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

NHS
Southport and Ormskirk Hospital
NHS Trust






Annual Report and Accounts 2017/18

For You. With You.

Southport and Ormskirk Hospital NHS Trust

Annual Report and Accounts for the Year Ended 31 March 2018

In Accordance with the Department of Health Group Accounting Manual 2017-18

Annual Report 2017-2018

Performance Report

JOANNA FRANKLAND A&E EMERGENCY ASSESSOR

OVERVIEW OF PERFORMANCE

Chair and Chief Executive Statement on the Trust's performance

Southport and Ormskirk Hospital NHS Trust provides healthcare in hospital and the community to 258,000 people across Southport, Formby and West Lancashire.

Acute care is provided at Southport and Formby District General Hospital and Ormskirk and District General Hospital.

This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities. Women's and children's services, including maternity, are provided at Ormskirk hospital.

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

The Trust also provides sexual health services across the Metropolitan Borough of Sefton and a wheelchair service for users across Southport, Formby, Chorley, South Ribble and West Lancashire.

Until 30 April 2018, the Trust was also responsible for many adult community health services in North Sefton and West Lancashire provided in health centres, clinics and at patients' homes. The Trust also provided community urgent care services at Skelmersdale Walk-in Centre and West Lancashire Health Centre at Ormskirk hospital.

Our vision and values

The Trust's vision is to provide safe, high quality services. Our values are expressed through ***"Scope",*** developed from what staff told us was important to them about the Trust. They are:

- *Supportive*
- *Caring*
- *Open and honest*
- *Professional*
- *Efficient*

Staff at all levels have worked tirelessly and with dedication to give our patients both high quality care and a good experience this year.

Work, such as the *Safe at all Times* programme means our wards are better organised for the benefit of both patients and staff. A much-needed day surgery unit opened at Ormskirk hospital in February 2018 followed by ring-fenced hyper-acute stroke beds at Southport.

A £1.25m investment in urgent care at Southport hospital continues as we end the year. The most eye-catching aspect was the lifting by crane into a courtyard next to A&E of four ready-made modules. These will become an eight-bay clinical decision unit which, with other improvements, will give patients a better experience of care in a modernised clinical environment.

We have continued to see steady improvements in maternity care at Ormskirk hospital. More mothers chose to have their babies with us this year and a national patient survey ranked our service 11th best in England.

The Trust's key infection rates also continue to be among the best in the region.

These are important milestones on our quality improvement journey, achieved against a background of increasing patient demand, many with more complex needs, and from the oldest population served by any NHS Trust.

This was a key a factor in the Trust missing the national A&E four-hour standard. The loss of our community service contracts in May to separate providers, including elements of discharge planning, added a further challenge which is only now being remedied.

Progress has been made but there remains much to do. Not least the Trust needs to embed and cherish the improvements staff work so hard to make. The Care Quality Commission (CQC) inspected the Trust in November and December 2017. Their report made clear some areas had slipped back from the progress shown at the last inspection. (Table 6, page 18)

The past few years have been an uncertain and sometimes bewildering time for staff and our local community with no permanent leadership at the top of the organisation.

An investigation which followed whistleblowing complaints against four members of the leadership team in summer 2015 was concluded in June 2017.

It had earlier determined that the Deputy Director of Performance had no case to answer and a disciplinary panel later exonerated the Chief Operating Officer of the allegations made against her.

Following a disciplinary hearing and subsequent appeal, which was successful in part, it was found that the former Director of Human Resources and Communications had committed acts that could be construed as misconduct and would have been dismissed had she not retired from her position before the convening of the disciplinary hearing.

It was further found, by a separate independent disciplinary panel and appeal panel, that the former Chief Executive had committed acts of gross misconduct. He was dismissed without notice.

In a separate development, the Executive Medical Director was excluded from work in August following an independent review of the culture at the Trust. The review was commissioned following concerns raised by staff with the CQC. The matter remains under consideration.

We want to thank staff and local people for their patience and forbearance during this uncertain time.

It is a credit to staff they have got on with the job of caring for patients. Their commitment to this task was especially notable during the *WannaCry* cyberattack which affected computer systems at a significant number of NHS organisations in May 2017.

Staff kept patients safe despite challenging operational conditions. Of note was the IT team who worked round the clock for several days to get systems back online.

The Trust was pleased to work with the National Guardian's Office on a review of how speaking up by staff was, and had been, handled.

We encouraged staff from across the organisation to take part and they raised a range of concerns. Most of those concerns went back a good number of years.

The learning from the review, published in November 2017, was a welcome and helpful addition to the robust action plan the Trust has in place to ensure that *Speaking Up* is seen as a way to make improvements for our staff and for our patients.

Like many NHS organisations, our financial performance was challenged by tight national settlements and lower than expected outpatient and elective activity.

The Trust had approved a revised financial forecast of a deficit of £29.1m however the final position was £33.6m due to the impact of an Independent Expert Determination ruling on contract disputes and sanctions for contract performance.

A bright spot was agency spend which achieved the target of £7.2m. A significant contribution to this success was the introduction of a medical bank and compliance with framework agency rates, and recruiting temporary medical staff on longer term contracts, has helped to keep costs down.

Through necessity the Trust has had the services of several interim executive directors while the whistleblowing investigation took place. These included chief executives Ian McInnes, Karen Jackson and Ann Farrar.

Between them with the support of the Board, they have contributed to initiating the changes that will be required to the shape of our Trust for future years.

We are particularly grateful to our clinical leaders – nurses, doctors, therapists and clinical support leads – for bringing their professional knowledge and experience to the questions of how services provided locally can best meet the needs of patients.

Getting our services right will need the support of partner organisations to ensure that decisions proposed for Southport and Ormskirk fit with plans in other parts of the NHS.

That's why *Care for You* is being sponsored by Sefton Health and Care Partnership, a group of health and care organisations helping to shape these services across Sefton and into West Lancashire.

A lot work remains to be done and we will be consulting widely as our plans develop.

Improving care for patients

Staff members are constantly working to improve the service for patients, especially where their condition stops them leading a near-normal life.

- In the autumn, a father-of-two in his forties was the first Trust patient to benefit from a technique to improve bladder control due to an enlarged prostate. It was carried out by a team led by Consultant Urologist Rahul Mistry at Ormskirk Hospital.

- Dr Paula Briggs, Consultant in Sexual and Reproductive Health, has the only consultant-led menopause clinic in the area. She has also run education roadshows for police, the fire and rescue service, other NHS Trusts and HM Revenue and Customs.

- An adult gymnast from Southport was made fit to compete again thanks to the skill of Consultant Orthopaedic Surgeon Prof Adnan Saithna, a specialist in sports injuries. The repair to his shoulder helped the school teacher become a medal winner at a national competition. Prof Saithna, meanwhile, was presented with the Richard J O'Connor Award by the Arthroscopy Association of North America in June for research conducted through his collaboration with the Fédération Internationale de Football Association (FIFA) Centre for Medical Excellence at the Santy Clinic in Lyon.

The work of the North West Regional Spinal Injuries Centre was celebrated in June 2017 when it hosted the 34th international Guttmann Conference.

More than 200 delegates, experts and professionals in the field of spinal injury rehabilitation and care attended the event which also marked the 70th anniversary of spinal care in Southport.

Promoting health and well-being

The Trust supports initiatives that promote the health and well-being of staff, patients and visitors:

- An Older People's Day in October brought together hospital services with Macmillan, the Stroke Association and the Alzheimer's Society to provide in one place information about dementia, orthopaedics, mental health and many other conditions

- World Kidney Day gave visitors the opportunity to receive on the spot testing for kidney disease

- For World Aids Day the sexual health team pushed the "know your status" message as well as raising awareness about other sexually transmitted infections

- 80% of frontline staff took advantage of a free flu vaccination to protect themselves, their families and patients. The Trust was one of the NHS's best performers against the 75% target.

PRIDE AWARD WINNERS 2017

Remembering loved ones and supporting bereaved families

The Chaplaincy and Spiritual Care service offers pastoral, spiritual and religious support to those who need it whether they are people of faith or no faith.

A baby and child remembrance service is becoming an increasingly popular and appreciated event. Organised by Trust chaplain, the Rev Martin Abrams, at Ormskirk hospital, it offers support to families in the weeks before Christmas.

An annual memorial service in Southport held at Marshside Methodist Church, Southport, for anyone wanting to remember a loved one has similarly grown in size.

Celebrating staff and volunteers

The Trust drew on the knowledge and experience of staff to create a vision for the organisation – "Providing safe, high quality service" – and a strapline to accompany it, '*For you. With you'*.

These were celebrated with a poster campaign in our buildings, *Time-To-Shine*, featuring quotes from staff about why they loved working for the Trust. Some of those posters have been used in this annual report.

The annual Pride Awards were held again in June at the Floral Hall in Southport. More than 300 staff and guests attended the awards dinner and ceremony at which nine awards recognising the skill and dedication of staff were presented.

The winners were:

- Community Team of the Year: **Sefton Sexual Health**
- Excellence in Service Improvement: **Maternity IT Team**
- People's Choice Award: **Claire Albo**, **Community Midwife**
- Support Service Team of the Year: **Information Analysts**
- Volunteer of the Year: **Spinal Unit Action Group**
- Excellence in Patient Experience: **Ward 15A (Southport)**
- Chief Executive's Award: **Children's Cystic Fibrosis Team**
- Lifetime Achievement Award: **Bakul Soni; Sandra McCarthy; Julie Jones**
- Acute Team of the Year: **Accident and Emergency**

We continue to be indebted to the many contributions to the life of the Trust made by our volunteers.

These include *Welcomers* at our hospital receptions, dining companions for patients, chaplaincy volunteers and radio volunteers at Ormskirk.

We also fortunate to benefit from a number of long-standing volunteer groups whose fund-raising activities make a valuable contribution to patient care. These include the RVS hospital shops, the Spinal Unit Action Group, and the League of Friends at Ormskirk hospital.

Apprenticeship programmes

The Trust has a long-term commitment to apprenticeship training. With the introduction of the Apprenticeship Levy in April, apprenticeships were re-evaluated to better utilise the programmes to meet the variety of individual and professional training needs.

Our new apprenticeship manager secured 42 new registrations in her first six months.

The Trust held two open events for local colleges, universities and private training providers to showcase their programmes to staff.

In 2017/18, the focus has been on the development of the current staff; the next step is to look at recruiting apprentices from the local community to fulfil future workforce needs and adopt the new trailblazer programmes to enhance new roles and ways of working.

The Trust also became the first organisation in the country to sign up to Unison (the union's) Apprenticeship Charter.

The charter ensures that apprenticeships deliver a positive outcome for both apprentice and employers. It also commits the Trust to provide apprenticeships that are well-funded, high quality and that lead to a meaningful job.

Library and Knowledge Management Services

The Library and Knowledge Service supports the information needs of clinical and non-clinical staff across the Trust.

Quality: The service maintained its "green" rating by achieving a 97% result against the standards of the Library Quality Assurance Framework, making our service one of the top ranking in the region.

Organisational Support: The service supports evidence-based practice and decision-making by liaising with colleagues from across the Trust. It provides a range of information consultancy services to underpin policy development and review, lessons learned, clinical practice, service development, education and research.

Contracts: Service level agreements with Edge Hill and Central Lancashire universities have been successfully renewed for another year. Students have access to the full range of library services and resources including 24/7 swipe-in access at both library sites and remote access via the library website.

Service development: A range of services and resources continues to be developed to meet the information needs of the Trust's staff and students. Most recently purchased and funded through external bids:

- Wi-fi access for the library at Ormskirk hospital
- A range of interactive learning resources on topics such as patient flow, sepsis and infection control
- Reminiscence materials to support the patient experience agenda
- BMJ Best Practice for evidence-based summaries to clinicians at the point of care

Statutory and mandatory staff training

Mandatory training compliance has risen from 76.74% (March 2017) to 85.15% (March 2018) and achievement of the Trust's 85% target was maintained during the final six months of the year. The roll-out of the MyESR portal now gives the Trust:

- Employee self-service, including access to personal data, pension information, training compliance
- Manager self-service (single point access to full team information and compliance)
- Remote access to ESR via mobile devices
- eLearning for all level 1 core mandatory training subjects

The Trust is seventh best-performing in the North West with 79.8% of staff with an ESR account.

Appraisals

The appraisal policy and documentation were simplified to encourage managers to focus more on the quality of the conversation rather than form filling. This was supported by a series of *ManagersNet* workshops and the development of a dedicated web page on the Education and Training website.

