whilst this is a significant improvement it is still outside of the 40 working day target. 43% of the complaints closed in January were done so within 40 working days but the average turnaround time was impacted by 6 complaints closed more than 100 working days from receipt. The CBU's continue to work to address the backlog of open complaints, as at 11th February there were 34 open complaints over 40 working days, of which 18 related to Urgent Care, 11 Planned Care and 5 Women & Children's. The Complaints Review Group continues to meet weekly to review the oldest complaints.	

NHS
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 on previous month but remains slightly below target of 94%. - Performance improved on previous month but remains slightly below target of 94%. Since the implementation of the ENVOY system , the Trust continues to see an improvement in response rates (Jan- 20.09%) and an increase in qualitative comments supporting the ratings given. Planned care - those that would recommend has decreased to 95.8% from 97%. Urgent care- those that would recommend has increased to 91.31% from 88.61%. This includes a score of 90.59% (Dec 19 - 88.11%) that would recommend from the Adult Emergency Department. Maternity - those that would recommend has increased to 99.05% from 98.48%. Paediatrics - those that would recommend has increased to 95.86% from 91.82% This includes a score of 95.3% (Dec-19 91.82%) that would recommend from the Paediatric Emergency Department. From qualitative comments received alongside negative ratings the top themes identified were staff attitude, communication, implementation of care. All senior ward/dept staff now have the opportunity to access ENVOY for live FFT data to enable timely action to be taken at a local level in response to poor ratings /comments and the ability to identify positive/negative themes to direct local improvements. FFT data is also presented on ward/dept dashboards alongside the number complaints/concerns to support identification of any trends. The matron for patient experience receives daily alerts for ratings of unlikely / extremely unlikely to monitor themes and action any responses that require immediate attention The Trust has now received results from all four National Patient Experience Surveys. Local action plans in pace for Inpatients, Urgent and Emergency Care Services and plans to be developed by leads within the Paediatrics and Maternity. Once developed these will be presented to and monitored through the Trust Patient Experience Group as part of CBU patient experience reports. The draft 2020-2021 Trust patient experience strategy has been presented for consultation at the Jan-20 Patient Experience and Community Engagement Group. It is to be shared across the organisation for consultation within Trust news to support engagement from all staff groups. FFT % that will recommend will continue to be monitored and reported to wards/depts. on a monthly basis.	

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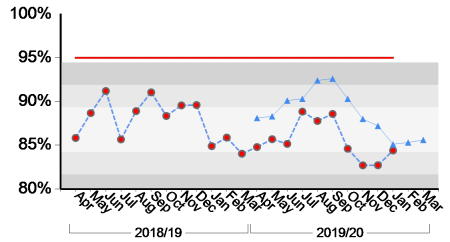
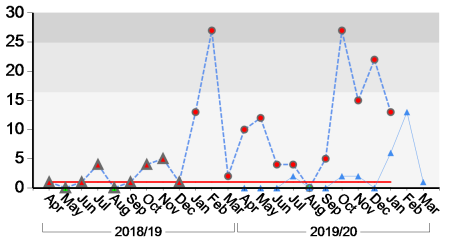
NHS
Southport and Ormskirk Hospital
NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	- There was a 1.6% improvement in performance against the 4-hour standard compared to last month. On the Southport site there were 1,532 patients who spent longer than 4 hours in ED. There is continued concern regarding the shift in case mix with 116 extra patients who were categorised as majors compared to last year and just under 1,000 additional patients who were categorised as majors compared to Jan 2018. ED is regularly seeing over 82% of patients attending across the month categorised as majors. This results in an increasing number of patients requiring specialty input prior to decisions being made and, as a result of continued bed pressures, patients remain in ED for these reviews and investigations to take place. There were an additional 49 admissions via ED compared to January 2019 and an increase in 100 compared to last month. This is despite continued senior in-reach into ED and streaming to ambulatory pathways to consider alternative options to ED. ED has successfully managed to have 4 doctors on nights, however the shift in attendances and the delays in patient flow has seen the department routinely tracking high occupancy levels and an increase in care delivered on the corridor (533 patients received care delivered on the corridor in January 2020 compared to 391 patients in January 2019). there are continued difficulties in the late identification of discharges across the wards and the impact that this has. There is a need fo a reduction in the use of ACU as an escalation area to enable consistent streaming during the week - the loss of the 6 spaces results in clinicians working from 1 cubicle on SAU which does reduce the number and casemix of patients that ACU can accept. There is optimism that there is further interest in substantive ED consultant posts in the Trust and an advert has been placed. increasing the consultant would enable rotas to be reviewed to enable command and control model to be maintained and consider extending consultant presence out of hours. PDSAs have been run in ED reviewing times to triage with a 2nd cubicle recently adapted to enable bloods, ecgs, obs and repeat obs to be taken which releases the triage cubicle to enable triage nurses to triage timely and support better patient flow.	
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0.	- There were x13 patients who breached the standard across the month of January. 12 of those were awaiting admission to an inpatient ward and 1 was awaiting admission to a mental health unit. 10 of the breaches occurred either during or immediately following a weekend, which corresponds with the pressures experienced across the system and the urgent need for a system that is able to step up capacity during periods of pressure. Within the Trust, key schemes had been implemented as part of winter planning, including the opening of orthopaedic beds at Ormskirk, enhanced medical cover, continuation of discharge huddles at weekends, extended pharmacy opening, and SAFER start campaign for the first 2 weeks of January. A key admission avoidance scheme had been the opening of ACU at weekends to stream appropriate patients away from ED to ambulatory pathways; 34 patients were streamed in January at weekends. Undoubtedly this mitigated the risk of further patients remaining ED and admission pathways. The stranded and super stranded metrics continue to cause concern with the number of patients recorded as being medically optimised for discharge having doubled compared to 2018. Timelines have been completed for all patients who breached the 12 hour standard. Assurance has been provided that all patients had reviews, specialty reviews, commenced on treatment plans, had regular observations and nursing interactions whilst in the department.	

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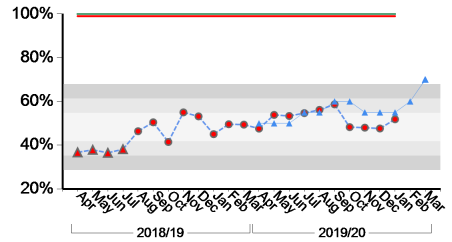
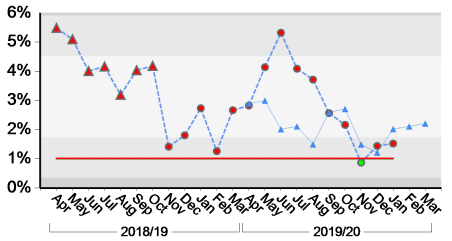
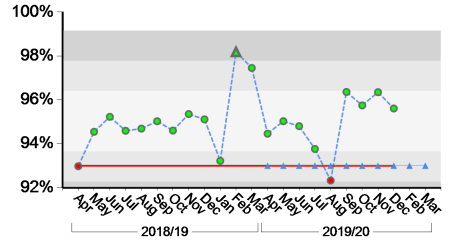
NHS Southport and Ormskirk Hospital NHS Trust

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.	- Ambulance handovers completed within 15 minutes in January saw some improvement to 51.83%, which is a 6% improvement on January 2019, however remains a disappointing position, particularly given the focus that ED has had on Hospital Handovers. Data is still awaited from NWAS to test the compliance with the recently relocated HAS screen for patients brought directly into resus as concern remains the timestamp of handovers for these patients are still inaccurate. PDSAs continued in January with relocation of wheelchairs and stretcher trolleys, additional linen cupboard put into place, regular restocking of linen cupboards, communication aids with radios, presence of ALOs, senior doctor presence in triage, and more recently the opening of a 2nd cubicle for patients to have bloods, ECGs and obs taken, to release triage nurse to see the next patient. Particular pressure points have been noted out of hours when handover times often increase and during the latter part of the afternoon into the evening when surges in activity occur at the same period that the department accumulates patients awaiting admission to wards. ED continued to use the corridor to 'reverse queue' patients awaiting admission to reduce the frequency of holding ambulances. Joint meetings continue to be held between NWAS and the Trust and daily handover and turnaround data is now shared. PDSA planned for April 2020 to stream appropriate patients directly from NWAS to ACU, which would negate the need for crews to attend ED.	
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.	Marginal drop in performance in January by 0.8% compared to December. Performance remains significantly lower than previous year. - Colonoscopy 11/130 breaches due to patients choice and the Trust was unable to adhere to the 3 week reasonableness notice period. There was a delay in prescriptions being written for bowel prep which impacted bookings which has now been resolved. All patients have a confirmed date in the month of February. Cystoscopy 16/147 breaches - 6 breaches due to patients unable to attend within 6 weeks, 5 cases are theatre cases due to lack of capacity and 5 due to Urology/Spinal consultants that can only see the patients. Cystoscopy Gynae one patient who was delayed at pre-op due to presence of MRSA. Gastroscopy 3/127 breaches all due to patients unable to attend within time and Trust was unable to adhere to 3 week reasonableness period. All patients have confirmed dates in February. Non Obs Ultrasound 5/923 breaches due to Christmas bank holidays. Urodynamics total 5/51 breaches, 3 patient choice, 1 patient had infection and 1 cancellation. All rebooked in February.	
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 maintains compliance - The trust continues to meet this standard which breaches primarily being for reasons of patient choice.	

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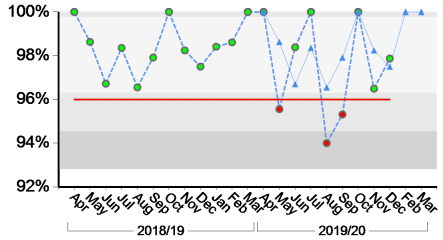
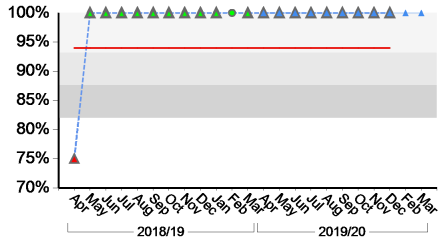
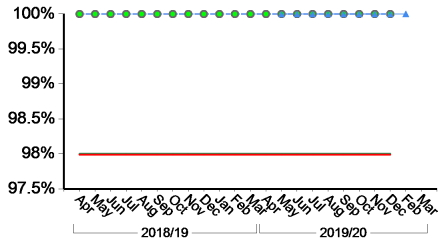
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Target 96%. Good performance is higher.	Trust improves compliance against standard - Trust only had one patient who breached this target in December. This has improved since the previous month.	
31 day treatment (Surgery)	Percentage of patients receiving first definitive surgical treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Trust maintains 100% compliance against standard - All patients reported against this standard in December were treated in time.	
31 day treatment (Anti-cancer drugs)	Percentage of patients receiving first definitive anti-cancer drug treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	No patients reported against this standard in December - This measure looks at patients receiving drugs as a subsequent treatment. There were no patients reported against this measure in December.	

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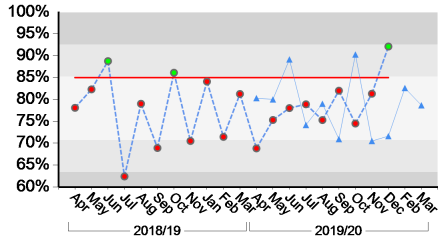
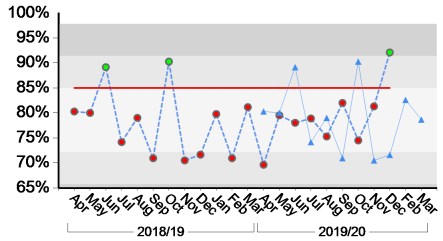
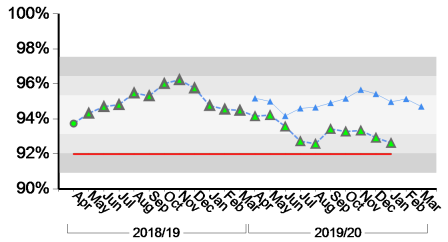
NHS Southport and Ormskirk Hospital NHS Trust

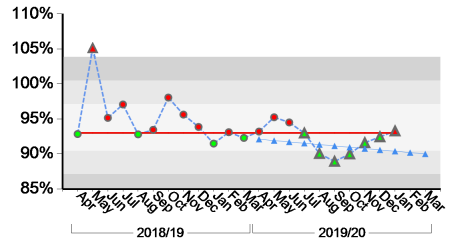
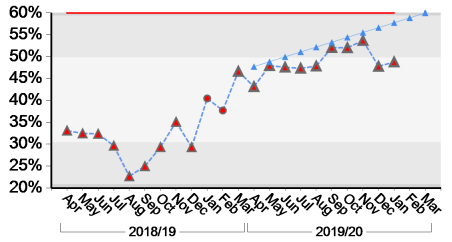
Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Trust compliant against standard - There were four patients who breaches the 62 day target in December, amounting to 3.5 breaches. There was one gynaecology breach due to delays to diagnostics caused by workforce pressures, one colorectal patient who changed his mind twice about what treatment he wanted, and two urology breaches, one due to patient choice and one delayed at a tertiary centre.	
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 compliant against standard - The trust was compliant against this standard for the first time since October 2018. Smaller numbers were treated in December due to patient choice to defer their treatment until after the festive period. This may result in poorer performance next month. The trust wide improvement plan is well underway for cancer with a recovery trajectory of 0.5% per month. This has been achieved for the last two months.	
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 remains above national target. - last 2 months has seen a fall in overall performance. This is being impacted by closing to new referrals in haematology due to lack of clinical workforce. Action plans are in place across all specialities to ensure performance is maximised to mitigate this effect.	

Board Report - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Bed Occupancy - SDGH	Percentage bed occupancy at the Southport site. A lower percentage is good. Threshold is 93%.	Southport bed occupancy has increased to 93.27% from 92.43% in December. - The marginal increase in occupancy in month took this site above the recommended 93% level. This is the highest occupancy since June 2019 and also 1.79% higher than last January. January was expected to see increases in demand and acuity and this bed occupancy rate has been achieved with the addition of 14 beds at Ormskirk on H ward.	
Bed Occupancy - ODGH	Percentage bed occupancy at the Ormskirk site, based on open beds. A higher percentage is good. Threshold is 60%.	Ormskirk bed occupancy increased in month to 48.79% from 47.79% in December. - Despite being slightly lower than occupancy levels in Autumn this is actually 8% higher than January last year and is a direct result of the success of H ward. This 14 bed ward opened in January and has achieved 80-85% occupancy on average.	

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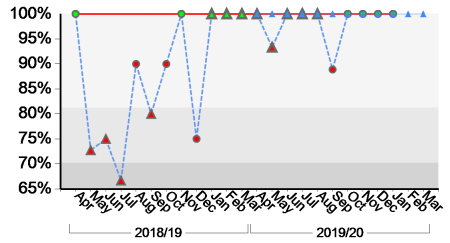
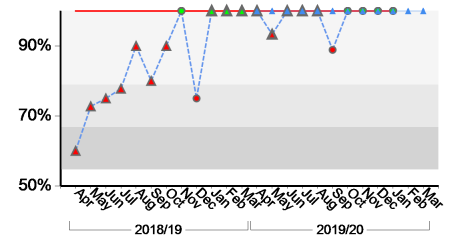
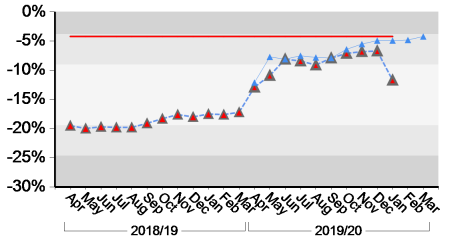
Southport and Ormskirk Hospital NHS Trust

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 January - The Trust maintained 100% compliance against this statutory requirement in January. 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 January - The Trust maintained 100% compliance against this statutory requirement in January. 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 worsened following a fromal communication of the Trust's forecast outturn. - PSF/FRF funding will not be received for Quarter 3 and month 10 as the Trust will not achieve its financial plan by the year end. Negotiations with commissioners are ongoing but no improvement is likely in this financial year. The metric will improve in 2020/21 providing the financial plan is achieved.	

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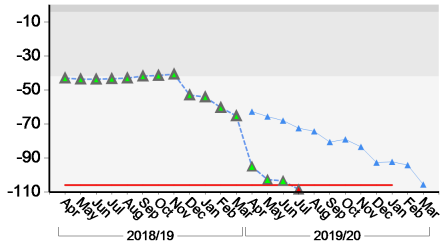
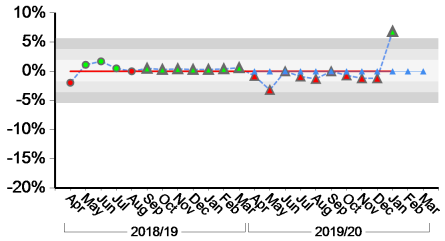
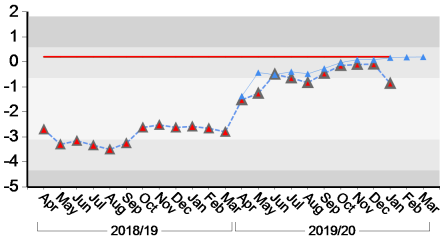
NHS Southport and Ormskirk Hospital NHS Trust

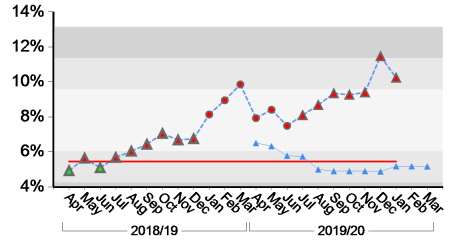
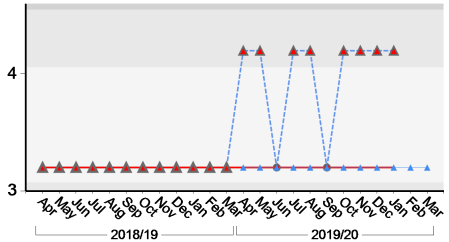
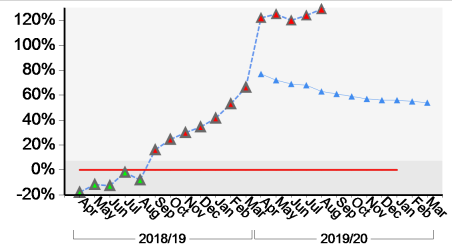
Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	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. However, the 20/21 operating plan is looking at restructuring revenue loans as PDC which will dramatically improve this metric next financial year.	
Distance from Control Total	Distance from Control Total.	Trust is now significantly away from the control total - The month 10 performance recognises that the Trust will not achieve the financial plan at the year end and, therefore, the control total. As a result the Trust will not receive PSF/FRF funding for Quarter 3 and month 10 resulting in a significant deterioration this month.	
Capital Service Capacity	The level of debt the Trust is required to service. This indicator is 1 of 5 used to derive the 'Use of Resources (Finance)' score.	Metric has deteriorated in month - The deterioration is entirely connected with the removal of the income accrual for PSF and FRF (Provider Sustainability Fund and Financial Recovery Fund).	

Board Report - January 2020

NHS
Southport and Ormskirk Hospital
NHS Trust

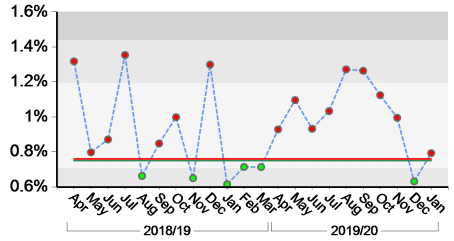
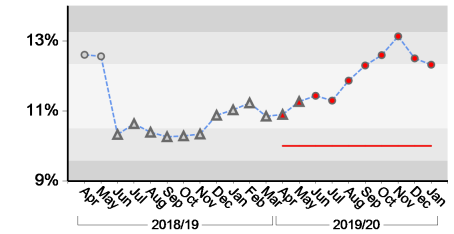
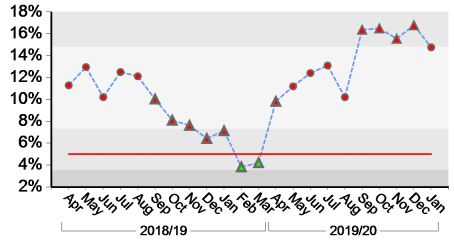
Well-Led

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.	Marginal improvment in performance in month - Current agency staff usage is high due to the requirement to open additional beds during the winter period without being able to hire staff substantively. A material improvement to this metric can only be made once vacancies are appointed to. A business case for the international recruitment of nurses is currently being considered but it will take time to get new staff through the pipeline.	
Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Performance is static - This metric remains at a 4. It is an overall value based on 5 separate metrics. All of these individual metrics are also at a 4. Last month there was only one metric - I&E margin: distance from financial plan that was a 3. Due to the removal of the PSF/FRF income accrual this has now deteriorated to a 4.	
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Perfomance continues to deteriorate as the cap has already been breached - There will be no improvement in this metric in 2019/20 and the Trust has not yet been notified of any agency spend cap for 2020/21. Plans are in place to recruit to vacancies and reduce agency spend. Progress has already been made in reducing non clinical agency spend.	

Board Report - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

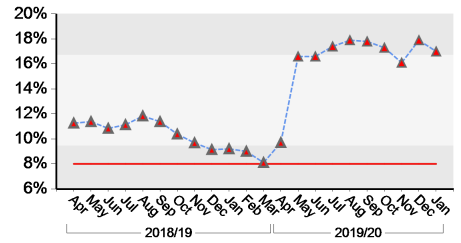
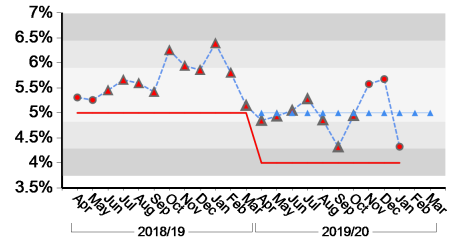
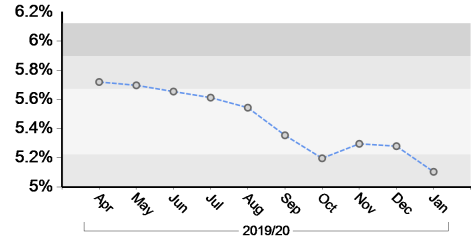
Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month.	January experienced an increase in staff turnover to 0.79% from 0.63% in December 2019. - Despite an increased number of leavers in January to 24 from 19 the rolling staff turnover has decreased for the third consecutive month in January to 12.32% from 12.5% in December 2019. This can be attributed to the significant reduction in monthly labour turnover in December 2019. Workforce Improvement Group has agreed the proposal for a 2020/21 Strategic work stream that will focus on Attraction, Attrition and Retention Group. The group will focus on the achieving the Trust's strategic aim of becoming Employer of Choice by reducing the labour turnover, increasing staff engagement and achieving a low stability index. 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.	
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 for the third consecutive month in January to 12.32% from 12.5% in December 2019. This can be attributed to the significant reduction in monthly labour turnover in December 2019. - The number of leavers increased in month to 24 from 19 in December 2019. Workforce Improvement Group has agreed the proposal for a 2020/21 Strategic work stream that will focus on Attraction, Attrition and Retention Group. The group will focus on the achieving the Trust's strategic aim of becoming Employer of Choice by reducing the labour turnover, increasing staff engagement and achieving a low stability index. 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.	
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	-	

Board Report - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Performance remains aligned to reported position across Q3 - Trust turnover reasons -leavers/age profile/retire and return reported and monitored through WIG to support action planning. Trust Nursing Recruitment and Retention re-commencing and re-engagement with NHSE/I retention pilot (cohort 3) continues.	
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 4%. Lower is better.	January 2020's sickness absence rate has decreased from 5.68% in December 2019 to 4.32% in January 2020 and is therefore now below the Trust target of 5% - The monthly sickness absence percentage demonstrates a notable reduction in sickness absence levels between December 2019 and January 2020. The absence percentage in January 2020 is significantly lower than the percentage in January 2019 when absence was 6.39%. The HR team is working closely with the CBU's to continue to identify and support areas that continue to experience high levels of sickness absence. The reviewed Supporting Attendance Policy is in the final stages of the ratification process.	
Sickness Rate (Rolling 12 Month)	The cumulative number of available WTE hours against the WTE hours of sickness in a 12 month period.	January 2020's rolling year to date sickness absence rate has decreased to 5.10% from 5.28% (December 2019). - The reduction in the monthly sickness absence percentage in January 2020 will have contributed to the continued reduction in the rolling year to date sickness absence percentage for the Trust. The decrease in the rolling year percentage demonstrates positive progress in the Trust reducing its sickness absence levels.	