Leadership programmes

The Trust launched a suite of management and leadership apprenticeship programmes sourced through our local colleges from level 2 team leading to Level 5/6 leadership and management programmes. A pharmacy services manager successfully achieved his ILM Level 5 leadership and management apprenticeship and received a Star Award at the Southport College Apprenticeship Awards. The Trust is also a member of the NHS Leadership Academy.

Widening participation through community engagement

There has been an increase in community engagement activity and the Trust has strengthened its links with local schools, colleges and community groups through the employment of a Community Engagement Manager. In 2017/18, the Trust has engaged in a wide range of career events and activities to increase young people's awareness of NHS careers as well as the opportunities available at the Trust.

The Trust worked closely with Southport College to design and deliver the Acorn cadet programme (BTEC diploma Level 3) and has implemented a traineeship programme offering four students a six-week work placement. The Trust is developing a 10-week pre-employment programme in partnership with the Department of Work and Pensions which will offer five unemployed adults the opportunity to gain practical work experience.

Non-Medical Clinical Education Committee (NMCEC)

The Trust has a newly formed non-medical clinical education committee NMCEC established as a sub group of the Workforce committee and sub group to the Trust board which will escalate items using the Alert/Advise/ Assure framework. NMCEC has been formed to bring together the clinical education leadership voice in the delivery of high quality effective and sustainable education and training. The group will provide assurance to the Trust Education

Committee and Workforce Committee that the Trust is fulfilling its regulatory activity in line with CQC, HEE and other statutory bodies.

Practice Educators

The Trust has recently employed more practice educators in each of the CBUs bringing them together at the NMCEC to share best practice and supporting the roles of educators in a more structured forum and developing the clinical education leadership voice.

Trainee Nursing Associates

The Trust is a pilot site for Trainee Nursing Associates (TNA) and is part the second fast follower site partnership in Mersey and Cheshire. We have 2 TNAs who have just entered their 2nd year. This is an exciting new role which aims to bridge the gap between Health Care Support Workers and Registered Nurses. The government aims to expand the numbers over the next 2 years; 3,000 in 2018 and 5,000 in 2019 and so on.

The Trust has also joined the Lancashire and Cumbria 3rd Wave Partnership and will be recruiting a further 3/5 for the June 2018 intake. Further opportunities will be dependent on the workforce 5 year Projected Plan in regards to numbers.

Trainee Assistant Practitioners

The Trust will celebrate the achievements of 3 Trainee Assistant Practitioners (TAPs) this year from Urgent Care who will have successfully completed 2 years of study with Chester University progressing from a Health Care Support Worker Band 3 to an Assistant Practitioner with promotion to Band 4.

The Trust has 12 Trainee Assistant Practitioners recruited from different clinical settings in January 2018 studying the 2 year work based learning programme with the University of Central Lancashire (UCLAN) to become Assistant Practitioners again exiting with a foundation degree and promotion to Band 4.

Preceptorship Southport and Ormskirk Graduation Programme

The Clinical Education Team has been re - developing the 12 and 18 month preceptorship programmes which will align to the Southport and Ormskirk Graduation Programme. The Graduation Programme is based on three awards: Bronze, Silver and Gold, taking the new Preceptees and progressing them through these three levels.

The Clinical Education Team has developed a rotational clinical skills programme that every Southport and Ormskirk Preceptorship Nurse new to the Trust will complete in their first 12 /18 months. Our Health Care Support Worker (HCSW) and Multidisciplinary Team (MDT) Acute Illness Management (AIM) is part of this framework. AIM courses run monthly and include human factor and scenario base education designed to recognise and respond to the deteriorating patient. On completion the Preceptee will graduate with their bronze certificate and badge. The clinical skills framework aims to ensure patients receive the right care in the right place at the right time delivered by the right person with the right skills. The framework will have Silver and Gold awards as the Nurse progresses. This will include

leadership development and succession planning for the future. The Annual pride awards will see Preceptor of the year a new award in 2018 in recognition of supporting our new staff.

Medical Education

Medical Education has been under scrutiny from Health Education England North West and the University of Liverpool to ensure a quality experience was being delivered for our medical students and trainees.

A great deal of good work has been undertaken with the full support and direction of the Board to develop and implement significant change which meets the specific requirements of our external stakeholders. The measures undertaken include:

- Job planning for our consultant and Specialty and Associate Specialist (SAS) doctors which provides full acknowledgement of each individual's educational remit.
- Organisational change and expansion of the medical education team to ensure that service requirements are addressed in the most effective and efficient manner.
- Software tools to support trainers and students.
- Two additional medical education leads to address existing gaps in leadership, support and direction for our undergraduate cohorts.
- Embedding robust systems of educational governance, aligned to that of clinical governance, has provided clarity, structure and accountability for the department.

Clinical skills and simulation

We have seen a substantial increase in clinical skills and simulation-based education, supported by investment in new equipment.

Simulation in particular has seen an unprecedented increase, with a further rise in medical student numbers this year and the roll out of the Health Education England Foundation Year Simulation Programme. More than 120 hours of simulation activity has been delivered.

The Trust was the first to successfully implement the full Foundation Simulation Programme, with all foundation year doctors who attended, receiving eight hours each of simulation-based education.

Clinical skills teaching has also expanded, and is now firmly embedded in nursing, medical and undergraduate programmes, with further investment in curriculum specific part task training equipment.

Finally, our thanks go to Sheila Lloyd, Director of Nursing, Midwifery and Therapies, who moved to a director's post at another Trust in March, and non-executive directors, Ann Pennell, Carol Baxter, Su Fowler-Johnson and Paul Burns, whose terms of office each came to an end during the reporting period. Their successors are in place as this Annual Report goes to press.

Richard Fraser Chair

Silas Nicholls Chief Executive

Statement on the purpose and activities of the Trust

The Trust is commissioned to provide acute services to a community of approximately 258,000 people across Southport, Formby and West Lancashire. Acute care is provided from two hospital sites, Southport Hospital and Ormskirk Hospital. Women and Children's services, including maternity, are provided from Ormskirk Hospital. Acute services include accident and emergency services, intensive care and a range of medical and surgical specialties as set out in the table below:

Dermatology	ENT	Genito-urinary medicine
Nephrology	Ophthalmology	Oral and Maxillofacial
Orthodontics	Orthopaedics	Paediatrics
Palliative Medicine	Pathology	Radiology
Spinal Injuries	Urology	

Table 1

History of the Trust

Southport & Ormskirk Hospital NHS Trust (the Trust) is a body corporate which was established under the Southport & Ormskirk Hospital NHS Trust *National Health Service Trust* (Establishment) Order 1999 No 890 (the Establishment Order). The principal place of business of the Trust is Southport District General Hospital, Town Lane, Kew, PR8 6PN.

Key risks and issues that could affect delivery of the Trust's objectives

Strategic objectives for 2017/18 and the associated principal risks

Key Area of Concern	Proposed Objective	Principal Risk
Lack of Strategic Direction	***SO1 Agree with partners a long term acute services strategy***	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards
Aspects of Clinical Quality, e.g. mortality figures	***SO2 Improve clinical outcomes and patient safety***	Poor clinical outcomes and safety records
Financial Performance	***SO3: Provide care within agreed financial limit***	Failure to live within resources leading to increasingly difficult choices for commissioners
Performance on statutory targets	***SO4 Deliver high quality, well-performing services***	Failure to meet key performance targets leading to loss of services
Staffing Issues, including morale, sickness levels and need to meet safe staffing	***SO5 Ensure staff feel valued in a culture of open and honest communication***	Failure to attract and retain staff

levels		
Managerial capacity and capability	***SO6 Establish a stable, compassionate leadership team***	Inability to provide direction and leadership

Table 2

Going Concern disclosure

The basis of management's going concern assessment is the continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents.

There are future uncertainties, however, like other NHS providers the Trust is working with local and regional NHS organisations to return to a financially sustainable organisation within the five year forward time-frame of 2020/21. Cash support is being given by the Department of Health via interest-bearing loans and NHS Improvement is providing support to aid efficiency and productivity. In addition the Trust has successfully appointed a permanent Chief Executive to lead the organisation with a clear vision of what needs to be done.

Final financial plans for 2018/19 were submitted to NHS Improvement (NHSI) on 30th April 2018 and show a forecast deficit of £28.8m. This is an improvement on 2017/18 however; this does not return the organisation back into balance. The new Chief Executive has made some senior management changes with the appointment of a Director of Strategy. In addition NHSI are providing support in the recruitment of a Turnaround Director. A new Director of Nursing has taken up her post and a new permanent Medical Director will be appointed later in the year. The organisation will finally have a stable leadership with a long-term view to work with our local commissioners and other stakeholders to deliver safe, high quality, affordable healthcare to the local population.

Our external auditors, Mazars LLP have made a Section 30 referral letter to the Secretary of State as the Trust has made a cumulative deficit over a 3 year period. This is a legal requirement for the auditors, however, given that the Trust has plans for the future and cash support, the Trust does not believe that this referral letter undermines management's view that the Trust is a going concern.

In accordance with IAS 1, management have made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

PERFORMANCE ANALYSIS

Performance indicator set by our commissioners against key contractual targets

Key financial targets

The major changes to the Trust's business in 2017/18 were as follows:

- Community services for both the Sefton and West Lancashire sides transferring function to other providers from May 2017.
- The outsourcing of payroll and the whole of the Human Resources function to St Helens & Knowsley NHS Trust from July 2017.

The main challenges in 2017/18 which affected financial performance were as follows:

- Under-performance on elective work. This was compounded by a number of other factors including the cyber-attack in May 18, a decontamination issue resulting in postponed theatre appointments and a national directive to reduce elective work to cope with increased A&E pressures.
- Reliance on temporary staff to fill gaps in junior doctor rotas and vacancies in nursing.
- Cost of agency staff at premium rates.
- Difficulty in achieving the Cost Improvement Programme target particularly on the workforce programme.
- Higher sickness absence rates than planned.
- Exceptional costs in relation to a Board exclusion.
- Imposition of financial penalties by our local Commissioners particularly around A&E targets as the Trust had not agreed to the control total.
- The outcome of Expert Determination around prior year disputes and current year local tariff prices for ambulatory care which resulted in further reductions in income.

NHS Trust financial targets and performance against those targets extracted from the audited accounts are shown below:

Performance indicator	Target 17/18	Actual 17/18	Variance	Achieved
Adjusted financial performance	-£29,200,000	-£33,601,000	-£4,401,000	Yes **
External Financing Limit	£30,473,000	£30,398,000	£75,000	Yes
Capital Resource Limit	£6,048,000	£6,041,000	£7,000	Yes
Better Payment Practice Code (non NHS) by no. of invoices	95%	64%	-31%	No
Better Payment Practice Code (NHS) by no. of invoices	95%	49%	-46%	No

Table 3

The adjusted financial performance is set out on the face of the Statement of Comprehensive Income and is after technical adjustments. The Trust made a loss of £33.601m.

Given the level of pressures, the Trust agreed with the regulator, NHS Improvement (NHSI) in January 2018 to amend its forecast outturn to a deficit of £31.7m. The Trust took further actions to reduce the forecast deficit to £29.2m the following month.

However the forecast specifically excluded penalties and the outcome of the Expert Determination. If the penalties and Expert Determination are excluded (£4.4m adverse

impact) then the Trust did achieve its revised forecast outturn target and this is the reason that this target is shown as being achieved.

The External Financing Limit (EFL) is a cash-based control for NHS Trusts, it is shown in note 33 of the accounts. Although no longer a statutory duty the Trust has achieved this target with an undershoot of £75k.

The capital resource limit (CRL) is a control on capital expenditure in full accruals terms. All NHS bodies have capital resource limits which they are not permitted to overspend. The Trust underspent against its CRL by £7k. This is shown in note 34 of the accounts.

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Up until the agreed change in the forecast outturn in January 2018, the Trust was restricted in the value of its loan applications and this impacted on having sufficient cash resources to meet the Better Payment Practice Code. As such the Trust did not achieve this target.

NHS Improvement measures the Trust's financial performance using 5 metrics which are consolidated into a use of resources risk rating from 1.