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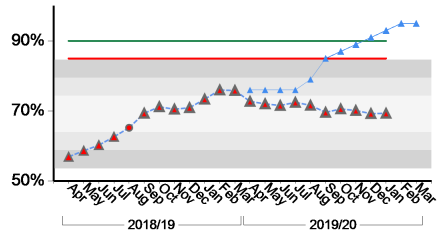
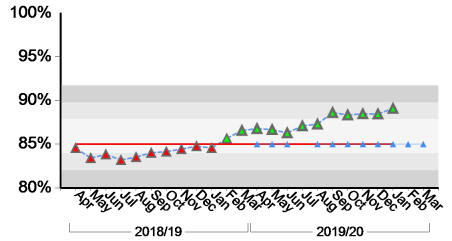
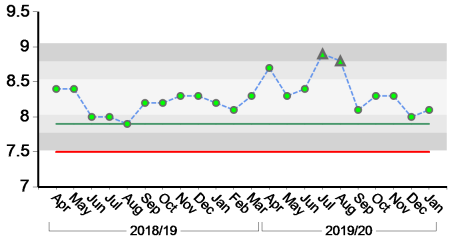
Southport and Ormskirk Hospital NHS Trust

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 increased slightly in month to 69.31% in January. - PDR performance and compliance continues to be challenge and improvement 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. The Learning and Education work stream that will be leading on improving PDR quality and compliance and the process of due diligence in relation to their project management documentation is underway.	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Rolling 12 month figure.	Core mandatory training reaches highest compliance since CSF implementation - 89.08% - Core mandatory training has reached a new peak at 89.08% with improved monitoring via CBU PRBs and a targeted approach by the Resuscitation Team to improve % compliance of annual basic resus . New role specific reports are now included in the monthly monitoring processes and a new Clinical Competency Working Group (CCWG) established in Feb 2020 will focus on delivering accurate TNA's and training to improve assurance of the clinical competence of patient facing staff. The initial plan is to focus on Band 5 Nurse clinical competence as the highest risk group.	
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Trust Performance CHpPD remains slightly higher than the national avaerage of 7.0 - Performance reported for January includes ODGH ward base changes. Higher levels of CHpPD are justifiable and reflective of the of the assessed level of acuity and dependency.	

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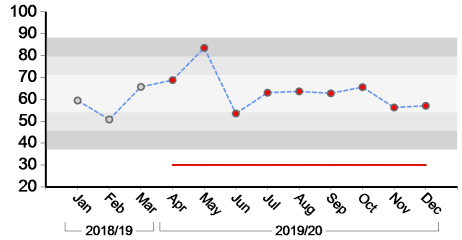
NHS
Southport and Ormskirk Hospital
NHS Trust

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.	-	

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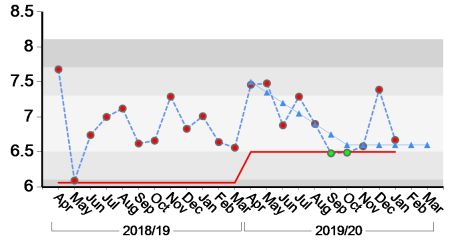
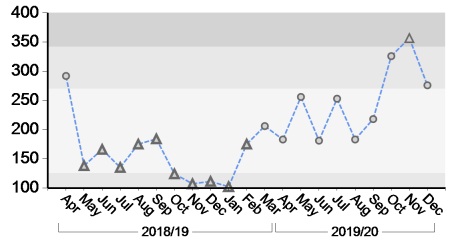
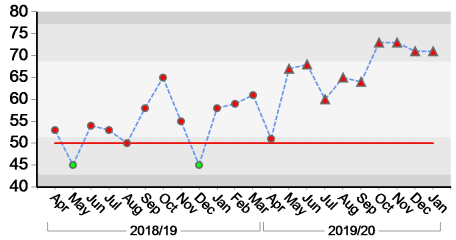
NHS Southport and Ormskirk Hospital NHS Trust

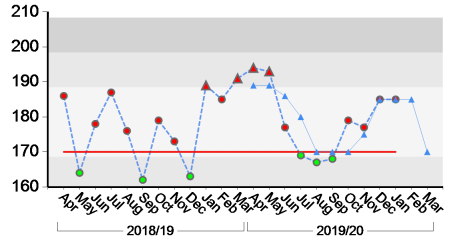
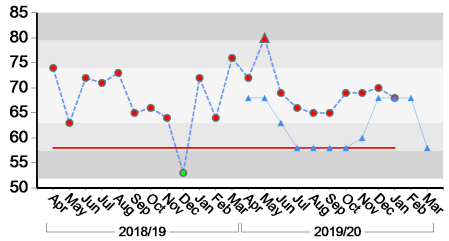
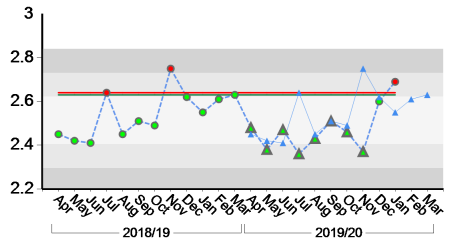
Efficient

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.	returned to previous performance following impact of holiday period - the increase in previous month likely to be due to the impact of the festive period; ALOS return 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.	reduction in month - There is continued work with partners from Community and LA supporting discharges through daily huddle and weekly long stay review. From October 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.	maintained - 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. working with DF to find alternative pathways to support discharge; 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 - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

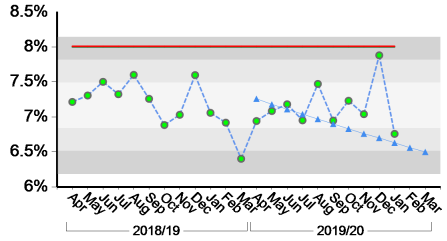
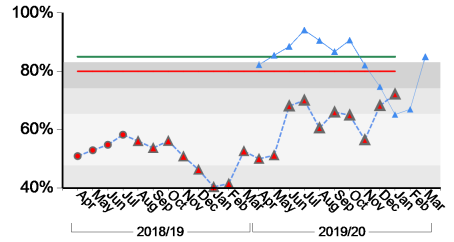
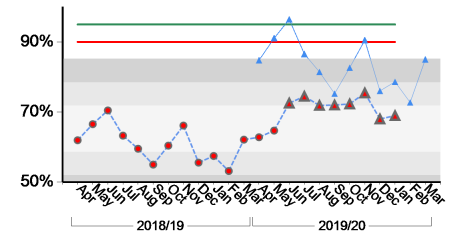
Efficient

Indicator Name (Colour - Perf | Traj)	Description	Narrative	Month Trend
Stranded Patients (>6 Days LOS)	Patients who spend 7 days or more as an inpatient.	increase from December remained - The impact of festive period on length of stay due to reduced LA availability has continued into January; daily huddles continued throughout and weekly LOS review completed. initial adhoc reviews of stranded patients have now been formalised into weekly review on 6 key wards, reviewing all patients with 7-19 LoS; identifying patients with likely complex care needs that will move into long stay. The SAFER roll out has been reviewed and although red2green compliance has improved - it is recognised that more work is required to support SAFER. 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. discussions to add ward flow performance onto ward dashboards	
Super Stranded Patients (>20 Days LOS)	Patients who spend 21 days or more as an inpatient.	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 initially commenced adhoc; now weekly process with Acute flow team on 6 identified wards to review all patients 7-19days LoS	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	KPI has deteriorated slightly for the first time since 2018. - KPI by speciality has been circulated to all speciality leads for review. There are some clear anomalies that need to be addressed or explained.	

Board Report - January 2020

NHS Southport and Ormskirk Hospital NHS Trust

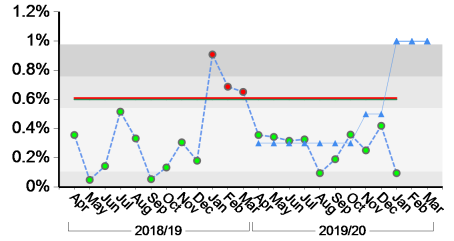
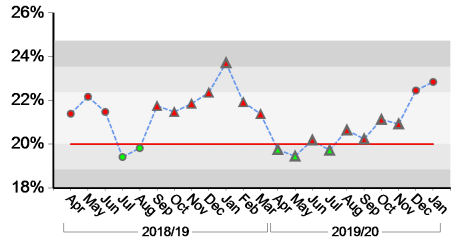
Efficient

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.	KPI remains within target for this matrix. - Business case for introduction of DrDoctor has been submitted to BDISC for electronic solution to management of DNAs and short notice cancellations.	
Theatre Utilisation - SDGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Southport site.	Performance improved to 72.15% , mainly as a result of safer start - In the first 2 weeks of Jan only cancer and clinically urgent cases were booked at SDGH. As a result there were fewer on the day cancellations for no beds and hence an improved efficiency. This has been at the "cost" of an increase in wait times for the routine patients requiring surgery at SDGH.	
Theatre Utilisation - ODGH	The proportion of elective Theatre slots used over the total elective planned capacity on the Ormskirk site.	Performance was improved slightly on December at 68.93% - Power BI is reporting 70.02% at ODGH. 53% of lists are now starting on time, with the majority of the late starts being the PM sessions. Performance was again impacted by OTD cancellations, these were sitting at 7.89% and impacting the early finishes. Theatre staffing review is underway to ensure we are maximising the operating time available.	

Board Report - January 2020

NHS 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	Performance in January is well below the 0.6% target. - Performance in January appears to be improved as a result of safer start. This involved no routine cases being booked for the SDGH site during the first 2 weeks. As a result there were no cancellations on the SDGH site due to bed pressures.	
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.	Performance marginally up but in line with seasonal expectations. - At 22.85% the adults A&E conversion rate continues to perform with natural variation. January was marginally better than last year with a similar pattern of attendances and acuity.	

Activity Summary – January 2020

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	January 2018	December 2019	January 2020	Trend
Overall Trust A&E attendances	10,362	10,825	10,266	▼
SDGH A&E Attendances	4,766	4,804	4,756	▼
ODGH A&E Attendances	2,408	2,900	2,380	▼
SDGH Full Admissions Actual	1,267	1,190	1,213	▼
Stranded Patients AVG	181	184	185	▲
Super Stranded Patients AVG	70	69	68	▼
MOFD Avg Patients Per Day	58	71	71	▲
GP Referrals (*Exc. 2WW*)	2,818	2,038	2,633	▼
2 Week Wait Referrals	706	601	743	▲
Elective Admissions	198	154	239	▲
Elective Patients Avg. Per Day	6	5	8	▲

Activity Summary – January 2020

Southport and Ormskirk Hospital NHS Trust

Indicator Name	January 2019	December 2019	January 2020	Trend
Elective Cancellations	34	27	22	▼
Day case Admissions	2,015	1,755	1,897	▼
Day Case Patients Avg. Per Day	65	57	61	▼
Day Case Cancellations	47	39	32	▼
Total Cancellations (EL & Day Case)	81	66	55	▼
Total Cancellations (On or after day of admission, non clinical reasons)	20	8	2	▼
Outpatients Seen	22,226	19,816	22,646	▲
Outpatients Avg. Per Day	717	639	731	▲
Outpatients Cancellations	5,169	3,818	3,999	▼
Theatre Cases	632	534	623	▼
General & Acute Beds Avg. Per Day	376	407	419	▲
Escalation Beds Avg. Per Day	32	15	15	▼
In Hospital Deaths	94	103	96	▼

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	**TB 028/20**	**Report Title**	**Finance Report – Month 10 2019/2020**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

This report contains the month 10 performance against the plan submitted to NHSI on 4th April 2019.