Metric	Value		Risk rating	
	Plan	Actual	Plan	Actual
Capital service cover rating	-1.47	-2.79	4	4
Liquidity rating	-20.52	-43.74	4	4
I&E margin rating	-11.01%	-21.26%	4	4
I&E margin: distance from financial plan		-10.25%		4
Agency rating	7,220	6,845		1
Overall				3

Table 4

The Metric definitions are as follows:

- Capital service capacity - This metric assesses the degree to which the organisation's generated income covers its financing obligations.
- Liquidity (days) - This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
- Income and Expenditure (I&E) margin - This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
- Distance from financial plan - This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
- Agency spend - Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.

Financial analysis

The following table gives a high level comparison between the two financial years:

Accounting heading	2017/18	2016/17	Variance	Variance
	£'000s	£'000s	£'000s	%
Turnover	158,277	186,695	-28,418	-15.2%
Operating expenses	185,545	204,015	-18,470	-9.1%
Non-current asset base	126,790	123,991	2,799	2.3%
Total assets employed	26,997	56,453	-29,456	-52.2%

Table 5

Turnover

Income has decreased by £28.4m from 2016/17 levels. This is due to the following:

- Loss of community services, -£20m.
- Under-performance on commissioner contracts due to reduced elective activity, -£3.5m.
- Expert Determination provision, -£2.8m.
- Financial penalties, -£1.7m.
- Reduction in winter planning monies compared to previous year, -£0.3m.

Operating expenses

This shows a decrease of £18.5m from 2016/17. Of this decrease, £14.5m relates to pay and this is a combination of reductions due to the transfer of community, payroll and HR staff to other providers, significant reductions on agency spend, offset against increases due to pay inflation, new appointments and the impact of the apprenticeship levy.

The remaining £4m decrease is on non-pay. Again in a similar vein to pay there are reductions due to the transfer of community services and the reduction in activity offset by increases in clinical negligence premiums.

Non-current asset base

The overall value of capital assets has increased in 17/18 by £2.8m. A revaluation exercise at 1st January 2018 of land and building assets resulted in an upward revaluation of £3.1m offset by disposals of £0.7m (relating to community assets). This gives a net upward movement of £2.4m. The remaining £0.4m is the difference between in year additions at £6.3m less depreciation/amortisation of £5.9m.

Total assets employed

The total value of the Statement of Financial Position has reduced by £29.5m. This is a combination of the in-year deficit position (£33.6m) offset by the revaluation increase of £3.1m and an increase in public dividend capital (equity funding) of £1m.

Clinical Performance

The Trust's clinical performance is described in detail in the annual Quality Account published in June 2018.

Of note was an inspection of the Trust by the Care Quality Commission in late November and early December. Their report published in March rated the Trust as *'requiring improvement*'.

Once again, the CQC scored the Trust for caring with the compassionate one-to-one care in A&E highlighted in particular. The inspectors also commented on:

- Improvements in safety in surgery services at Southport
- A proactive and engaged approach to safeguarding adults, children and young people
- Fewer complaints received and handled in a timely manner in line with national regulations
- Our key infection rates also continue to be among the best in the region

All this has been achieved against a background of increasing patient demand, with ever more complex needs, from the oldest population served by any NHS Trust in the country.

The CQC also recognised the effect over the past two years of not having a stable and established Trust leadership team.

Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Table 6

Staff members at all levels have worked tirelessly and with dedication on practical solutions to give our patients both high quality care and a good experience.

This is evident in the steady improvements seen in maternity care at Ormskirk Hospital. These changes for the better are not only recognised by CQC but by patients too. Their feedback last year ranked the service 11th best in England.

Ormskirk Hospital's maternity unit was also ranked in the top 10 in the country for detecting unborn babies who are small for their age, which can lead to stillbirths.

In 2017, the team also reduced the average monthly Caesarean section rate in 2017 from 27.7% to 22.4%, well below the national average.

In January Health Secretary Jeremy Hunt wrote to praise staff praised staff for improvements to cancer waiting times. Between June and November 2017, the proportion of cancer patients starting their cancer treatment within 62 days rose from 76.1% to 88%. The national target is 85%.

Mr Hunt, who spoke to staff during a visit to the Trust in August, also wrote last year to congratulate the Trust on getting patients home from hospital.

Elective clinical activity declined due to patient choice and changes to referral practices. The urgent care team saw adult A&E attendances rise but admissions into hospital fell thanks to better management of patients, especially the frail elderly.

Complaints as a percentage of patient contacts fell from 0.11% to 0.08%. This is in part due to training to ward leaders and matrons to manage patient concerns as they arise and finding a local resolution.

Cases attributed to the Trust of C. difficile infection were half the maximum set by NHS England. One case of MRSA bacteraemia was recorded in August.

Summary Hospital Level Mortality is a measure used to compare the actual number of patients that have died either in hospital or within 30 days of discharge against the expected number of deaths based on national figures. The Trust is ranked 106th out of 136 English NHS Trusts.

Mortality is now a core priority for the Trust which is now focussed through a reducing avoidable mortality project. This has resulted in the creation of a Mortality Operational Group which focuses entirely on this issue and reports monthly to the Quality and Safety Committee with a Monthly Mortality Report to the Board by the Medical Director. The Committee is chaired by the Associate Medical Director for Patient Safety.

Key performance measures

Key clinical targets	Target	2017/18
% of urgent care patients seen within 4 hours	95	85.1
% of patients first seen within two weeks when referred from their GP with suspected cancer	93	95.3
% of patients receiving treatment within 62 days of GP referral	85	82.3
% admitted patients treated in 18 weeks of referral	92	93.4
% of patients treated within 28 days following a cancelled operation	100	100
% waiting more than 6 weeks for diagnostic test	1	2.90
Hospital-acquired MRSA bacteraemia	0	1
C Difficile cases attributed following appeal	36	21

Table 7

Key clinical activity data	2016/17	2017/18
Outpatient 1st attendances	72,260	65,390
Outpatient follow-up attendances	193,442	179,769
Elective inpatients	3,239	2,805
Day cases	23,773	22,298
Non-elective inpatients *(excluding maternity)*	23,849	21,918
Adults A&E attendances	48,671	50,498
Adult A&E admissions	17,397	16,315
Child A&E attendances	27,542	27,802
Child A&E admissions	4,038	4,335
All births	2,312	2,437

Table 8

External audit

The annual accounts were reviewed by our independent external auditors, KPMG, who issued an unqualified opinion. So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all the steps they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Mazars LLP has been approved as the Trust's external auditors by the Board of Directors through to 2017/18 having taken over from KPMG. The audit is conducted in accordance with International Standards on Auditing (UK and Ireland) as adopted by the UK Auditing Practices Board (APB), the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Trusts issued by NHS Improvement.

The total external audit fee for 2017/18 was £47k comprising statutory audit work. Non-audit work relating to the Quality Account was £7,335. Fee includes some KPMG work.

Anti-fraud activities

In order to counter fraud and corruption, the Trust engages a dedicated local Anti- Fraud Specialist (AFS) through MIAA. We have an Anti-Fraud, Bribery and Corruption Policy and work plan approved by the Board of Directors' Audit Committee, reflecting the NHS Counter Fraud and Security Management Services framework, with regular reports received throughout the year by the Audit Committee. The Trust has also adopted a *Standards of Business Conduct and Managing Conflict of Interests Policy* based on the new guidance issued in February 2017 and effective 1 June 2017. The Policy is accessible from the Company Secretary.

Related Parties

During the year a party related to one of the Board members undertook a material transaction with the Trust. That interest was declared on the Board of Directors, Declaration of Interest Register.

Charitable Funds

As an NHS Trust we make no political or charitable donations. However, we do continue to benefit from the receipt of charitable funds arising from donations and fund raising activities and is extremely grateful to fundraisers and members of the public for this continued support. The Trust Board acts as Trustees ensuring appropriate stewardship for these funds which are used for the purchase of equipment or services according to the purpose of the funds. Where funds are for 'general purpose', these are used more widely for the benefit of service users and staff. Further financial information on our charitable funds for the financial year 2017/18 is available on request from the Executive Director of Finance. There is no charge for the provision of this.

The Southport and Ormskirk Hospital NHS Trust's Charitable Funds fall within the definition of a subsidiary. The Trust has chosen not to consolidate the charitable funds into these financial statements as the amounts of the charitable funds are not material and would not provide additional value to the reader of the Trust's Financial Statements.

Cost allocation and charging requirements

We have complied with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information Guidance.

Information about environmental matters

The Trust has programmes aimed at minimising power and water use, and maximising the amount of waste sent for recycling *Power and Water***:** Both Southport and Ormskirk hospitals generate their own energy from a combined heat and power (CHP) plant at each site.

Excess energy from these plants is exported to the National Grid. This was enough to supply 1,071 three-bedroomed houses for a whole year.

The power plants have also reduced the Trust's reliance on the National Grid with only 19% of total power used on site being derived from that source (7% Ormskirk, 31% Southport).

The Trust continues to make inroads into saving water. Improved working practices within the laundry and early detection of issues around the Trust have delivered savings of around 434,416 litres a month – that's the content of two Olympic-sized swimming pools a year.

At the beginning of 2016, the Trust took delivery of an all-electric vehicle, loaned for four years by Veolia which runs the CHP plants, to help reduce fuel emissions and reduce costs.

This year the van has travelled 2,500 miles and has cost the Trust £43 (£102 at average National Grid rate). This is a cost of £1.80 per 100 miles – the approximate cost for an equivalent diesel vehicle is £14.65 per 100 miles, a saving of £300 for the year. We hope to see greater utilisation of the vehicle in 2018/19.

In addition to investigating the viability of reopening a borehole at Ormskirk hospital to supply water for the laundry, next year the Trust will consider:

- Installing solar panels for electrical generation at both sites
- Modifying all large motors and pumps at Southport to make them run more efficiently
- Utilising solar heat for heating the swimming pool

*Waste Management***:** The switch across the NHS from reusable items to single-use, disposable items increases the quantity of waste produced and the cost of waste disposal. However, less clinical activity, better segregation and re-using items where possible meant the waste generated fell from 2016/17 to this year**.**

*Waste Segregation***:** Better waste segregation saves the Trust money. Initial results from a trial of the Bag to Bed system indicate that the Trust could divert as much as 54% of its infectious waste to offensive waste and 7% of its healthcare waste into general waste. This would be a significant cost saving to the Trust.

Information about social, community and human rights issues including E&D, The Modern Slavery and Human Trafficking Act 2015.

The work of equality and diversity team is based on the Trust's wider inclusion and engagement policy and assist with mainstreaming the Equality and Diversity agenda. The inclusion and engagement agenda comprises:

- Equality and Human Rights
- Patient Involvement
- Spiritual Care and Chaplaincy

Summary of activities through the year

The Trust's work around Equality & Diversity is centred around ensuring we comply with the Public Sector Equality Duty and are delivering best practice as a lead for equality and diversity. The sections below provide an overview of this activity.

The Trust has appointed a substantive Equality and Diversity Manager and a Freedom to Speak-Up Guardian.

There is also a Chaplain in the Trust, who leads on provision of spiritual services.

Overview of activity to eliminate unlawful discrimination

Southport and Ormskirk NHS Trust has processes in place to ensure that any unlawful discrimination is prevented or eliminated. The Trust does not tolerate any action of unlawful discrimination and such acts or behaviour would be subject to disciplinary proceedings and referral to Anti-Fraud to progress criminal proceedings.

The Trust is committed to the promotion of Equality, Diversity and Inclusion for both patient experience and in the workplace. There is an Equality and Inclusion Strategy which is updated on an annual basis and a new substantive Equality and Diversity Manager has been appointed.

All staff are required to complete the mandatory Equality Training module and communications have been provided with regards to unconscious bias for all existing staff and new recruits. The Trust has completed a Workforce Race Equality Standard (WRES)

action plan for 2017/18 and will have a similar action plan for the Workplace Disability Equality Scheme once the figures are published later in the year. The Trust has recently appointed an Equalities Lead who will be involved with patient groups, staff groups and the development of training and communications with regards to Equality, Diversity and Inclusion.

The Modern Slavery and Human Trafficking Act 2015

Southport and Ormskirk Hospital NHS Trust is committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation. We realise that slavery and human trafficking can occur in many forms, such as forced labour, domestic servitude, sex trafficking and workplace abuse.

Our policies and governance and legal arrangements are robust, ensuring that proper checks and due diligence take place in our employment procedures to ensure compliance with this legislation.

Important events since the end of the financial year affecting the Trust
The Trust has appointed a substantive Chief Executive, Director of Nursing, Midwifery and Therapies and a Director of Strategy.

KPMG is leading on a programme of acute service change in co-ordination with the Sefton Transformation Board, of which the Trust is a part.