The Month 10 financial plan has not been achieved with the cumulative deficit £24.632 million before PSF and FRF, which is £2.619 million worse than plan.

The Trust has signalled to the NHSE/I that the 2019/20 plan will not be achieved. This has been formally accepted by the regulator as an adverse variance from plan of £3.6 million.

This has meant the removal of £5.481 million of non- recurrent PSF/FRF accrued at the end of Quarter 3.

Month 10 has seen further slippage in the CIP programme with a projected year end shortfall of £2.2 million.

There is a risk emerging that the Trust will not be £3.6 million adverse variance from plan given the continued temporary pay spend, the non-delivery of CIP and the contract over performance from Southport & Formby CCG and South Sefton CCG, which would have an impact on the Southport System forecast outturn position set by NHSE/I

Recommendation
The Board is asked to receive the Finance Report – Month 10 2019/20.

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	
☐ Compliance	☐ Legal
☐ Engagement and Communication	☐ Quality & Safety
☐ Equality	✓ Risk
✓ Finance	☐ Workforce
Equality Impact Assessment	☐ Policy
	☐ Service Change
	☐ Strategy
Next Steps	
Previously Presented at:	
☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
✓ Finance, Performance & Investment Committee	☐ Workforce Committee

Finance Report – Month 10 2019/20

1. Purpose

1.1. This report provides the Board with the financial position for Month 10 (January 2019) and the progress on delivery of the Trust's deficit control total of £26.567 million before non-recurrent funding of £18.271 million, and a net deficit of £8.296 million.

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

2. Executive Summary

2.1. The Trust has been forecasting that it will not achieve the 2019/20 financial plan since early in the financial year and NHSE/I has now formally agreed that the financial plan will not be achieved due to a projected year end overspend of £3.6 million as highlighted in the System Recovery Plan.

2.2. As a result, the Trust will no longer receive non-recurrent funding (PSF/FRF) for Quarter 3 and Quarter 4 and the accrual for Quarter 3 PSF/FRF in month 9 has now been reversed.

2.3. The month 10 position YTD is a deficit before PSF/FRF of £24.632 million which is £2.619 million worse than plan.

2.4. The in-month positon is a deficit is £2.967 million before PSF/FRF.

2.5. The table below is the I&E statement for Month 10

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	166,713	138,973	138,184	(789)	13,934	13,784	(150)
PP, Overseas & RTA	1,098	916	648	(268)	93	91	(2)
Other Income	12,389	10,390	10,874	484	1,036	1,048	12
PSF & FRF	18,271	14,007	6,394	(7,613)	2,131	(5,482)	(7,613)
Total Operating Income	**198,471**	**164,286**	**156,101**	(8,185)	**17,194**	**9,441**	(7,753)
PAY	(141,091)	(117,343)	(118,266)	(923)	(11,733)	(12,075)	(342)
NON PAY	(53,560)	(44,828)	(46,019)	(1,191)	(4,409)	(4,818)	(409)
Total Operating Expenditure	**(194,651)**	**(162,172)**	**(164,285)**	**(2,114)**	**(16,142)**	**(16,893)**	**(751)**
EBITDA	**3,820**	**2,114**	**(8,184)**	**(10,299)**	**1,052**	**(7,453)**	**(8,504)**
Net Financing Costs	(12,149)	(10,157)	(10,130)	27	(1,035)	(1,009)	26
Retained Surplus/Deficit	**(8,329)**	**(8,043)**	**(18,314)**	**(10,272)**	**17**	**(8,462)**	**(8,478)**
Technical Adjustments	33	36	76	40	11	13	2
Break Even Surplus/(Deficit)	**(8,296)**	**(8,007)**	**(18,238)**	**(10,232)**	**28**	**(8,449)**	**(8,476)**
Less PSF/FRF Funding	(18,271)	(14,007)	(6,394)	7,613	(2,131)	5,482	7,613
SURPLUS/(DEFICIT) excluding PSF/FRF	**(26,567)**	**(22,014)**	**(24,632)**	**(2,619)**	**(2,103)**	**(2,967)**	**(863)**

2.6. The Trust's income assumes the full contract payment for Southport & Formby CCG, West Lancashire CCG and South Sefton CCG.

2.7. Current activity performance suggests that both Southport & Formby CCG and South Sefton CCG contract will over perform but none of this over performance has been built into either the month 10 position or the year end forecast.

2.8. As highlighted previously expenditure levels rose in October and have remained at this higher level up to January 2020.

2.9. These higher expenditure levels, together with the shortfall on the elective programme, are driving a higher overspend against plan than the £3.6 million.

2.10. The 2019/20 CIP programme is £2.084 million behind plan at month 10; the forecast outturn has been reduced to £4.168 million against the £6.314 million plan leaving an unidentified gap of £2.146 million.

2.11. There is a risk emerging that the Trust will not be £3.6 million adverse variance from plan.

3. Income and Activity Performance

3.1. Elective activity performance was improving during September and October but, following a downturn in November, performance has deteriorated while Non elective activity has over-performed significantly in January.

3.2. Trust activity and income performance at month 10 YTD is as follows:

- ✓ Elective – activity is 4.2% below plan; £647,000 loss of income.
- ✓ A&E – activity 7.0% above plan; £613,000 of additional income.
- ✓ Non Elective – activity is 1.5% below plan; £5,042,000 additional income due to case mix.
- ✓ Outpatients – activity is 3.2% above plan; £752,000 of additional income.

3.3. 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.
- ✓ The Southport & Formby CCG and South Sefton CCG contracts apply the "blended tariff" to all points of delivery.

3.4. The elective plan has been underperforming since the start of the financial year:

	Annual Plan	Variance to Month 10 YTD Plan									
	2019/20	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
WL CCG	9,364	(41)	(74)	(120)	(175)	(244)	(210)	(191)	(257)	(315)	(376)
S&F CCG	6,372	(27)	(135)	(188)	(164)	(175)	(140)	(69)	(144)	(97)	(97)
Other CCG's	2,420	(22)	(41)	(83)	(90)	(112)	(100)	(141)	(194)	(214)	(215)
Total	**18,156**	**(90)**	**(250)**	**(391)**	**(429)**	**(531)**	**(450)**	**(401)**	**(595)**	**(626)**	**(688)**

3.5. The System Recovery Plan did have an impact during the summer up until October 2019 but it has not been possible during the winter months to deliver the required activity to deliver the elective shortfall.

3.6. The majority of the other CCG activity relates to dental which is commissioned by NHS England.

3.7. Section 4 contains the impact of activity performance on the main commissioners.

4. Performance of Main Commissioning Contracts

4.1. Southport & Formby CCG

4.1..1. The value of the Southport & Formby CCG contract is £74.9 million and is a "Cost based contract" which has a number of "conditional income" elements.

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

	Annual Plan	M10 YTD Plan	M10 YTD Actual	M10 YTD Var
	£	£	£	£
Repatriation	600,000	500,000	0	(500,000)
Business Cases	1,300,000	825,691	825,691	0
CQC Contingency	300,000	250,000	21,200	(228,800)
BPT	850,000	708,333	92,284	(616,049)
Contingency - Other Conditional	450,000	375,000	0	(375,000)
Total	**3,500,000**	**2,659,024**	**939,175**	**(1,719,849)**

4.1..3. Despite the £1.720 million underperformance on conditional income, the Trust's activity performance, together with additional funding for escalation beds, means the CCG contract is over-performing by £1.060 million at month 10 YTD.

4.1..4. There has been no formal challenge from the CCG on the contract performance however working as a system the Trust has declared a month 10 YTD income position which is balanced to plan (and balanced to contract value) at £62.7 million.

4.1..5. Based on the forecast level of activity it is estimated that the Trust will over-perform at year end by circa £1.5 million (£76.4 million in total).

4.1..6. It is worth noting that the latest projections indicate that if Southport & Formby CCG was on a PbR contract the year end projection is in the region of £80.0 million before the application of a blended tariff to non-elective activity which would reduce this figure to £77.0 million.

4.2. South Sefton CCG

4.2..1. The value of the South Sefton CCG contract is £7.1 million.

4.2..2. The contract is a "Cost based contract" although there is no conditional income attached or any additional charge for escalation beds usage.

4.2..3. The Trust's month 10 YTD activity performance indicates an over-performance of £203,000.

4.2..4. Due to the Southport financial position the Trust is declaring a balanced contract position for South Sefton CCG in its month 10 YTD position (total contract payment of £5.9 million YTD).

4.2..5. Based on the forecast level of activity it is estimated that the contract will over perform by circa £0.4-0.5 million.

4.3. West Lancashire CCG

4.3..1. The contract is a PbR based contract.

4.3..2. The Trust plan is £51.0 million and the contract value is £50.5 million following arbitration due to timing issues on when the Trust could start counting CDU activity.

4.3..3. The plan is underperforming at month 10 YTD by £0.413 million which consists of:

- ✓ Arbitration issue for CDU (£0.4) million
- ✓ Elective activity (£0.4) million.
- ✓ Other activity £0.4 million

4.3..4. Other activity includes non-elective over performance of £1.051 million but this is reduced to £0.210 million after the application of the blended tariff at 20%.

4.3..5. The System Recovery Plan required an improvement in elective under performance which would have resulted in achievement of the income plan.

4.3..6. The Trust is now forecasting that West Lancashire CCG will perform to contract and not to plan which is a shortfall of £0.5 million.

5. Expenditure

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

5.2. Within pay the main staff groups driving the over spend are non-consultant medical staff (£1.2 million YTD) and nursing & midwifery (£2.5 million YTD).

5.3. High vacancy levels continue to contribute significantly to the over spends within these staff groups resulting in high levels of agency and bank usage (see section 6).

5.4. Whilst there have been new appointments the current vacancy rates (non consultant 11% and nursing & midwifery 17%) have not improved since May 2019 when the nurse establishment review was funded.

5.5. Prior to month 7 underlying monthly expenditure levels were fairly consistent but since then expenditure levels have increased and have not been mitigated by additional CIP or other recovery measures.

5.6. Previous reports have highlighted the material increase within nursing staff seen from October onwards. This trend has continued into January resulting in an average monthly increase of £160,000 above levels seen in the first half of the year (note this excludes nursing spend funded by winter pressures).

5.7. Additional nursing staff were required for specialling a patient with mental health needs on Ward 15A incurring £57,000 in month 10.

5.8. Underlying monthly non pay expenditure has been consistent up to December.

5.9. Non pay costs have risen in January with the main increases occurring in drugs and medical & surgical equipment.

5.10. Higher drug spend in MDU has been incurred alongside increased elective activity in clinical haematology.

5.11. In summary, average monthly expenditure levels rose in October 2019 and pay is the main contributor. The monthly rise has continued into January and is forecast to continue to the year end.

5.12. This is all having an impact on the Trust's forecast outturn despite mitigating actions been put in place

6. Bank and Agency spend

6.1. Both bank and agency attract a considerable premium element and recruitment to these posts would significantly improve the Trust's financial position.

6.2. The Trust is forecasting to spend £22.4 million on bank and agency staff in 2019/20.

6.3. The Trust spent £2.158 million in January on bank and agency staff which is lower than December's (£2.255 million) which was the highest recorded to date.

6.4. The reduction is a result of stopping non clinical agency spend, reductions in medical staff and increased nurse agency spend.

6.5. The numbers

- ✓ Monthly agency spend in January is £1.236 million (10.2% of the pay bill) down from £1.334 million in December; main spend Medical staff £0.593 million (month 9 £0.667 million); Nursing £0.608 million (month 9 £0.549 million).
- ✓ Year-to-Date (YTD) agency spend is £10.677 million (9.0% of the pay bill); main spend Medical staff £5.525 million; Nursing £4.231 million.
- ✓ Total Bank spend in January is £0.922 million (7.6% of the total pay bill) bringing YTD spend to £9.332 million (7.9% of the total pay bill).