The new Chief Executive has commissioned EY to undertake a rapid review of corporate governance arrangements in the Trust.

Accountable Officer's Approval

Signed as Accountable Officer of the Trust

Chief Executive: Silas Nicholls

Signed: …….

Date: ……

Accountability Report

ALEX CHRISTIE DOCTOR

CORPORATE GOVERNANCE REPORT

The Trust's Governance structure is illustrated below in Figure 1 below.

Annual Governance Statement (AGS) 2017/18

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Accountable Officers' Memorandum*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Southport and Ormskirk Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact, should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Southport and Ormskirk Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

The objectives for 2017/18 and the associated principal risks were approved by the Board at its 4 October 2017 meeting. They are shown below at **Table 9**.

Approved 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

Table 9

The Trust's Governance Structure

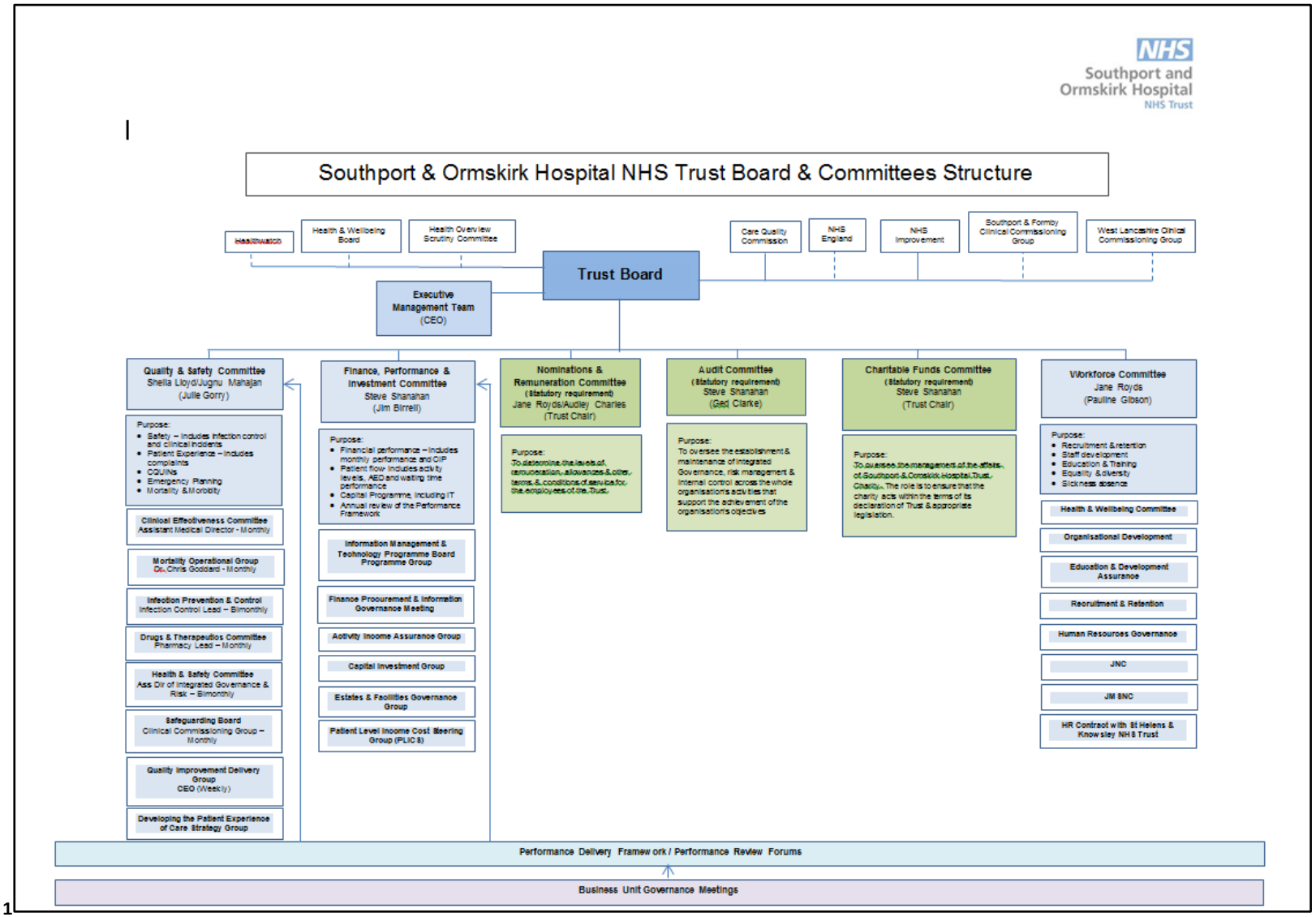

Figure 1

The means by which strategic and operational risks are managed, monitored and reported in the Trust are set out below.

Capacity to handle risk

As Accountable Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the Risk Management Strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Overall Risk Management	Executive Director of Nursing
Clinical Governance	Executive Director of Nursing
Clinical Risk & Medical Leadership	Executive Medical Director (Caldicott Guardian)
Corporate Governance	Company Secretary
Board Assurance & Escalation	Company Secretary
Financial Risk	Executive Director of Finance
Compliance with NHSI Regulatory Framework	Executive Director of Finance & Company Secretary
Compliance with CQC Regulatory Framework	Executive Director of Nursing
Information Risk	Executive Director of Finance (*Senior Information Risk Officer*-(SIRO)

Our governance structure at **Figure 1** above illustrates the robustness and effectiveness of our risk management and performance processes via our governance structure. **Figure 2 below** gives a snapshot of our assurance framework and shows relationship with external stakeholders including regulators and inspectors.

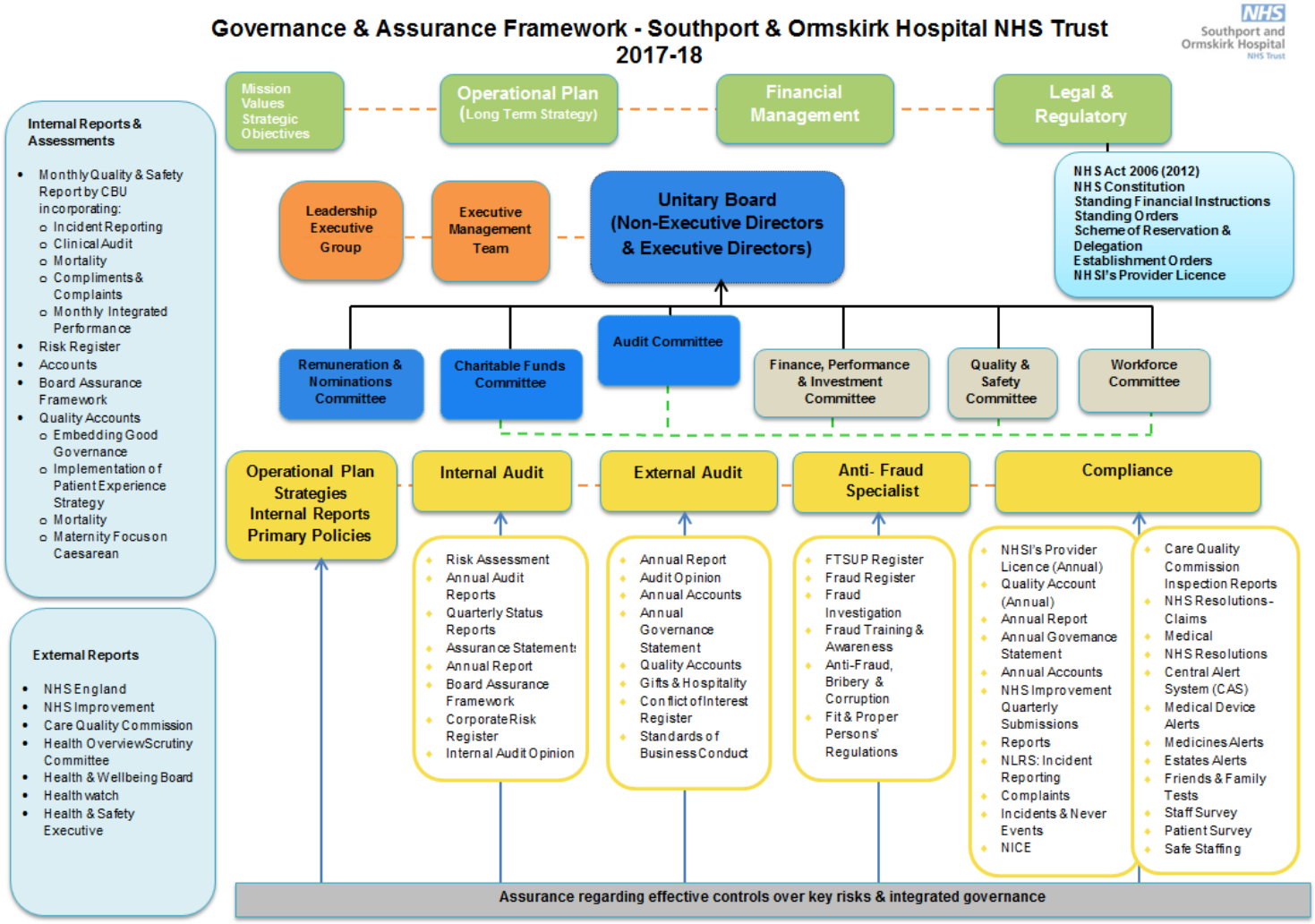
Governance & Assurance Framework - Southport & Ormskirk Hospital NHS Trust 2017-18
NHS Southport and Ormskirk Hospital NHS Trust
Mission Values Strategic Objectives
Operational Plan (Long Term Strategy)
Financial Management
Legal & Regulatory
NHS Act 2006 (2012)
NHS Constitution
Standing Financial Instructions
Standing Orders
Scheme of Reservation & Delegation
Establishment Orders
NHSI's Provider Licence
Leadership Executive Group
Executive Management Team
Unitary Board (Non-Executive Directors & Executive Directors)
Internal Reports & Assessments
Monthly Quality & Safety Report by CBU incorporating:
Incident Reporting
Clinical Audit
Mortality
Compliments & Complaints
Monthly Integrated Performance
Risk Register
Accounts
Board Assurance Framework
Quality Accounts
Embedding Good Governance
Implementation of Patient Experience Strategy
Mortality
Maternity Focus on Caesarean
Remuneration & Nominations Committee
Charitable Funds Committee
Audit Committee
Finance, Performance & Investment Committee
Quality & Safety Committee
Workforce Committee
Operational Plan Strategies Internal Reports Primary Policies
Internal Audit
External Audit
Anti- Fraud Specialist
Compliance
Risk Assessment
Annual Audit Reports
Quarterly Status Reports
Assurance Statements
Annual Report
Board Assurance Framework
Corporate Risk Register
Internal Audit Opinion
Annual Report
Audit Opinion
Annual Accounts
Annual Governance Statement
Quality Accounts
Gifts & Hospitality
Conflict of Interest Register
Standards of Business Conduct
FTSUP Register
Fraud Register
Fraud Investigation
Fraud Training & Awareness
Anti-Fraud, Bribery & Corruption
Fit & Proper Persons' Regulations
NHSI's Provider Licence (Annual)
Quality Account (Annual)
Annual Report
Annual Governance Statement
Annual Accounts
NHS Improvement Quarterly Submissions
Reports
NLRS: Incident Reporting
Complaints
Incidents & Never Events
NICE
Care Quality Commission Inspection Reports
NHS Resolutions - Claims
Medical
NHS Resolutions
Central Alert System (CAS)
Medical Device Alerts
Medicines Alerts
Estates Alerts
Friends & Family Tests
Staff Survey
Patient Survey
Safe Staffing
External Reports
NHS England
NHS Improvement
Care Quality Commission
Health Overview Scrutiny Committee
Health & Wellbeing Board
Healthwatch
Health & Safety Executive
Assurance regarding effective controls over key risks & integrated governance

Figure 2

In addition, the Chief Operating Officer is responsible for the day-to-day management of risk and performance within the Clinical Business Units and there are designated roles of Assistant Director, Safer Care and Standards and Deputy Director of Nursing providing leadership and support in their respective areas. The Associate Director of Human Resources is responsible for workforce and organisational development risks.

Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust. Mandatory training on key risk areas is undertaken by all staff at induction into the Trust and on a regular refresh basis.

Risk management training is part of the Trust's Induction programme and mandatory training for all staff throughout the Trust which includes health and safety, fire, security, incident reporting, claims and complaints.

In order to support staff with writing responses to complaints, formal training has been provided to support all Clinical Business Units and departments. Training on managing complaints on a face to face basis has been in place to support staff on the wards and departments across the Trust.

To support investigations of serious incident, *root cause analysis* training has been provided to all areas of the Trust and was well supported by the clinical teams across the Trust.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component of maintaining the risk management culture within the Trust. Learning is shared through Clinical Business Units Meetings and Trust wide Forums such as the Quality and Safety Committee and Clinical Excellence Committee. Learning is acquired from a variety of sources which include:

- Analysis of incidents, complaints, claims and acting on the findings of investigations.
- External Inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections relating to other organisations.

In accordance with its *Standing Orders* and as required by NHS Act 2006 (amended 2012), the Trust has an Audit Committee whose role is to review and report upon the adequacy and effective operation of the organisation's overall system of governance and internal control which encompasses risk management – both clinical and non-clinical.

In order to assist both the Board and the Audit Committee, specific risk management is overseen and scrutinised by three Board Assurance Committees:

- *Quality and Safety Committee* (which receives reports from the Mortality Operational Group and Clinical Excellence Committee) and has the specific purpose of delivering assurance to the Board on the management of clinical risk and operational performance against the CQC domains.
- *Finance, Performance and Investment Committee*, which provides assurance on management of risks relating to resources – both financial and human; and the strategic direction of the Trust
- *Workforce Committee, which provides*

Please see our Risk Management diagram at **Figure 3** below and our Risk Escalation Model at **Figure 4.**

The risk and control framework

Risk management by the Board is underpinned by four (4) interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Clinical Business Units, Departments and Teams)
- Audit Committee
- Annual Governance Statement

The *Risk Management Strategy* and Risk Management Policy, which are effective guides on risk management, have continued to work effectively during 2017-18. Our Risk Management System, Datix, has continued to be a source of effective risk management across all levels and a source of just-in-time reports when needed. The risk management processes remained the same as defined within the Board Assurance and Escalation Framework. This clearly outlines the leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Board Assurance Framework, the Risk Registers, Business Planning and Performance Management processes enabling the coherent and effective delivery of risk management throughout the organisation.

As **Figure 3** below illustrates, risk management involves the identification, analysis, evaluation and treatment of risks – or more specifically recognising which events (hazards) may lead to harm and therefore minimising the likelihood (how often) and consequences (how badly) of these risks occurring:

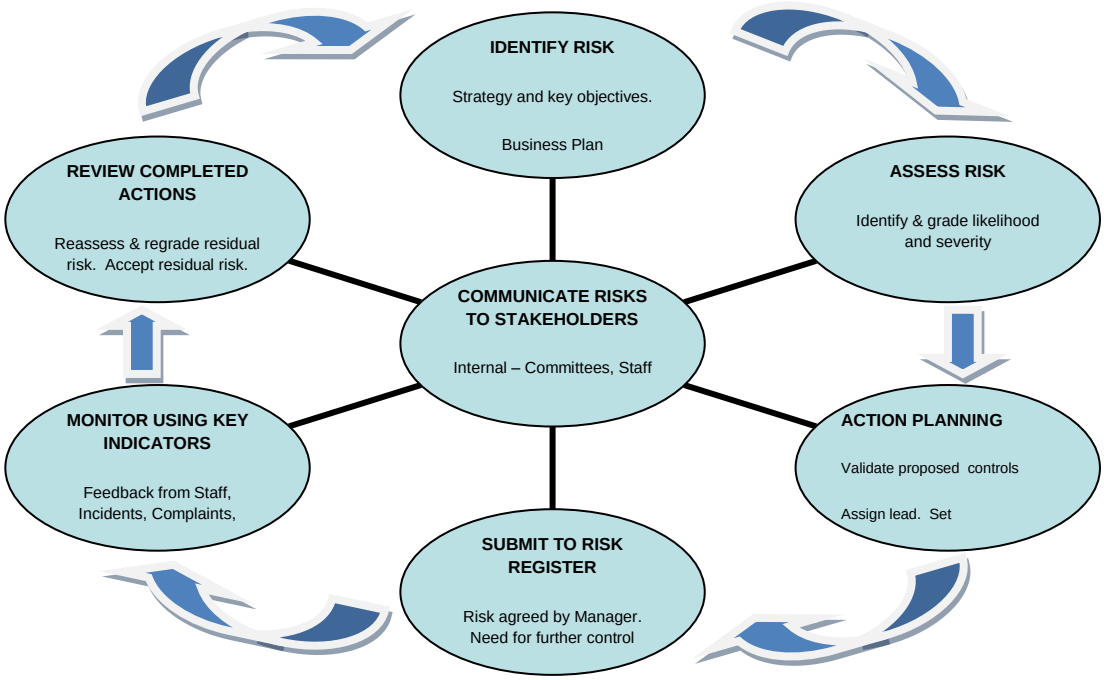

Figure 3 – Risk Management Process

Identifying Risks

Risk is managed at all levels, both up and down the organisation and in order to ensure triangulation between the *Operational Plan* and the *Board Assurance Framework (BAF),* the Trust produces an Integrated *Performance Report* for the Board on activity within the Trust's Risk Register which details the risks that have either come onto the Trust risk register or those that the Executive Team has approved to come off the Risk Register.

The Trust recognises the need for a robust focus on the identification and management of risks and therefore risk is an integral part of our overall approach to quality and the management of risk is an explicit process in every activity in which the Trust and its employees take part.

Risk management in the Trust is discharged through clearly focusing executive responsibility for all clinical and corporate governance and risks with the respective Executive Directors. The Directors, working closely with the Chief Executive, have responsibility for all Trust's clinical services and supporting corporate functions in this context. The management lead for clinical risk rests with the Director of Nursing and Medical Director, who is also the Caldicott Guardian.

The Trust has a good track record in the identification and mitigation of risks, and when there have been untoward and serious incidents, responding to them quickly and ensuring that the lessons learned from them are being implemented swiftly across the organisation. The processes for these are embedded in the culture of the organisation and through robust processes and procedures such as concerns at work and the '*floor to board'* assurance and risk escalation processes.

Discussions have taken place at board meetings concerning the Trust's appetite for risk, the strategic parameters within which decisions involving various types of risks can then be made on a sound and consistent basis. There is a clear process for escalating risks (see **Figure 4** below) from Ward to Clinical Business Units and onto the Corporate Risk Register. There is a clear process for escalating high or significant risks (see **Figure 4** below).

Risk Appetite is *'The level of risk that an organisation is willing to accept'*. The appropriate level will depend on the nature of the work undertaken and the objectives pursued. Precise measurement is not always possible and risk appetite may be defined by a broad statement of approach. The Trust has an appetite for some types of risk and may be averse to others, depending on the context of the risk and the potential losses or gains.

The Trust will develop measures for different categories of risk. For example it may inform a project to know what level of delay or financial loss it is permitted to bear, in the addition to using measures described in the *'Risk Matrix Severity definitions'* to define the likelihood and impact of risks; this can be used to define the maximum level of risk tolerable before action should be taken to lower it [Risk Appetite]. By defining its risk appetite, the Trust can arrive as an appropriate balance between uncontrolled innovation and excessive caution. It can be used to guide managers on the level of risk permitted and encourage consistency of approach across the Trust, and ensure that resources are not spent on further reducing risks that are already at an acceptable level.

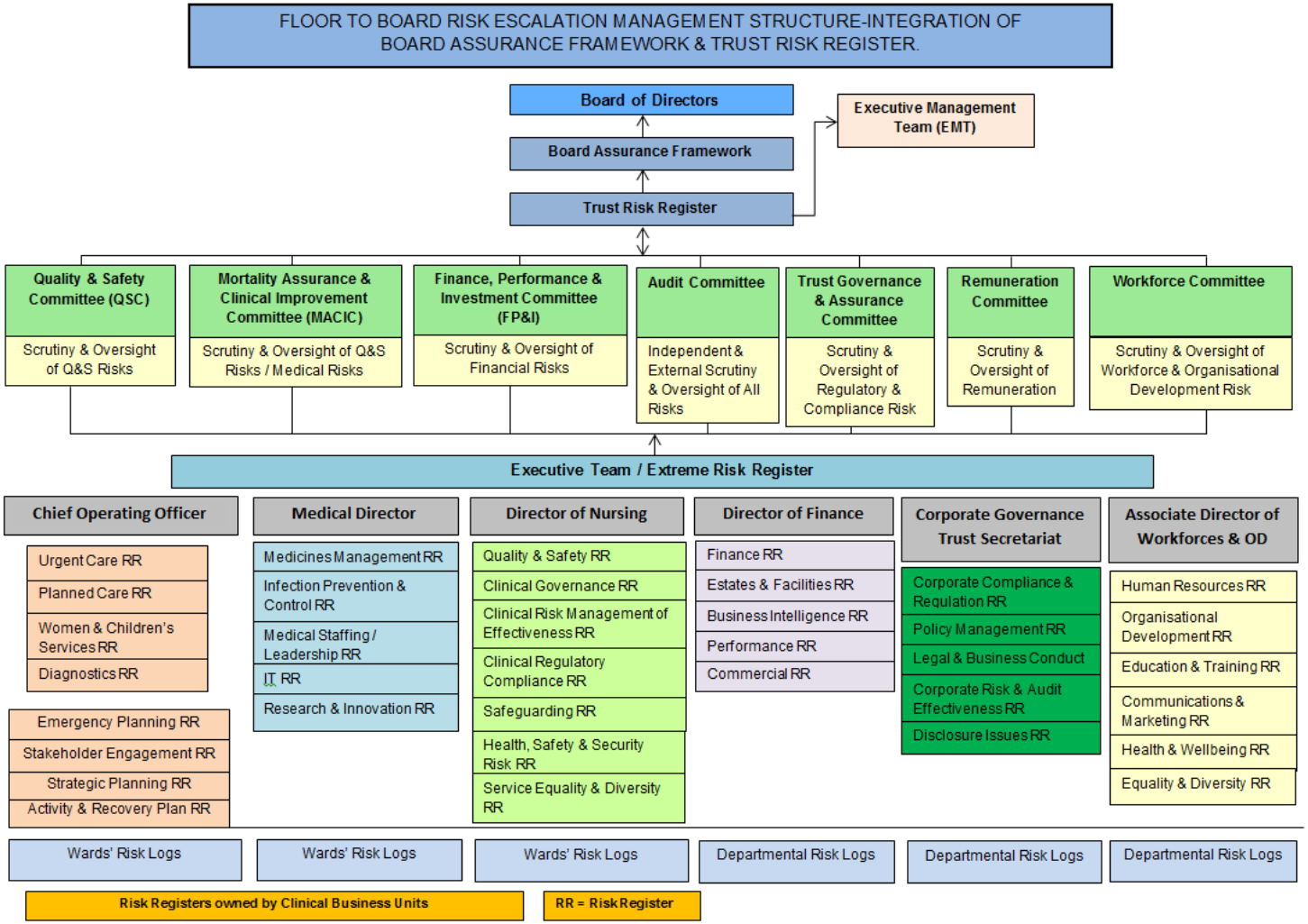
FLOOR TO BOARD RISK ESCALATION MANAGEMENT STRUCTURE-INTEGRATION OF BOARD ASSURANCE FRAMEWORK & TRUST RISK REGISTER.
Board of Directors
Executive Management Team (EMT)
Board Assurance Framework
Trust Risk Register
Quality & Safety Committee (QSC)
Scrutiny & Oversight of Q&S Risks
Mortality Assurance & Clinical Improvement Committee (MACIC)
Scrutiny & Oversight of Q&S Risks / Medical Risks
Finance, Performance & Investment Committee (FP&I)
Scrutiny & Oversight of Financial Risks
Audit Committee
Independent & External Scrutiny & Oversight of All Risks
Trust Governance & Assurance Committee
Scrutiny & Oversight of Regulatory & Compliance Risk
Remuneration Committee
Scrutiny & Oversight of Remuneration
Workforce Committee
Scrutiny & Oversight of Workforce & Organisational Development Risk
Executive Team / Extreme Risk Register
Chief Operating Officer
Urgent Care RR
Planned Care RR
Women & Children's Services RR
Diagnostics RR
Emergency Planning RR
Stakeholder Engagement RR
Strategic Planning RR
Activity & Recovery Plan RR
Medical Director
Medicines Management RR
Infection Prevention & Control RR
Medical Staffing / Leadership RR
IT RR
Research & Innovation RR
Director of Nursing
Quality & Safety RR
Clinical Governance RR
Clinical Risk Management of Effectiveness RR
Clinical Regulatory Compliance RR
Safeguarding RR
Health, Safety & Security Risk RR
Service Equality & Diversity RR
Director of Finance
Finance RR
Estates & Facilities RR
Business Intelligence RR
Performance RR
Commercial RR
Corporate Governance Trust Secretariat
Corporate Compliance & Regulation RR
Policy Management RR
Legal & Business Conduct
Corporate Risk & Audit Effectiveness RR
Disclosure Issues RR
Associate Director of Workforces & OD
Human Resources RR
Organisational Development RR
Education & Training RR
Communications & Marketing RR
Health & Wellbeing RR
Equality & Diversity RR
Wards' Risk Logs
Wards' Risk Logs
Wards' Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Risk Registers owned by Clinical Business Units
RR = Risk Register

Figure 4

Board Assurance Framework (BAF)

Board assurance is a systematic method of:

- Identifying
- Analysing
- Evaluating, treating, monitoring, reviewing; and
- Communicating all risks-clinical and non-clinical and the integration and management of both types of risks.