7. Cost Improvement Plan (CIP) Performance

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

7.2. At month 10, the Trust has transacted an additional £0.108 million in month for a number of smaller schemes covering procurement, electronic discharge letters and private patient fertility income, bringing the total of transacted schemes to 52 with a total value of £3.470 million (CYE) and £2.693 million (FYE).

7.3. Of the overall £3.470 million transacted, £2.275 million is recurrent, £1.195 million is non-recurrent and the analysis by pay, non-pay and income can be seen in table below:

CIP Pay, Non Pay, Income split

	Recurrent	Non-Recurrent	Total
	£m	£m	£m
Pay	0.831	0.664	1.495
Non-Pay	1.344	0.234	1.578
Income	0.100	0.297	0.397
Total	**2.275**	**1.195**	**3.470**

7.4. The forecast outturn is £4.128 million leaving an unidentified gap of £2.186 million.

7.5. The in-month performance is £324,000 bringing total CIP delivered to date to £3.004 million, £2.1 million behind plan.

Table – Month 10 performance

	Annual Plan £000	Annual Budget £000	Month 10 Budget £000	Month 10 Actual £000	Month 10 Var £000	YTD Budget £000	YTD Actual £000	YTD Var £000	CYE £000	FYE £000
19/20 Plan - Expenditure (pay)	2,465	3,965	378	120	(258)	3,206	1,325	(1,881)	1,495	1,034
19/20 Plan - Expenditure (non pay)	1,724	1,724	161	172	11	1,395	1,341	(54)	1,578	1,459
19/20 Plan - Income (other op income)	325	325	39	32	(7)	246	338	92	397	201
19/20 Plan - Income (BPT)	1,800	300	29		(29)	241		(241)		
19/20 Plan - Total	**6,314**	**6,314**	**607**	**324**	**(283)**	**5,088**	**3,004**	**(2,084)**	**3,470**	**2,694**

7.6. The main schemes contributing towards 2019/20 delivery are:

- ✓ Procurement work plan
- ✓ Tactical finance schemes
- ✓ Corporate interim reduction
- ✓ Bio-similar drug savings
- ✓ CNST discount.

7.7. Quarter 4 2019/20**;** Trust continues to work to identify further saving opportunities focusing on Patchwork, single site valuation of assets, time to hire and length of stay.

7.8. The Patchwork project commenced in December 2019 as planned, but uptake in December and January is lower than anticipated, this is being closely tracked; an additional provider has joined the consortium which is expected to reduce the rates and transaction costs going forward. The implementation of this revised medical bank was to increase fill, ensure compliance to governance processes, decrease agency spend and support patient experience and quality.

7.9. The PMO is working with the HR Team to validate the time to hire value, as significant reductions have been made against this scheme as we are now below the peer median for time to hire metrics.

7.10. Whilst Length of Stay has reduced by a day from the start of 2019/20 the associate value is an efficiency improvement but will not impact on the expenditure run rate.

7.11. Single Site Valuation of assets; discussed and agreed with external auditors; initial desktop valuation by Cushman and Wakefield indicates savings of £0.280 million before costs.

8. Cash

8.1. The cashflow in the appendices shows actual performance each month and a forecast for February and March.

8.2. For January the target was a month-end balance of £1 million and the Trust was marginally above that at £1.112 million.

8.3. February revenue loan of £3.664 million was received on 17th February 2020.

8.4. March's loan request at £5.819 million was submitted to NHSE/I on 12th February 2020; this includes additional working capital of £2 million to resolve prior-year expert determination outcome; for this to be considered by NHSE/I the Trust was require to submit aged debt, aged creditors, better payment practice code and liquidity information.

9. Debtors

9.1. Overall debt has reduced from £5.75 million last month to £5.44 million this month.

10. 2019/20 Forecast Outturn

10.1. NHSE/I have written to the Southport System and have revised the Trusts forecast outturn deficit before PSF and FRF to £30.167 million, £3.6 million adverse variance from plan.

11. Recommendations

11.1. The Board is asked to **receive** the Finance Report – Month 10 2019/20.

List of Appendices

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

1. Activity run rate by month

	2018/19			2019/20									
	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10
AandE	7,269	6,756	7,595	7,176	7,446	7,162	7,783	7,224	7,393	7,677	8,104	7,791	6,917
Day Case	1,878	1,731	1,854	1,707	1,706	1,605	1,815	1,801	1,825	1,887	1,685	1,656	1,776
Elective	180	175	179	144	187	183	177	175	153	193	182	148	207
Non Elective (Including Short Stay)	2,741	2,480	2,646	2,368	2,504	2,339	2,662	2,706	2,559	2,770	2,801	2,800	2,744
Non Elective Non Emergency	241	254	262	75	78	60	76	62	69	71	79	52	68
Outpatients (Including Procedures)	14,926	14,462	15,302	15,074	15,615	14,365	16,777	14,066	15,286	16,049	15,456	13,451	15,571

2. Expenditure run rate by month - £000

Class	STAFF GROUP	STAFF TYPE	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
PAY	Consultants	Substantive	(1,395)	(1,324)	(1,118)	(1,238)	(1,239)	(1,234)	(1,321)	(1,235)	(1,396)	(1,282)	(1,267)	(1,246)	(1,244)
		Bank	(101)	(78)	(104)	(98)	(70)	(65)	(112)	(65)	(75)	(84)	(80)	(77)	(40)
		Agency	(179)	(206)	(272)	(279)	(279)	(201)	(275)	(266)	(341)	(264)	(290)	(363)	(314)
	Consultants Total		(1,675)	(1,608)	(1,494)	(1,615)	(1,587)	(1,500)	(1,708)	(1,566)	(1,812)	(1,630)	(1,636)	(1,686)	(1,598)
	Other Medical	Substantive	(1,319)	(1,307)	(1,256)	(1,337)	(1,305)	(1,327)	(1,297)	(1,313)	(1,431)	(1,328)	(1,316)	(1,323)	(1,310)
		Bank	(137)	(115)	(167)	(165)	(167)	(195)	(155)	(174)	(171)	(146)	(182)	(139)	(151)
		Agency	(244)	(273)	(316)	(256)	(257)	(277)	(288)	(255)	(235)	(247)	(258)	(304)	(279)
	Other Medical Total		(1,699)	(1,695)	(1,739)	(1,758)	(1,730)	(1,799)	(1,740)	(1,742)	(1,837)	(1,722)	(1,756)	(1,766)	(1,740)
	Nurses & Midwives	Substantive	(3,704)	(3,672)	(3,388)	(3,954)	(3,818)	(3,797)	(3,745)	(3,722)	(3,771)	(3,749)	(3,820)	(3,769)	(3,816)
		Bank	(595)	(588)	(684)	(609)	(637)	(645)	(632)	(671)	(656)	(684)	(665)	(669)	(696)
		Agency	(427)	(415)	(436)	(372)	(397)	(319)	(303)	(400)	(370)	(458)	(455)	(549)	(608)
	Nurses & Midwives Total		(4,726)	(4,675)	(4,508)	(4,935)	(4,852)	(4,761)	(4,680)	(4,793)	(4,796)	(4,891)	(4,941)	(4,987)	(5,119)
	Scientific, Technical & Theraputic	Substantive	(1,320)	(1,319)	(1,260)	(1,437)	(1,349)	(1,329)	(1,323)	(1,348)	(1,372)	(1,384)	(1,360)	(1,367)	(1,315)
		Bank	(9)	(12)	(12)	(7)	(7)	(7)	(8)	(6)	(5)	(5)	(4)	(12)	(10)
		Agency	(12)	(8)	(14)	(4)	(8)	(20)	(35)	(26)	(72)	(28)	(39)	(38)	7
	Scientific, Technical & Theraputic Total		(1,341)	(1,339)	(1,286)	(1,448)	(1,364)	(1,355)	(1,366)	(1,380)	(1,449)	(1,417)	(1,403)	(1,417)	(1,318)
	Other Staff	Substantive	(1,965)	(2,008)	(1,731)	(2,284)	(2,156)	(2,147)	(2,090)	(2,115)	(2,150)	(2,120)	(2,126)	(2,128)	(2,190)
		Bank	(27)	(19)	(34)	(38)	(17)	(27)	(34)	(40)	(28)	(24)	(26)	(23)	(25)
		Agency	(59)	(50)	(54)	(59)	(54)	(48)	(64)	(78)	(34)	(112)	(87)	(80)	(42)
	Other Staff Total		(2,051)	(2,077)	(1,818)	(2,381)	(2,227)	(2,223)	(2,188)	(2,232)	(2,213)	(2,256)	(2,239)	(2,231)	(2,257)
	Pay Reserves	Substantive	232	798	(176)	(57)	(56)	149	(191)	(54)	914	(0)	0	501	(0)
	Pay Reserves Total		232	798	(176)	(57)	(56)	149	(191)	(54)	914	(0)	0	501	(0)
	Pay CIP	Substantive	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pay CIP Total		0	0	0	0	0	0	0	0	0	0	0	0	0
	Apprenticeship Levy	Substantive	(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)	(46)	(39)	(46)	(43)
	Apprenticeship Levy Total		(41)	(40)	(47)	(44)	(42)	(38)	(50)	(36)	(43)	(46)	(39)	(46)	(43)
PAY Total			(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)	(12,014)	(11,632)	(12,075)
NON-PAY	Supplies & Services Clinical		(2,249)	(2,227)	(2,413)	(2,263)	(2,325)	(2,259)	(2,420)	(2,264)	(2,227)	(2,382)	(2,299)	(2,334)	(2,481)
	Supplies & Services General		(203)	(199)	(212)	(186)	(172)	(173)	(164)	(189)	(219)	(211)	(191)	(204)	(203)
	Non-Executive Directors					(6)	(6)	(6)	(8)	(4)	(6)	(6)	(10)	(6)	(6)
	Establishment Expenses		(298)	(292)	(268)	(191)	(226)	(232)	(221)	(245)	(242)	(237)	(231)	(249)	(214)
	Premises & Fixed Plant		(953)	(917)	(775)	(1,018)	(1,035)	(991)	(985)	(1,055)	(948)	(1,061)	(1,132)	(1,109)	(1,109)
	Miscellaneous		(638)	(654)	(595)	(717)	(720)	(716)	(735)	(717)	(666)	(740)	(723)	(460)	(705)
	Services From Other NHS Bodies		(287)	(253)	(328)	(103)	(61)	(69)	(145)	(188)	(136)	(137)	(106)	(114)	(100)
	Non Pay Reserve		0	0	0	(7)	7	0	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			(4,628)	(4,543)	(4,590)	(4,491)	(4,538)	(4,446)	(4,678)	(4,662)	(4,443)	(4,775)	(4,692)	(4,477)	(4,818)
NON-OPERATING EXPENDITURE			(939)	(940)	(479)	(1,031)	(1,023)	(1,037)	(1,006)	(1,042)	(1,016)	(998)	(1,005)	(1,015)	(1,013)
Grand Total			**(16,868)**	**(16,119)**	**(16,137)**	**(17,761)**	**(17,418)**	**(17,009)**	**(17,608)**	**(17,506)**	**(16,694)**	**(17,733)**	**(17,710)**	**(17,124)**	**(17,906)**

PAY	Substantive		(9,511)	(8,871)	(8,975)	(10,351)	(9,964)	(9,723)	(10,016)	(9,822)	(9,248)	(9,908)	(9,928)	(9,378)	(9,917)
	Bank		(869)	(813)	(1,001)	(918)	(898)	(940)	(942)	(956)	(936)	(944)	(956)	(920)	(922)
	Agency		(920)	(952)	(1,092)	(970)	(995)	(864)	(966)	(1,024)	(1,050)	(1,109)	(1,129)	(1,334)	(1,236)
PAY Total			(11,301)	(10,636)	(11,068)	(12,239)	(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)	(12,014)	(11,632)	(12,075)