The requirement to develop a Board Assurance Framework (BAF) was established by the Department of Health (now NHS England), *Assurance: The Board Agenda (July 2002).* The BAF is a tool for the Board to satisfy itself that risks are being managed and strategic objectives are being achieved. The Board has established a robust BAF so that I, as Chief Executive, can confidently sign the *Annual Governance Statement* which deals with statements of internal control.

A Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the 2017/18 *Annual Governance Statement*. The BAF, which is Board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved.

The BAF is robustly discussed and analysed at the Board. Updates of progress against actions are provided at each meeting of the IGC, Audit Committee and quarterly by the Board.

Risks monitored over the year included:

- Strategic Direction
- Financial Resources
- Workforce-recruitment and retention
- Breach of performance data
- Leadership and culture
- Quality, patient safety and clinical outcomes

The BAF has been reviewed by the Board on a quarterly basis during 2016/17 and provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives and therefore, the operational plan. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Board of the assurances received about the effectiveness of these controls. The Board receives assurances directly or via its statutory and assurance Committees-Audit, Remuneration, Integrated Governance and Finance and Investment.

It is a dynamic tool which supports the Chief Executive to complete the *Annual Governance Statement* at the end of each financial year. It is part of this wider 'Assurance and Escalation Framework' to ensure the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

The formation and maintenance of the BAF is the responsibility of the Company Secretary and is regularly reviewed by each Principal Risk Owner (Executive Directors). This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions.

Trust's Risk Monitoring Escalation and Assurance Process

The Risk Management Strategy sets out how risk is identified and assimilated into the Risk Registers and reported, monitored and escalated throughout the directorate and corporate governance structures.

In addition to the Board Assurance Framework (BAF), the Trust operates five tiers of risk management which are all interlinked via an escalation process. The escalation of a risk is dependent upon the level of the risk, or on whether it is felt that the risk needs specialist management at a higher tier, such as the risk requiring a multi-directorate approach to its management.

The registers are recorded using a standardised risk matrix and the severity of each risk is rated according to the Consequence x Likelihood risk assessment matrix within the Risk Management Strategy to establish the risk score which helps guide action at the appropriate level.

Local and Directorate Risk Registers

Each ward team or department produces a local risk register. The register is developed in response to the identification of local risks that may impact on the delivery of their immediate service. Local risk registers are recorded using the Risk module on Datix.

Appropriate steps have been taken to ensure that processes are in place at both clinical service and departmental levels to update and maintain their risk registers. Monthly updates from local and directorate risk registers are provided via the Risk & Compliance Manager for inclusion into the Trust's Risk Register.

All local risks are systematically reviewed within a specified time frame by the local teams to ensure that controls in place are effective, and assess whether the risk changes over time.

Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may also be identified by external factors e.g. national reports and recommendations or regulatory and enforcement notices etc.

Care Quality Commission Regulatory Requirements

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust registered with the Care Quality Commission (CQC) on 1st April 2010 and was inspected in December 2017 as part of a planned comprehensive inspection. Prior to the planned inspection in December, the CQC undertook an unannounced Well Led inspection of the Trust. The actions from that inspection are being addressed. The Trust achieved an overall rating of 'Require Improvement'. The Action Plan which emerged from the inspection focused on some 'Must Dos' and 'Should Dos'. In March 2018 the CQC also undertook an unannounced visit to A&E department. The Quality and Safety Committee has received monthly updates on the CQC action plan and so has the Board.

Pension Schemes

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Schemes

regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Schemes are in accordance with each Scheme's rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that the organisation complies with all relevant equality, diversity and human rights legislation.

The Trust is committed to its duties under the *Equality Act 2010* and ensures that all of its service changes, organisational changes and transformation programmes are assessed to ensure that there is no detriment to any protected characteristic groups through the use of Equality Impact Assessments (EQUIA). Where the EQUIA identifies a potential detriment, consideration is given to appropriate mitigation or potential withdrawal of the service, organisational or transformation change.

With regards to the *Modern Slavery and Human Trafficking Act 2015*, we are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation. We realise that slavery and human trafficking can occur in many forms, such as forced labour, domestic servitude sex trafficking and workplace abuse.

Our policies and governance and legal arrangements are robust, ensuring that proper checks and due diligence take place in our employment procedures to ensure compliance with this legislation set out in the *Modern Slavery and Human Trafficking Act 2015.*

Internal and external stakeholders and service user and carer involvement

Within the Trust we have a Patient Experience Group which meets monthly and a Pledge Group which meets quarterly. They raise and discuss a variety of topics with Trust staff at all levels, and are vital critical friends that the Trust can approach for honest feedback and comment from the perspective of lived experience.

Quality Governance Framework

The Trust's Risk Management Strategy details the relationship between the Trust's strategic objectives, principal risks and the Board Assurance Framework. **The Risk Management Policy** outlines the process for assessing, prioritising and managing all types of risks through risk registers and includes:

- Risk Assessment and Risk Register flow charts
- Risk definitions including Risk Appetite
- Duties and responsibilities of individuals and committees
- The risk assessment process
- The risk management process
- The Integrated Governance and Risk Management Structure
- Board Assurance Framework and risk register templates

The Risk Management Strategy and Policy are enhanced by the Practice Governance Framework and the Quality Strategy.

The principal strategic and operational risks are outlined in the Risk Strategy and sets out how the Trust endeavours to ensure that they do not prevent the Trust from achieving its

strategic objectives. The Strategy, therefore, sets out the role of the Board, its statutory and assurance committees in the identification, management and mitigation of risks. **Figure 3** above illustrates the risk escalation process.

The Strategy emphasises role of the Board Assurance Framework and Risk Register in the management of strategic and operational risks respectively.

The Internal Audit Plan has as part of its remit audit of the Risk Management processes and the Board Assurance Framework. The Quality and Safety Committee, The Finance, Performance and Investment Committee, the Workforce Committee and the Audit Committee scrutinise and monitor clinical and non-clinical risks where appropriate, on behalf of the Board. **Figure 2,** our governance structure above, depicts the role of Board Committees and their inter-relationship in the management of quality and risk. The whole corporate and clinical structure is designed to ensure that the Trust has and maintain robust quality governance arrangements.

Information governance

All new staff members are provided with Information Governance (IG) training at corporate induction. This includes an outline of the relevant legal position, NHS guidance and the Trust's polices relating to the safe and appropriate processing, handling and storage of information.

Additionally, in accordance with the requirements of the IG Toolkit, all existing staff members are required to undergo IG training on an annual basis. This training is available as classroom training, workbook or E-learning.

Information security-related incidents are reported via the Trust's incident reporting system. Incidents are reviewed by the Information Governance Steering Group which has been chaired by the Head of Information and the Executive Medical Director. Where an ongoing information risk is identified, this is recorded on the relevant risk register, along with a note of actions to be taken to minimise the chances of re occurrence and impact.

There were six serious incidents requiring investigation during the period from April 2017 to March 2018, five of which were reported to the Office of the Information Commissioner.

All six incidents related to patient sensitive information, therefore the Caldicott Guardian advised on the incident grading and approved the reporting to the ICO.

Two of these incidents related to the theft or loss of a work diary and laptop which contained information relating to a number of patients. Both of these incidents were closed by the ICO and a robust action plan was developed by the Trust to install measures to prevent any future incidents.

The third incident related to the loss of a blood sample and request form and occurred shortly after the first two incidents.

The fourth incident related to the disclosure of patient information in error via email to an NHS employee outside of the Trust. This incident has been closed by the ICO and no further action taken.

The fifth and sixth incidents relate to the wrong hand held maternity record being given to a patient after attending the Trust.

All six incidents occurred within the same Business Unit.

All the patients involved in the incidents were contacted by the Trust and received apologies.

The incidents have all been discussed at length with actions implemented to prevent re occurrence.

Review of economy, efficiency and effectiveness of the use of resources

The key financial governance policies and processes

As Accountable Officer I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

The *Standing Orders* are contained within the Trust's legal and regulatory framework and set out the regulatory processes and proceedings for the Board of Directors and its committees and working groups including the Audit Committee, whose role is set out below, thus ensuring the efficient use of resources.

Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's *Standing Orders* and the Scheme of Reservation and Delegation and the individual detailed procedures set by directorates.

Scheme of Reservation and Delegation

This sets out those matters that are reserved to the Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

Anti-Fraud, Bribery and Corruption Policy

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board places reliance on the *Audit Committee* to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Anti-Fraud Service, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Counter Fraud Authority (formerly NHS Protect), reports from which are reviewed by the Audit Committee.

Work of the Board of Directors

The Board of Directors receive on a monthly basis, a Director of Finance report which includes sustainability and CIP issues.

The Finance, Performance and Investment Committee meet on a monthly basis to scrutinise finance and performance issues and gives assurance to the Board where applicable. It further analyses finance and performance strategic and operational risks and make recommendations to the Board as to what actions are needed in relation to those risks.

Work of the Audit Committee

The Audit Committee provides an 'oversight' role on behalf of the Board, reviewing the adequacy and effectiveness of controls. It is supported by the Quality and Safety Committee, Finance and Performance Investment Committee, Remuneration and Nominations Committee, Charitable Funds Committee and Workforce Committee which carry out their duties as assurance committees, in reviewing systems of control and governance in relation to all matters of clinical quality and safety, financial control and investment and workforce and organisational development.

Work of the Finance, Performance and Investment Committee

As stated above *The Finance, Performance and Investment Committee* have delegated authority to monitor and scrutinise:

- Financial performance – includes monthly performance and CIP
- Patient flow- includes activity levels, AED and waiting time performance
- Capital Programme, including IT
- Annual review of the Performance Framework
- Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee

- Scrutinise strategic and operational risks in relation to performance and finance and receives reports on the above on a monthly basis. Any major concerns are escalated to the Board of Directors.

CIP Delivery Process

1. The Trust is in a deficit financial position and there is a requirement to demonstrate financial improvement and control in 2018/19 and beyond.

2. The Trust's draft financial plan submitted on 8 March 2018 is dependent on achieving CIP savings of £7.0m in 2018/19.

3. Taking short-term reactive decisions to maintain financial stability, risks the deterioration in the quality of services and patient safety.

4. Preparing and implementing a CIP that links to the organisation's strategic plan is essential if quality services are to be delivered and financial stability achieved.

5. In order to deliver a sustainable CIP it is essential that the Trust engages with staff, identifies detailed plans, has robust monitoring arrangements and continually evaluates both individual CIP schemes and overall performance.

6. Factors in the successful delivery of CIPs include a rigorous structure, clear lines of accountability, performance management processes and strong clinical engagement and leadership.

7. Process, structure, governance and accountability are key elements of safe, effective CIP delivery but the people delivering CIPs on the ground are crucial.

8. Structures and processes will not deliver unless staff are engaged and have the capability, capacity and competence to comply with the process

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Governance Process

1. The Trust has implemented a comprehensive recording and monitoring process for the CIP programme.

2. This includes the completion of standard documentation incorporating quality impact assessments (QIAs), risk assessment, financial assurance and sign off at Divisional level.

3. The process facilitates the monitoring of delivery of plans and achievement of savings targets.

4. A meeting structure has been established to report and monitor performance and review the underlying causes of any variance from plan.

5. The CIP Run Rate Meetings are chaired by the Improvement Director and take place

fortnightly.

6. The required attendees include the Director of Finance, Chief Operating Officer, Deputy Chief Operating Officer, Directorate Managers, Finance, PMO and Information leads.

7. Comprehensive documentation regarding the governance process has been developed by the Improvement Director and the Project Management Office (PMO).

2017/18 Achievement

1. There has been limited success in the achievement of the 2017/18 CIP target.

2. The annual target was £5.6m with actual achievement of £3.4m equating to 61% of target a shortfall of £2.1m.

Success Factors

1. Factors in the successful delivery of CIPs include a rigorous structure, clear lines of accountability, performance management processes and strong clinical engagement and leadership.

2. Process, structure, governance and accountability are key elements of safe, effective CIP delivery but the people delivering CIPs on the ground are crucial.

3. Structures and processes will not deliver unless staff are engaged and have the capability, capacity and competence to comply with the process.

4. It is evident that there has not been full delivery of CIPs at the Trust.

5. It would appear that there are a number of factors that have contributed to the lack of achievement that require further discussion and clarity.

Next Steps

1. The successful delivery of the CIP target is reliant on the behaviours and values of all Executives, managers, clinicians and staff.

2. It is evident that there is a requirement for further review of the culture within the organisation regarding CIP.

3. The requirement to identify the causes of blockages to success and to embed ownership and accountability is paramount.

4. To undertake an independent and objective review of CIP within the Trust; KPMG have been commissioned to undertake this review.

5. The key areas of their review are identified below;

   a) A comparison of the Trust's CIP governance processes against good practice.

b) Provide a view on the proposed level of PMO resource to be assigned to CIP delivery under the new PMO structure.
c) Comment on adherence to the Trust's CIP governance processes during the 17/18 financial year assessed through interviews with relevant members of the Trust's staff and sample testing of CIP documentation.
d) In respect of 1, 2 and 3 above, highlight areas which could enhance the Trust's ability to deliver CIPs and provide recommendations on how these could be addressed.
e) Provide a high level assessment on progress towards identifying schemes to meet the FY18/19 CIP target.

6. The requirement for process review is minimal following previous NHSI review which should result in a more detailed focus on the other four areas.

7. KPMG completed their fieldwork which commenced on 23rd April 2018. They assessed the Trust's process for CIP and the adherence within the organisation against seven (7) key areas:

- Leadership
- Clear Vision and Compelling Case
- Adequate Resourcing
- Effective Communication
- Progress Visibility
- Well defined Plans
- Performance Management

The Report identified a number of recommendations to strengthen governance around CIP. The Trust is preparing an Action Plan to address the areas highlighted. This will be presented to the Trust Board in June 2018 and will include Lead Executives, Timelines and Monitoring Processes.

Financial Plans

The Trust submitted final 2018/19 financial plans to NHS Improvement on 30th April 2018. This showed a forecast deficit of £28.8m in 2018/19 and is after a £7m cost improvement programme.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. The Department of Health and Social Care has issued relevant guidance

The Trust has continued with following these steps to assure the Board that the Quality metrics present a balanced view:

- A stakeholder consultation process to agree quality priorities for the reporting and coming year, involving service users, carers, staff and partner agencies
- A review of all Trust services before the priorities are agreed
- A monthly report via the Integrated Performance Report to the Board leading to scrutiny of whether the focus is right

- Sharing the draft Quality Account with partner agencies for comment, with the primary commissioners having the legal right to point out inaccuracies.

Processes are established to monitor compliance against Care Quality Commission (CQC) regulations (Health and Social Care Act 2008 Regulated Activities, Regulations 2014) using the updated Well Led Review Action Plan process which is based on the CQC's key lines of enquiry.

The content of the Quality Account has been prepared within the established Governance structures and framework and in accordance with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) and other guidance from NHS Improvement. The Draft Quality Account is shared with partner agencies and stakeholders and commissioners for comment. Leadership comes from the Board of Directors with clearly devolved responsibility and accountability for individual quality improvement priorities.

Quality improvement priorities informed the Trust's Quality Strategy and reflected the priorities of the Trust. These measurable goals, against which progress can be monitored, are overseen by the Quality and Safety Committee.

The Director of Nursing is responsible for the preparation of the Quality Account and for ensuring that the document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads.

The Quality and Safety Committee is responsible for reviewing the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Board of Directors. The Trust's External Auditors KPMG (until 31 March 2017). In December 2016, Mazars was appointed as External Auditors of the Trust to take effect from 1 April 2017 in line with the changes to the local external audit arrangements from the Local Audit Accountability Act 2014.

Mazars undertook a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Progress against the Quality Account priorities for the reporting period, 2017/18, has been reported through the Trust's governance framework via the Annual Business Cycles of the Quality and Safety Committee and the Board of Directors receiving monthly reports on:

- Implementing the Patient Experience Strategy - The patient experience Pledge Group work commenced in October 2017 with the aim of each pledge group meeting bi-monthly. The groups are led by the matron for patient experience and also have a further matron aligned. The majority of groups also have patient representatives. For those that have not, there are links into the appropriate patient forums for any consultation. The Pledge Groups are now regularly reporting into the Trust Patient Experience Group and Quality and Safety Committee using the AAAs highlight reports.

- Mortality: Implement national guidance and focus on the deteriorating patient. Mortality data was reported at the Mortality Assurance and Clinical Improvement Committee, a committee dedicated solely to look at Mortality issues. The Mortality Operational Group, chaired by the Associate Medical Director for Patient Safety, was reintroduced to deal with these issues. The Group now reports into the Quality and Safety Committee

During 2017 / 2018 we aimed to reduce our number of caesarean sections which we have successful achieved.

Our overall Caesarean Section rate has decreased from 32.18% to 23.56% in March 2018.

The national average rate for elective caesarean sections is 16% and in March 2018 our rate was 10.23%

The national rate for instrumental births is 11% and the Trust is currently at 11.49%

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete.

This year the Trust has worked closely with the NHSI Intensive Support Team (IST) to ensure the validity and accuracy of our elective waiting times data. This has involved rigorous data quality and validation checks over the year on all aspects of waiting time information including recording, processing and reporting. Where advice was given additional training and processes have been embedded to mitigate any risks to quality and accuracy of this data.

Priorities for 2018/19 have been developed in line with the Trust's draft Quality Improvement Strategy 2018-2021and include:

- *Preventing harm*
- *Reducing mortality*
- *Safer staffing at all times*
- *Developing the experience of care*
- *Delivering care for you*

Robust outcome metrics will be set for each priority and action to identify progress and success in achieving this improvement Strategy. The metrics we will use will be meaningful to both staff and patients. Measurement will be used to demonstrate the impact of change and then continued as on-going performance measures following the implementation of successful change, quarterly reports will be reported via Quality and Safety Committee to Board. Processes are established, previously set up to collect evidence of compliance in line with the CQC Inspection recommendations (Must and Should Dos) from 2016 and 2017. The new CQC Insight Reports are used to check our performance and anticipate any potential risks in the future. The Quality and Safety Committee is kept informed of the completeness of the data and any breaches.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report/Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their Annual Audit Letter management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Integrated Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Board and Committees in this process:

- The Board reviews the Board Assurance Framework on a quarterly basis along with the Risk Register on a monthly basis.

- A programme of Risk Management training for all staff

- The internal audit plan which is risk based, is approved by the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit Committee on a quarterly basis with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly escalate any areas of concern to the Board via a Committee Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness.

- The Executive Team meets on a weekly basis and has a process whereby key issues such as performance management, serious incidents, recruitment and retention, safe staffing, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need. It also reviews the Trust Risk Register on a monthly basis.

- The Board and its statutory and assurance committees have a clear cycle of business and reporting structure to allow issues to be escalated via the *'ward to board'* risk escalation framework.(**see Figure 4**) The purpose of each committee is outlined in the Governance Structure at **Figure 1** and their work summarised at section 3.24.4 above.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the Clinical Negligence Scheme along with the NHS Resolution and the Care Quality Commission.

In 2017-18, a Well Led Review was undertaken by the Board in preparation of a planned inspection by the Care Quality Commission in December 2017. The CQC published its Report in March 2018. A summary of the Report's findings is set out below:

Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Table 10

Work has commenced on a robust action plan to address the Must Dos and other recommendations. The Executive Team has prepared a robust action plan to meet the recommendations made by the CQC and this is monitored at each Executive Team meeting. Updates on the CQC Action Plan are discussed on a monthly basis at both the Quality and Safety Committee and the Board of Directors.

There are internal discussions on-going to ensure that the response to the recommendations should be used as an opportunity to move from *Requires Improvement* to *Good.*

Director of Internal Audit Opinion

Internal Audit reviews the system of internal control during the course of the financial year and report accordingly to the Audit Committee. The Director of Internal Audit has provided an overall opinion of **moderate assurance** based on their work during 2017-18, which gives me confidence that we have a good foundation on which to build our improvement work.

Specifically, the Director of Internal Audit has stated:

Based on an assessment of the design and operation of the assurance framework and supporting processes; an assessment of the range of assurances arising from the risk-based internal audit assignments undertaken (taking into account the relative materiality of systems reviewed and management's progress in addressing weaknesses identified); and on an assessment of the organisation's response to recommendations made and the extent to which they had been implemented, the Director of Internal Audit's overall opinion was that, for the period 1 April 2017 to 31 March 2018, moderate assurance could be given that there was an adequate system of internal control. There were, however, weaknesses in design and/or inconsistent application of controls in some areas which had put the achievement of some of the organisation's objectives at risk.

In addition, the Director of Internal Audit reminded the Committee that, previously, 4 levels of assurance had been achievable and that, in 2016/17, the Trust had been given 'significant' assurance, although this had been border line. For 2017/18, given the challenges being faced, an additional assurance level of '**moderate'** had been created to recognise that, whilst MIAA may not have been able to give significant assurance, limited assurance would have been unfair. It was confirmed that the majority of NHS organisations within MIAA's client base had achieved either 'moderate' or 'limited' assurance in 2017/18.

Conclusion

Notwithstanding the risks and challenges highlighted above, no significant internal control issues have been identified.

Accountable Officer

Silas Nicholls

Chief Executive

Date: 24 May 2018

Board Statutory and Assurance Committees

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local anti-fraud services. The Audit Committee reports to the Board quarterly via an Assure, Alert and Advise Highlight Report along with minutes from the meeting after every meeting and annually on its work via the Annual Report of the Audit Committee in support of the *Annual Governance Statement*, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements.

The Committee met on a quarterly basis except for an extra meeting in May to review and make recommendations to the Board on the Annual Report, Annual Accounts and Quality Accounts.

The Annual Report 2017/18 of the Audit Committee is set out below:

Work of the Audit Committee during 2017/18

Role of the Audit Committee

The Audit Committee's (Committee) main role is to provide independent assurance to the Board of Directors (Board) on the effectiveness of SOHT's internal control and governance arrangements. It follows the best practice guidance set out in the current NHS Audit Committee Handbook1. Its responsibilities are described in terms of reference; these were reviewed in April 2018 and are available on the SOHT website:

Membership and Meetings

a. Three (3) independent non-executive directors are members of the Committee:

Mr Ged Clarke	Member from May 2016 and Chair from May 2016
Mr Jim Birrell	Member from September 2017
Mrs Ann Pennell	Member from March 2016

Table 11

b. Brief biographical sketches of members including any declared interests are available on the Trust website:

Both Ged Clarke and Jim Birrell have recent and relevant financial experience.

c. The Committee met four (4) times during the year and attendance at the meetings is recorded below:

Audit Committee Attendance 2017/18												
	Role	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Members:												
Ged Clarke (Chair)	NED	✓				✓		✓			✓	
Jim Birrell	NED					✓		✓			✓	
Ann Pennell	NED	✓				✓		A				
In Attendance:												
Ian McInnes	Interim Chief Executive	✓										
Shelia Lloyd	Director of Nursing	A				A		A			A	
Steve Shanahan	Director of Finance	✓				A		✓			✓	
Audley Charles	Interim Company Secretary					✓		✓			✓	
Jane Hindle	Interim Company Secretary	✓										
KPMG	External Audit	✓										
Mazars	External Audit					✓		✓			✓	
MIAA	Internal Audit	✓				✓		✓			✓	
MIAA	Anti-Fraud Specialists					✓		✓			✓	
	✓ = present; A = apologies; S = sickness absence; DNA = did not attend											

Table 12

d. The internal and external auditors, the finance director, deputy finance director, and the company secretary regularly attend meetings to assist the Committee with its duties. Other directors and senior managers are invited to attend to provide assurance on specific items. The anti- fraud service provider attends two (2) times a year and the chief executive attends annually to discuss the annual accounts and annual governance statement. The chief executive attended the meeting held in May 2017.

e. The Committee members also held private meetings with both the external audit partner and the Director of internal audit during the year.