3. WTE run rate by month

WTE worked

As at 31 January 2020

Southport and Ormskirk Hospital NHS Trust

STAFF GROUP	STAFF TYPE	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Consultants	Substantive	94	99	97	96	95	94	94	95	95	95	95	97	95
	Bank	4	5	5	5	5	3	5	3	3	4	5	4	1
	Agency	8	10	12	12	12	9	12	12	13	14	13	13	14
Consultants Total		107	114	114	114	111	106	111	110	111	113	114	115	110
Other Medical	Substantive	223	229	228	231	230	221	232	229	221	221	221	226	225
	Bank	10	10	11	13	11	9	12	12	9	12	16	12	5
	Agency	21	24	28	20	23	24	22	20	20	21	23	22	22
Other Medical Total		254	263	266	263	264	254	267	261	250	254	261	260	252
Nurses & Midwives	Substantive	1094	1101	1110	1106	1121	1110	1109	1107	1102	1121	1142	1124	1148
	Bank	172	176	208	178	185	186	189	196	187	197	199	194	203
	Agency	62	59	69	63	60	54	57	66	65	75	84	91	105
Nurses & Midwives Total		1329	1336	1387	1347	1367	1350	1355	1369	1354	1394	1425	1409	1457
Pay Reserves	Substantive	0	0	0	0	0	0	0	0	0	0	0	0	0
Pay Reserves Total		0	0	0	0	0	0	0	0	0	0	0	0	0
Scientific, Technical & Theraputic	Substantive	397	402	400	400	396	383	391	396	404	401	400	399	396
	Bank	2	3	2	2	2	1	2	2	1	1	2	2	2
	Agency	3	2	2	1	1	4	6	5	6	5	5	5	6
Scientific, Technical & Theraputic Total		401	406	405	402	399	388	399	403	411	407	408	406	404
Other Staff	Substantive	760	772	773	810	802	805	797	803	804	824	818	810	816
	Bank	9	11	14	15	13	10	14	14	13	12	12	12	11
	Agency	7	10	8	8	10	13	10	12	9	11	10	10	5
Other Staff Total		777	793	795	833	825	828	821	829	826	848	839	833	832
Grand Total		**2868**	**2912**	**2967**	**2959**	**2966**	**2926**	**2952**	**2972**	**2952**	**3015**	**3047**	**3023**	**3054**
SUMMARY BY STAFF TYPE														
	Substantive	2,569	2,603	2,608	2,642	2,643	2,613	2,623	2,630	2,626	2,663	2,677	2,657	2,680
	Bank	198	205	240	213	215	210	222	227	213	226	234	225	223
	Agency	101	104	119	103	108	103	107	115	113	126	135	142	152
Grand Total		**2,868**	**2,912**	**2,967**	**2,959**	**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**	**3,047**	**3,023**	**3,054**

4.

Statement of Financial Position (Balance Sheet)

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2019	31/01/2020		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,067	121,112	(1,955)	(31)
Other assets	966	1,320	354	(93)
TOTAL NON CURRENT ASSETS	**124,033**	**122,432**	**(1,601)**	**(124)**
CURRENT ASSETS				
Inventories	2,382	2,439	57	51
Trade and other receivables	11,678	9,179	(2,499)	(5,616)
Cash and cash equivalents	1,042	1,112	70	(71)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**15,102**	**12,730**	**(2,372)**	**(5,636)**
CURRENT LIABILITIES				
Trade and other payables	(22,771)	(19,049)	3,722	2,062
Provisions	(199)	(238)	(39)	8
PFI/Finance lease liabilities	(1,153)	(1,153)	0	0
DH revenue loans	(20,487)	(62,481)	(41,994)	(2,199)
DH Capital loan	(411)	(400)	11	0
Other liabilities	(1,025)	(3,273)	(2,248)	1,074
TOTAL CURRENT LIABILITIES	**(46,046)**	**(86,594)**	**(40,548)**	**945**
NET CURRENT ASSETS/(LIABILITIES)	(30,944)	(73,864)	(42,920)	**(4,691)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**93,089**	**48,568**	**(44,521)**	**(4,815)**
NON CURRENT LIABILITIES				
Provisions	(207)	(145)	62	15
DH revenue loans	(82,953)	(57,643)	25,310	(3,201)
PFI/Finance lease liabilities	(13,831)	(12,875)	956	58
DH Capital loan	(1,000)	(600)	400	0
TOTAL NON CURRENT LIABILITIES	**(97,991)**	**(71,263)**	**26,728**	**(3,128)**
TOTAL ASSETS EMPLOYED	**(4,902)**	**(22,695)**	**(17,793)**	**(7,943)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	98,214	98,733	519	519
Retained earnings	(112,432)	(130,744)	(18,312)	(8,462)
Revaluation reserve	9,316	9,316	0	0
TOTAL TAXPAYERS EQUITY	**(4,902)**	**(22,695)**	**(17,793)**	**(7,943)**

Southport and Ormskirk Hospital NHS Trust

In month material movements are as follows:

The main issue this month has been the removal of the accrual for PSF/FRF income and this is reflected in the movement in trade and other receivables.

A significant loan in January of £5.4m has allowed the Trust to tackle some of the prior-year issues with local commissioners and this is reflected in the reduction in trade and other payables.

5. 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**

6. Cashflow Forecast – 2019/20

	Actual Apr-19 £'000s	Actual May-19 £'000s	Actual Jun-19 £'000s	Actual Jul-19 £'000s	Actual Aug-19 £'000s	Actual Sep-19 £'000s	Actual Oct-19 £'000s	Actual Nov-19 £'000s	Actual Dec-19 £'000s	Actual 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)	(8,024)	(2,313)	(2,313)	(18,598)
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	572	619	620	7,033
Impairments and Reversals	0	0	0	0									0
(Increase) in Inventories	59	(86)	200	(143)	(74)	216	(105)	(44)	(30)	(50)	(30)	(33)	(120)
(Increase) in Trade and Other Receivables	(949)	(2,096)	(1,115)	1,143	1,947	1,011	(2,702)	179	(1,047)	5,774	(1,100)	(1,045)	0
Increase in Trade and Other Payables	3,517	(1,123)	(1,871)	(1,887)	5,822	(512)	514	(2,786)	(601)	(4,399)	(10)	1,020	(2,316)
Increase in Provisions	1	(8)	(3)	10	0	(14)	14	(1)	(4)	(18)	(3)	(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)	(6,145)	(2,837)	(1,842)	(14,168)
Cash Flows from Investing Activities													
Interest Received	3	4	5	5	8	17	(1)	5	6	3	6	5	66
(Payments) for Intangible Assets	(57)	0	(2)	(152)	127	0	(2)	(5)	(107)	95	(263)	(324)	(690)
(Payments) for PPE and investment property	(190)	(117)	(186)	40	(1,144)	(325)	(189)	(227)	(1,118)	451	(645)	(3,994)	(7,644)
Receipts from disposal of fixed assets	0	0	0	0	0	0	0	0	38	3			41
Receipt of cash donations to purchase capital assets	9	(1)	0	34	0	0	8	0	0	0		50	100
Net Cash Inflow/(Outflow) from Investing Activities	(235)	(114)	(183)	(73)	(1,009)	(308)	(184)	(227)	(1,181)	552	(902)	(4,263)	(8,127)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0						519	910	1,115	2,544
Public dividend capital repaid	0	0	0	0						0			0
Loans received from DH	2,456	1,458	2,386	2,179	0	0	0	3,693	2,458	6,097	3,664	5,819	30,210
Loans repaid to DH	(200)	0	0	0	0	0	(2,941)	0	0	(697)			(3,838)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(596)	(8)	(8)	(8)	(240)	(24)	(932)
Capital element of PFI, LIFT	(16)	(15)	(118)	(16)	(15)	(119)	(15)	(16)	(119)	(93)	(28)	(28)	(598)
Interest Paid	(190)	(234)	(225)	(195)	(228)	(545)	(207)	(243)	(244)	0	(441)	(525)	(3,277)
Interest element of finance lease	0	0	0	0			(240)	0	0	0	(158)		(398)
Interest element of PFI, LIFT	(80)	(81)	(209)	(80)	(81)	(209)	(81)	(80)	6	(296)	(80)	(210)	(1,481)
PDC dividend (paid)/refunded	0	0	0	0	0	0	0	0	65	0	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	5,522	3,627	6,147	22,295
NET INCREASE/(DECREASE) IN CASH	**3,347**	**(2,718)**	**(571)**	**374**	**5,535**	**210**	**(6,100)**	**724**	**(660)**	**(71)**	**(112)**	**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	1,112	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**	**1,112**	**1,000**	**1,042**	**1,042**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

4 March 2020

Agenda Item	**TB029/20**	**Report Title**	**Segmental Reporting and Charitable Funds**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

This paper reviews the number of operating segments required to be reported in the 2019/20 annual accounts and whether to consolidate the charitable funds into the main Trust's accounts.

Recommendations:

The Board is requested to **approve** the following in line with approvals from the 2018/19 Accounts:

- The Trust should report one operating segment in 2019/20 accounts.
- Charitable fund results should not be consolidated.
- An annual review of both segmental reporting and charitable fund consolidation

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

Impact	
☐ Compliance ☐ Engagement and Communication ☐ Equality ✓ Finance	☐ Legal ☐ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment	☐ Policy ☐ Service Change ☐ Strategy

Next Steps
In the preparation of the statutory accounts, the Trust will ensure that only one operating segment is reported and that the charitable fund results are not consolidated into the Trust's accounts.

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

Operating segments and charitable fund consolidation

1. Purpose

1.1. The purpose of this report is to provide the Board with the relevant information to decide on whether to declare only one operating segment and whether to consolidate the charitable funds into the Trust's 2019/20 statutory accounts.

2. Introduction

2.1 International Financial reporting standards (IFRS) requires the amount reported for each operating segment item to be the measure reported to the chief operating decision maker for the purposes of allocating resources to the segment and assessing its performance.

2.2. In 2018/19 the Trust reported only one segment in the final accounts.

2.3. This brief report will review this approach and provide a recommendation to the Board for approval.

3. Segmental reporting

3.1 The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Trust Board.

3.2 The Trust Board reviews the financial position of the whole organisation in their decision making process, rather than individual Business Units.

3.3 All contractual income for the Trust is held in the Corporate Business Unit and this accounts for more than 90% of total revenue. Therefore only one Business Unit exceeds the 10% revenue threshold.

3.4 If the Trust implements full Service Line Management (SLM) including utilising it to allocate resources at a Clinical Business Unit (CBU) level then the Trust would be likely to have to report at that CBU level in its statutory annual accounts.

4 Charitable Fund consolidation

4.1 In determining whether to consolidate the charity accounts there are two tests

- Control and
- Materiality.

4.2 The Trust has the power to govern the financial and operational policies of the charity so as to obtain benefits from its activities and therefore under IFRS 10 (International Financial Reporting Standard on consolidated financial statement) the Trust is deemed to have control.

4.3 Materiality has both a quantitative aspect and a qualitative one.

4.4 Firstly on the quantitative side the value of the charity's income, expenditure, assets and liabilities all fall below 1% the value of the Trust's.

4.5 Secondly on the qualitative side omission of the charity figures in the Trust accounts would not affect a user's understanding of the accounts.

4.6 The Trust's position is that although the control criteria is met, the value is not material. As such it is not necessary to consolidate the charity's accounts into the Trust's annual accounts. A disclosure to this effect though will be included in the accounting policies note.

4.7 These matters have been discussed with the external auditors, and, consistent with prior years, are not minded to challenge the Trust's approach.

5 Conclusion

5.1 Only one segment has revenue above the threshold level and therefore the Trust should continue to report one operating segment in 2019/20 accounts.

5.2 It is likely that if Service Line Management (SLM) is fully implemented the Trust would need to report operating segments at a divisional level.

5.3 The Trust should not consolidate the results of the charity into the Trust's accounts as these are not material.

6 Recommendation

6.1 It is recommended that the Board approve the following:

- The Trust should report one operating segment in 2019/20 accounts.
- Charitable fund results should not be consolidated.
- An annual review of both segmental reporting and charitable fund consolidation.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**16 DECEMBER 2019**
LEAD:	**MR DAVID BRICKNELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The majority of the actions fall within the remit of Quality & Safety but others are for full Board, FPI and Workforce and we need to ensure oversight so that issues do not fall between the cracks.

ADVISE

- Whilst much good work had been done, there was too much variability of implementation at the ward/ departmental level, hence the low “Good governance” ratings. The SONASS reviews and ward reports already in action will encourage uniformity and the sharing of good practice.
- Many of the required actions were already being addressed through this year’s Quality Improvement Programme. The CQC requirements will be coordinated with and used to reinforce, this programme.
- Within the detail of the report it appeared that we had not completed actions required by previous inspections. Our assurance/reporting/audit process must ensure we do not get caught like this again.

ASSURE

- An extra Quality & Safety Committee meeting had been convened to discuss the progress of the response to the CQC and actions arising from the report.
- Meetings have been held with national and regional representatives of CQC who assure us that our plans for improvement are appropriate and on track.
- As required by CQC, our response to the report with our action plan will be delivered by 29th December 2019 in a format that will have been cleared with them in advance.
- Urgent actions, for example, in Medicines Management and Health & Safety, have already been taken and advised.
- All regulatory breaches will be addressed in programmes approved by CQC.
- A detailed programme addressing all 124 actions identified in the report is being prepared, but many of the steps are already being implemented.
- The format of supervision and separately, assurance is being developed, but there is greater emphasis on the role of the CBUs and involvement of Internal Audit at the appropriate time to give assurance of implementation will be discussed.

New Risk identified at the meeting	• No new risks were identified at the meeting.

Review of the Risk Register
(Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE (QSC)**
MEETING DATE:	**24 FEBRUARY 2020**
LEAD:	**MR DAVID BRICKNELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- (Risk 2122) | Medicines Management - Embedding good practice at ward level. Introducing a new, relatively untested, EPMA system will be a challenge.

- Mortality Review - Despite the assurance over the reduction in HSMR/ SHMI and the ongoing research into the complexities of resistant areas like Acute Kidney Injury (AKI), there is an Alert in relation to the current level of Structured Judgement Reviews (SJRs), particularly at level 2, because of the availability of Reviewers.

ADVISE

- (Risk 1862) | Safe quality of nursing with the current level of vacancies - A paper is coming to Trust Board regarding international recruitment.

- (Risk 2056) | Patients missing follow-ups - High risk patients tracked with no further significant reports of harm. Case for recruitment for tracking all patients or other management of cases being developed.

- (Risk 2173) | Older patients care - The main challenges to delivering the planned workstreams are current documentation (under detailed review) and training of staff.

ASSURE

- Coronovirus - We have taken all steps we are required to do, but there remains a concern as to the regional/national planning if the situation escalates within the UK.

- (Risk 1902) | CQC compliance - A work programme is in place and approved by the CQC, to address all the Must Do's and Should Do's. This will be reviewed monthly by QSC, where appropriate at the level of ward compliance.

- Southport & Ormskirk Nursing Assessment and Accreditation Scheme (SONAAS) - The scheme continues to deliver assurance both of the systematic review of issues at ward level, and the enthusiasm and appetite for improvement and monitoring.

New Risk identified at the meeting	No new risks were identified at the meeting.

Review of the Risk Register

The Committee took assurance from the discussions held on the following High Risks which are detailed on its Risk Register.

- Risk 1688
- Risk 1862
- Risk 2056
- Risk 2123
- Risk 2173

Alert, Advise, Assure (AAA)
Highlight Report

COMMITTEE/GROUP MEETING DATE:	**FINANCE PERFORMANCE & INVESTMENT COMMITTEE 24 FEBRUARY 2020**
LEAD:	**JIM BIRRELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- the Trust's forecast outturn is anticipated to be £4.9m over the control total, which is an increase on the previous £3.6m forecast. The movement is due to higher than anticipated staff costs, slippage on the Cost Improvement Programme, (CIP), and revised assumptions around contractual income. It was agreed that an in-depth review would be undertaken with a view to presenting a more detailed analysis to the March FP&I meeting
- work to produce the draft Financial Plan 2020/21 is ongoing prior to submission to NHSI/E on March 5th. The biggest variable factor at this stage is the level of contractual income with the CCGs not accepting a number of the Trust's proposals. The Committee expressed concern at the lack of progress in identifying next year's CIP and requested that a realistic assessment of the position be presented to the next meeting.

ADVISE

- the Executive Team is reviewing the systems and processes surrounding the CQC Use of Resources assessment and feedback will be provided to the Board in due course
- Emergency Department performance remains below national targets but better than most Trusts in the country - recently the Trust was ranked 20th out of 123 Trusts. Patient pathways continue to be developed, including pathways that will effectively allow for the ring-fencing of the Ambulatory Care Unit to ensure it is available for use seven days a week.
- a meeting of local Chairs and Accountable Officers to discuss the effectiveness of the winter planning process is scheduled to take place in March. It is hoped that, inter alia, this will result in improved provision of hospital-at-home services as a way of reducing A&E attendances/admissions.
- the Committee considered a report on the international recruitment of nurses. Whilst accepting that it may be the best way to resolve the short/medium term nurse staffing problem, the initial outlay was felt to be very significant given the Trust's financial position. However, it was also noted that the scheme had a relatively short payback period provided the scheme is successful and the staff recruited replace high cost agency nurses.

ASSURE

- The Committee was pleased to receive assurance that the Trust has an effective system for tracking cancer patients and to note that the Trust met the 62 day GP referral to treatment target in January for the first time since October 2018. However, it was also pointed out that further similar challenges faced in other specialties are the subject of ongoing discussions on developing sustainable services.
- it is anticipated that agreed revisions to the capital programme will ensure that the Trust fully utilises its 2019/20 capital allocation. Next year's programme will be amended to incorporate the 2019/20 slippage.

New Risk identified at the meeting	None.
Review of the Risk Register	

Alert, Advise, Assure (AAA) Highlight Report

COMMITTEE/GROUP MEETING DATE:	WORKFORCE COMMITTEE 20 FEBRUARY 2020
LEAD:	GURPREET SINGH

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Multi-Professional Competence for Workforce

It was alerted that the Trust is currently experiencing an extreme risk relating to clinical competencies and role-specific training. This follows the 2019 CQC inspection where it was identified that clinical staff aren't compliant with their training. It was agreed that role-specific training and mandatory training figures be reported into the Committee from the Clinical Competency Working Group. It was additionally highlighted that the current PDR paperwork does not include a section to monitor training in clinical competencies, and thus the Committee approved the commission of a piece of work to collaborate both issues and the relation and to resolve.

Vacancies

The Committee were informed that the HCA Band 2/3 vacancy for inpatient ward areas is currently 36.20 WTE, with the Registered Nurse Band 5 vacancy Trustwide at 128.17 WTE. Whilst ongoing and planned recruitment events are occurring, with the assurance of filling vacancies in the pipeline, this still remains as a significant problem.

ADVISE

Activity Summary

It was raised under the Integrated Performance Report that GP referrals are decreasing. The committee were advised, that whilst activity has relatively remained consistent over the last 12 months, there would be a further drop in GP referrals due to the redesigning of services.

ASSURE

Sickness Absence

The monthly sickness absence rate has decreased in month to 4.32% from 5.68% in December 2019. This is the lowest sickness absence rate figure for 3 years. In addition, the rolling year to date sickness absence rate has decreased from 5.28% in December 2019 to 5.10% in January 2020.

Empactis System

The HR Team are commencing implementation of the Empactis system, a tool which will be able to electronically manage absence, Employee Relations cases and data reporting. Full, Trustwide engagement we were assured, will result in efficiency and cost savings.

New Risk identified at the meeting	None.

Review of the Risk Register

Alert, Advise, Assure (AAAs)
Highlight Report

COMMITTEE/GROUP:	**HOSPITAL MANAGEMENT BOARD**
MEETING DATE:	**20 FEBRUARY 2020**
LEAD:	**TRISH ARMSTRONG-CHILD, HMB CHAIR**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

No alerts were noted.

ADVISE

- **Finance Report** – the Month 10 financial plan was not achieved. HMB reviewed the Finance Report which outlined the financial position for Month 10 and the progress on delivery of the Trust's deficit control total of £26.567 million before non-recurrent funding of £18.271 million, and a net deficit of £8.296 million.

- **CIP -** The Trust would be reporting further slippage in the CIP programme with a projected year end shortfall of £2.2 million as at Month 10. The Trust is currently developing its CIP plans for 2020/21 which will include schemes that have not delivered in 2019/20. All schemes including additional workforce schemes currently being developed would be tracked through fortnightly Efficiency Programme Group (EPG) meetings.

ASSURE

Integrated Performance Report

- Indicated improvement in 62 Day GP referrals and January's sickness rate which decreased from 5.68% in December to 4.32% in January 2020 also significantly below January 2019 at 6.39%.
- There was a pleasing slight drop in UEC demand in January at both sites compared to December and the year prior. 4 hour performance improved by 1.6% in January to 84.4% compared to December
- Performance on Fractured neck of femur is stable due to the increase in admissions. The opening of the Orthopaedic rehab ward at Ormskirk in January has had a positive effect on patient flow with the average overnight occupancy at 85%.

Patient Experience Report

The Deputy Director of Nursing outlined that overall Trust response rate for Dec-19 has slightly increased from 19.9% to 21.35%. However this remains significantly better since the recent digital enhancement. Those that would recommend have slightly increased from 90.63 % to 91.36%. Shared themes from negative ratings for Dec-19 were related to staff attitude; implementation of care, environment and communication. Following receipt of national survey results, action plans have been put in place or currently in development within the CBU's.

Highlight Reports from Performance Review Board meetings.

The HMB received and took assurance from the AAA reports and minutes from the Clinical Business Units PRB meetings held in February.

New Risks identified at the meeting: No new risks identified in meeting**.**

Review of the Risk Register:

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
4 March 2020

Agenda Item	**TB031/20**	**Report Title**	**Q3 Freedom to Speak Up Report**
Executive Lead	Bridget Lees, Executive Director of Nursing Midwifery & Therapies		
Lead Officer	Claire Harrington, Deputy Director of Nursing Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required	☐ To Approve ☐ To Assure ✓ For Information		☐ To Note ✓ To Receive

Executive Summary

This report identifies the number of concerns raised to the FTSU Guardian during quarter 3 2019 (1st October – 31st December). Over the quarter 25 concerns have been through the FTSU Guardian.

During quarter two a significant number of concerns were raised highlighting safety and management concerns within a department, which continued into quarter 3. The safety concerns are now being addressed by senior management and the appointment of a senior person from within the department as a safety champion, who is meeting staff regularly.

During the quarter we have trained 4 new Champions were trained making a total of 17 currently active champions.

Recommendation

The Board is asked to **receive** this report as assurance that people are feeling able to raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes are in place for staff to do this safely and confidently that action will be taken.

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

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

Impact

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

Equality Impact Assessment	☐ Policy
	☐ Service Change
	☐ Strategy

Next Steps

To receive the report and note progress made during 2019-2020.
To support future plans 2020 – 2021

Previously Presented at:

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

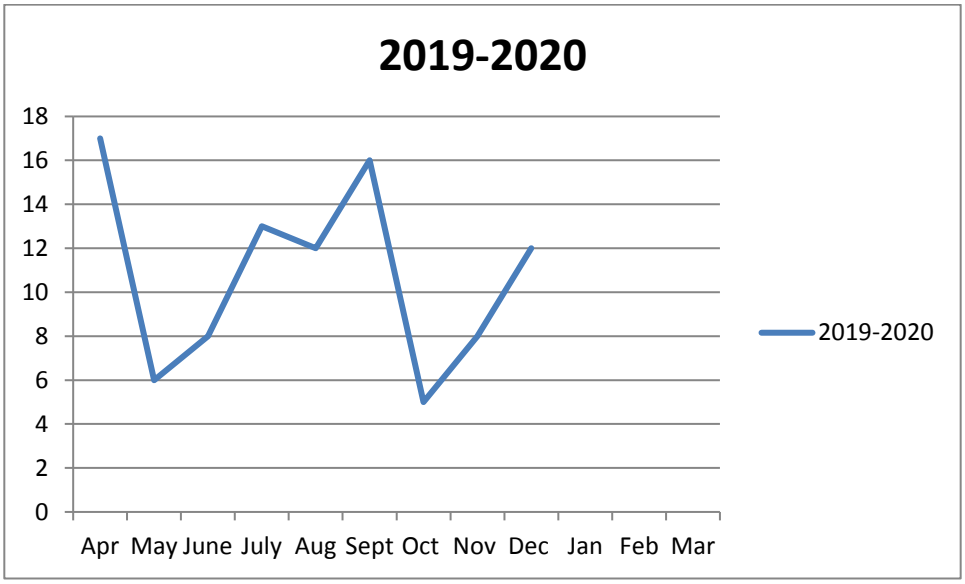
1 Report on Submission to National Guardians Office

Quarter 3 1st October – 31st December 2019

Date to be submitted to NGO: **Tuesday 14th January 2020**

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

Number of concerns raised: **25**



1.1 During quarter 3, 25 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG).

For reasons of confidentiality only general themes are recorded within this report.

Concern themes raised during Quarter 3
Team dynamics, relationships, communication, alleged bullying/harassment behaviours, clinical care standards, staffing levels, equality act adherence, hygiene standards, valuing staff, annual leave management, disciplinary process management, dignity at work, recruitment policy adherence, work pressures, car parking.

Concerns raised by pharmacy and a mixture of nursing, health care support and medical staff from a variety of areas. Other concerns raised by administration staff and human resources.

1.2 Anonymous concerns

Although there have been no “anonymous” concerns raised over the last quarter a number of people do not want their name to be known other than by the FTSUG.

1.3 Situations where detriment was expressed because of speaking up:

In the last quarter there has been none highlighted. However there is still an open concern where it is believed detriment has been issued. A person who previously expressed detriment because of raising a concern has now met with senior managers and it is hoped this concern is now on course for a positive outcome.

1.4 Feedback post raising concern

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

During quarter 2 feedback was received from 4 people. All of the feedback was positive with positive outcomes. The relatively low number in relation to feedback is due to the significant number of concerns still open. It is expected these will be resolved in a timely manner.

Given your experience, would you speak up again?

All answered yes.

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

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

There have not been any suggestions improving the service.

They are all pleased with the outcome and with the service and support offered by FTSU and would recommend it to others.

Some examples:

Thank you - you have both been an amazing support over recent months. Thank you both.

After my experience with raising a concern I would feel comfortable raising a concern again as I found the process and the people involved very supportive and positive. It was all dealt with in a private way which I am grateful of.

I was coming into work with a lot of anxiety and dread but it was eased after sharing my feelings and raising the concern with Martin who was very understanding. My managers had a lot to do with me feeling more comfortable too.

Changes as a Result of Speaking Up:

Recent changes as a result of speaking up include:

After many failed attempts, and a further concern raised by our Muslim Colleges, appropriate space being found for Islamic prayers (more details to be published next quarter)

After a concern raised about the cost of car parking, particularly for the bereaved and frequent visitors has been agreed for certain groups of people:

From Trust News 16-1-20

9. Free parking for some patients starts

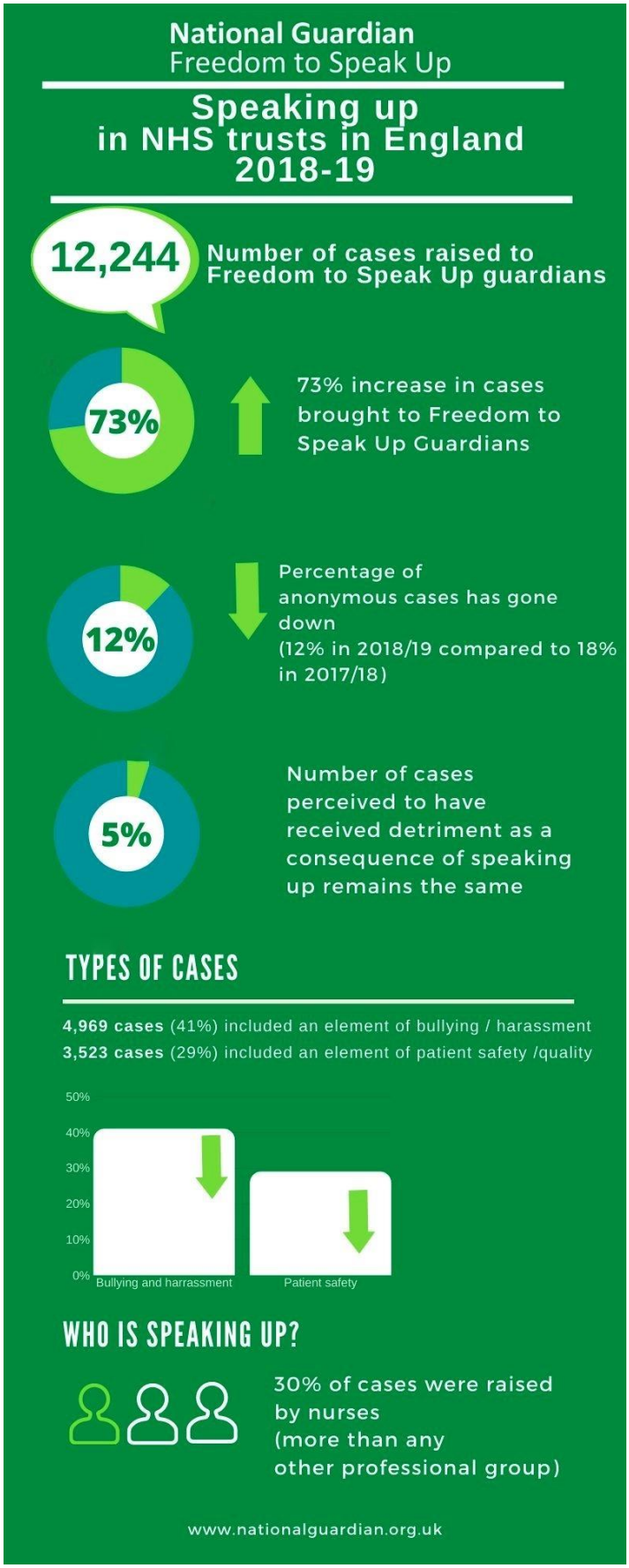
- From Monday, patients undergoing regular treatment in the Medical Day Unit will be entitled to free parking during their course of treatment. Tickets will be stamped by receptionists
- Families of any patients who have been recognised as sick enough to die and for whom an individualised plan of care is being developed, will be given a slip which can be exchanged for a free parking pass, which they can use during the final stages of their loved ones life
- Family who have experienced a sudden death will be given a slip to allow them to have their parking ticket stamped on the day. This can be stamped in the porters office, general office or switchboard if out of hours
- Families with babies in neo-natal have been able to borrow a free parking pass for some time - by leaving a deposit at the ward, so this will continue

Some of the mechanisms behind this are still being tweaked and the paperwork is still filtering through, so please bear with us for the next week or so.

TB031_20 - Freedom to Speak Up Report Q.3

The National Picture

The local trends are certainly reflected in the latest national statistics:



National Guardian
Freedom to Speak Up

NGO Press release - 14th January 2020, Supporting the Above Data

Report reveals more NHS workers feel confident to speak up... and more are doing so

Over the last two years over 19,000 cases of speaking up by NHS workers in trusts have been handled by Freedom to Speak Up Guardians. These include cases with an element of bullying and harassment and that have impacted on patient safety and quality of care.
A new report published today (14th January 2020) by the National Guardian's Office reveals that over the last year cases of speaking up to guardians have risen by 73 per cent, compared to 2017/18.

Of the 12,000 cases raised between 1 April 2018 and 31 March 2019, guardians reported that almost a third included an element of patient safety/quality of care, and just over forty per cent included an element of bullying/harassment.

There are now Freedom to Speak Up Guardians in every trust in England, introduced in the wake of the Francis Inquiry into the events at Mid-Staffordshire NHS Foundation Trust.
National Guardian for the NHS, Dr Henrietta Hughes OBE, said, "The confidence that NHS workers have in the ability of guardians to address the issues they raise is growing and more learning is being brought to organisations to help them improve.

"Our goal at the National Guardian's Office is to make speaking up business as usual, and while there is some way to go to achieve that, these latest figures are encouraging."
Other trends that the report draws from the data that guardians in trusts are providing to the National Guardian's Office are that the percentage of anonymous cases is falling, down to 12 per cent in 2018/19 compared to 18 per cent in 2017/18.

However, the report also reveals that while low, the number of workers who indicated they were suffering detriment as a result of speaking up has remained disappointingly static at five per cent.

There was also evidence that speaking up varied significantly from trusts to trust, with the highest number of cases in a single trust reported over the year being 270, while the lowest number was just one.

"Measures like the level of anonymity dropping are good indicators to suggest workers feel more confident to speak up, particularly when considered in tandem with the encouraging increase in the overall number of cases," said Dr Hughes.

"However, it is important that each individual trust looks at their data in context and tries to draw learning from it. Organisations where very few workers are speaking up or where levels of reported detriment are far higher than the norm should look to understand and address the issues that may account for that.

"Encouraging workers to speak up, and removing barriers that may prevent them from doing so, is in the best interests of every organisation that wants to deliver the highest quality care possible.

"We must never lose sight of the fact that while Freedom to Speak Up is there for workers, it ultimately all comes back to patients and service users - keeping them safe and treating them well."

TB031_20 - Freedom to Speak Up Report Q.3

About this report

The appointment of a Freedom to Speak Up (FTSU) Guardian is a requirement of the NHS Standard Contract in England for NHS trusts and foundation trusts.

Freedom to Speak Up Guardians in trusts and foundation trusts have been asked to provide quarterly reports on the number of cases they have received since April 2017. These quarterly reports are published on the NGO's webpages.

This end of year report represents a summary and analysis of the second year's return and compares across the two years for which data is available.

The report is available for download from www.nationalguardian.org.uk

Key data:

Between 1 April 2017 and 31 March 2019, **19,331** cases were raised to Freedom to Speak Up (FTSU) Guardians in trusts and foundation trusts.

• **12,244** cases were raised to FTSU Guardians in trusts and foundation trusts between 1st April 2018 and 31st March 2019.

• The total number of cases raised in 2018/19 was **73% higher** than that raised in the 2017/18 reporting period

• The number of cases raised in Q4 of 2018/19 was **38% higher** than that raised in Q1 of the same year

In 2018/19:

• More cases (3,728, 30% of the total) were raised by **nurses** than other professional groups.

• **1,491** cases (12%) were raised anonymously, compared to 18% of cases the previous year.

• **3,523** cases (29%) included an element of patient safety/quality of care

• **4,969** cases (41%) included an element of bullying/harassment

• **564** cases (5%) indicated that detriment as a result of speaking up may have been experienced

About the National Guardian's Office

The National Guardian's Office works to make speaking up becomes business as usual to effect cultural change in the NHS.

The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts case reviews of organisations when it appears that speaking up has not been handled according to best practice.

The role of Freedom to Speak Up Guardians and the National Guardian were established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and recommendations from Sir Robert Francis' Freedom to Speak Up Inquiry.

There are now over 500 fully trained guardians in NHS and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job. The National Guardian's Office also provides challenge and learning to the healthcare system as a whole as part of its remit.

About the National Guardian for the NHS
Dr Henrietta Hughes was appointed as the National Guardian in July 2016. She provides leadership and support to Freedom to Speak Up Guardians across England in national bodies, NHS and independent sector organisations to ensure that speaking up becomes business as usual. Previously a Medical Director at NHS England, Dr Hughes continues her clinical role one day a week as a GP in central London.