Board Governance arrangements

There are three statutory Board committees: audit; remuneration and nominations and charitable funds. There are three Board assurance committees: finance; performance and investment (FPI); quality and safety (QSC) and workforce, all with a monitoring and oversight role. Audit Committee members are familiar with the work of these committees, attending all of them between them. This strengthens the Audit Committee's effectiveness. This is particularly notable when it considers clinical risk issues. The QSC oversees all aspects of clinical governance including clinical audit and provides assurance on the annual quality account. The Audit Committee regularly cross-refers clinical matters to the QSC, who then report back on their discussions

Business of the Committee

The Committee has an annual work plan (business cycle), developed from its terms of reference. In 2017/18, assurance on data quality and the review of financial metrics were added to the plan. The following provides an overview of the business conducted during the year demonstrating how an effective Committee can bring benefits.

Risk Management, Assurance and Governance

a. The Committee has continued to review the operation and management of the risk and assurance framework. The principal SOHT risks are set out in more detail in SOHT's Annual Report 2017/18.

b. During the year, the Committee reviewed the Board Assurance Framework (BAF) and asked management to centre it on strategic rather than operational objectives. This enabled better monitoring of the strategic objectives and discussion focused on the key risks to their delivery as well as on the effectiveness of the BAF process. In year, the Committee sought additional information on the Board's role in the BAF and risk appetite and requested Mersey Internal Audit Agency (MIAA), our internal auditors to conduct a workshop for board members on these issues.

c. The Committee reviewed a quarterly risk report from the clinical risk team. As well as reviewing the Trust's principal risks, the Committee also focused on the high clinical and non-clinical operational risks. From additional information sought, the Committee received valuable information relating to cybersecurity, estate management, and data integrity and site security.

d. Preparing the Annual Governance Statement (AGS) is an important part of the governance process. To ensure that the AGS can be recommended for inclusion in the annual accounts, the Committee received regular reports on the control framework and the internal assurance processes throughout the year. These included:

- A revision of the Standing Orders, Standing Financial Instructions and Scheme of Delegation
- A report on finance metrics which included write-off of aged debts, losses and special payments
- Tenders
- Use of Trust Seal

Metrics such as agency and consultancy spend are reported directly to the FPI and via a AAAs report to the Board. The Committee agreed that this new comprehensive report will strengthen the assurance provided on financial control. It will be presented four times a year.

e. The Committee also requested and received separate reports from management on items including CQC preparedness and action plan, Raising Concerns, Business Continuity.

f. The Committee also followed up progress against issues it had identified in 2016/17 including medical job planning. It noted that management had focused on improving compliance with mandatory training (to limit risk and maintain safe working practice).

Raising Concerns (Whistleblowing) Processes

The Raising Concerns (Whistleblowing) Policy and process were reviewed by the Committee who discussed how concerns were investigated. It received quarterly reports on the declaration of concerns, how they were managed and outcomes from the Freedom to Speak Up Guardian. It also received assurance on this issue via the appointment of an independent NED Board lead as FTSU Champion and a substantive Freedom to Speak Up Guardian who is in the process of appointing local FTSU Champions across CBUs and departments.

Internal Audit

a. MIAA was appointed as internal auditors in March 2017 and remained as internal auditors for 2017/18. A draft risk-based work plan for the coming year will be approved in May 2018.

b. Each assurance report included an opinion and a management action plan to address any weaknesses. A senior member of the management team, if requested, attended the Committee to respond to the report and update on the action plan. The Committee subsequently followed up the actions.
c. The Committee referred some reports to other committees and the Board for a more in-depth discussion. For example, deep dive of quality risks to the Board, governance and management of the swimming pool to FPI and safe staffing issues to QSC.
d. It also reviewed the Internal Audit's Annual Report for the year including the Director of Internal Audit's (DOIA) opinion. The opinion was one of **moderate assurance** which was subsequently included in the AGS and the Annual Report. Some reports and related action plans will be carried forward into 2018/19.

Anti-Fraud, Bribery and Corruption

MIAA, the local anti-fraud services (AFS) provider, presented updates on fraud and an Anti-Fraud Annual Report to the Committee. These detailed the Anti-Fraud Policy work and gave an analysis of emerging fraud risks across the provider sector and the wider NHS. They showed that more pro-active anti-fraud work was being carried out and also included information about cases under investigation.

The Committee reviewed the revised Fit and Proper Persons' Policy and the Standard of Business Conduct and Managing Conflict of Interests and the Anti-Fraud, Bribery and Corruption Policy.

External Audit, Review of Financial Statements and Annual Reports

a. In September 2017, the Committee reviewed and agreed the external audit plan with Mazars and received quarterly progress reports and briefings throughout the year. In December 2016, Mazars was appointed as External Auditors of the Trust to take effect from 1 April 2017 in line with the changes to the local external audit arrangements from the Local Audit Accountability Act 2014.

   Reports received highlighted changes to accounting policy and recommendations for improvements in internal controls. The Committee discussed risks and weaknesses that required attention and the management response on how recommendations would be implemented. Further details about the plan and the audit fees can be found in the Annual Report and Accounts.

b. The final audited accounts had an unqualified opinion. The auditors will be obliged to make a statement to the Secretary of State for Health and Social Care (SOSH&SC) regarding the Trust's inability to abide by its duty under section 30 to break even.

c. The Committee reviewed both the Annual Report and Quality Accounts. Both provided a narrative on the achievements for 2017/18 and on the delivery of the Trust's strategic objectives and quality indicators. The findings on the quality report included a limited assurance opinion in respect of C.Diff and VTE indicators. Data integrity had already been added to the C.Diff and VTE annual work-plan. The Committee will track the data quality improvements relating to in the coming year.

c. The Committee recommended the 2016/17 Annual Report and Accounts and the Quality Accounts to the Board for approval.

External Audit Tender

1. Following an open tender process, Mazars LLP was appointed as External Auditors in December 2016 to provide the external audit service on an initial three year contract, with an option of extension for a further year, commencing with the 2017/18 Accounts.

2. The Committee will assess the auditors' work in June 2018 to ensure that the work is of a sufficiently high standard and fees are reasonable

Audit Work

The Committee reviewed the engagement of the external auditors' policy which governs the use of non-audit services.

Evaluation and Assessment and Briefings

1. The Committee's performance was evaluated using a Performance and Effectiveness Tool and self-assessed against the checklist in the Audit Handbook and the Committee's Terms of Reference. No significant issues were identified and it was considered that it could provide assurance to the Board that it functioned well.

2. The internal and external auditors also provided regular audit, governance and legal briefings for the Committee

Looking Forward to 2018/19

The Committee will give priority to the following areas:

- Consider how the BAF and risk register can be made more dynamic and delivered in a more use friendly way to the Committee and Board.
- Strengthen corporate governance arrangements within the Trust
- Deliver the CQC 'Must Dos' recommendations and going beyond with the aim of moving from *Requires Improvement* to *Good* by 2020
- Establish a sustainable leadership Team in the Trust
- Develop, embed and sustain a clear strategic direction for the Trust
- Review reports on data integrity and quality governance especially in light of the new General Data Protection Regulation (GDPR);
- Review the effectiveness of information governance processes especially in light of the new General Data Protection Regulation (GDPR);
- Review processes that relate to the raising concerns policy;
- Review the proactive AFS work in particular relating to cybersecurity;
- Firm up processes on how the Trust prepares its staff for a major incident;

The Committee will also keep under review the effectiveness of its own working arrangements twice per year using an internal bespoke Tool for mid-year assessment and via an externally facilitated process at the end of the year.

Conclusion

SOHT's System of Governance

The Committee feels that the information in this report and the reports provided to the Board throughout 2017/18 demonstrate how it adds value to the overall governance of SOHT. It has held management to account in particular for the implementation of improved internal control on financial policy. In completing its work it places considerable reliance on the work of both internal and external audit and is able to conclude that the SOHT's systems are generally sound.

Thanks and Appreciation and Review

In making this statement, the Committee thanks Steve Shanahan, Director of Finance and Audley Charles, Interim Company Secretary, for their support. It also acknowledges the support given by external audit.

The Audit Committee shall review the Annual Report, and financial statements before submission to the Board, focusing particularly on:

a) The wording in the *Annual Governance Statement* and other disclosures relevant to the Terms of Reference of the Committee.
b) Changes in, and compliance with, accounting policies, practices and estimation techniques.
c) Unadjusted mis-statements in the financial statements.
d) Significant judgements in preparation of the financial statements.
e) Significant adjustments resulting from the audit.
f) Letters of representation.
g) Explanations for significant variances.

Chair of Audit Committee

The ***Quality and Safety Committee*** scrutinises and gives overview on clinical risks and holds the Executives to account with ensuring that clinical risks processes as set out in the Risk Management Strategy are adhered to and how they are being managed and controlled. This includes oversight of the performance and quality dashboards which show compliance with CQC registration requirements and other statutory compliance with quarterly reports being scrutinised prior to their submission to the Board.

The Quality Committee's other duties include:

- Seeking and providing assurance to the Board in respect of the effectiveness of the Trust's Integrated Governance arrangements underpinned by organisational development.
- Overseeing the development and implementation of the Trust's Risk Management, Quality and Nursing and Care Strategies including the Quality Improvement Strategy.
- To provide the Board with assurance regarding the effectiveness of all aspects of mortality and morbidity in the Trust.
- Triangulate mortality and morbidity with patient safety, quality and risk issues with workforce performance addressing areas of concern or deteriorating performance as required.
- Reviewing mortality data

- Reviewing clinical outcomes
- Reviewing clinical service changes
- Seeking and providing assurance to the Board in respect of the effectiveness of the Trust's risk management arrangements in respect of mortality.
- Reviewing forecasts of future performance and lessons learned from past performance.

Table 13 below shows membership and attendance of the committee for the reporting period:

Quality & Safety Committee Attendance 2017/18													
	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Members:			Meeting Stood Down			No meeting scheduled				No Meeting Scheduled			
Ann Pennell (Chair to Nov 17)	NED	✓		✓	✓		✓	✓	✓				
Carol Baxter	NED	✓		✓	✓		✓	A	✓		A		
Jim Birrell	NED										✓	✓	✓
Su Fowler-Johnson*	NED	A											
Julie Gorry (Chair from Jan 18)	NED			✓	✓		✓	✓	✓		✓	✓	✓
Karen Jackson	Interim Chief Executive	✓		A	✓		A	✓	A				
Rob Gillies	Medical Director	✓		✓	✓		A	A	A		A	A	A
Arpan Guha	Interim Medical Director							✓	A				
Jan Hornby	Interim Associate Director HR	A											
Shelia Lloyd	Director of Nursing	✓		✓							✓	✓	
Jugnu Mahajan	Interim Medical Director										✓	✓	✓
Paul Mansour	Acting Medical Director						✓	✓	✓				
Therese Patten	Chief Operating Officer	✓		A	✓		✓	✓	✓		✓	✓	✓
Jane Royds	Associate Director of HR			A	✓		✓	A	✓		A	✓	✓
In Attendance													
Audley Charles	Interim Company Secretary										✓	✓	A
✓ = present; A = apologies; S = sickness absence; DNA = did not attend													

Table 13

The ***Finance, Performance and Investment Committee*** have delegated authority to monitor and scrutinise:

- Financial performance – includes monthly performance and CIP
- Patient flow- includes activity levels, AED and waiting time performance
- Capital Programme, including IT
- Annual review of the Performance Framework
- Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee

Table 14 below shows membership and attendance of the committee for the reporting period:

Finance, Performance & Investment Committee Attendance 2017/18														
	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 4th	Jan 29th	Feb	Mar
Members:														
Richard Fraser (Chair to July 2017)	NED	✓		✓										
Jim Birrell (Chair from August 2017)	NED					✓	✓	✓	✓		✓	✓	✓	✓
Ged Clarke	NED	✓	✓	A	✓	✓	A	✓	A		✓	✓	A	A
Su Fowler-Johnson*	NED	A	✓											
Julie Gorry	NED						✓	✓	✓		✓	✓	✓	✓
Ann Farrar	Interim Chief Executive											A	A	A
Karen Jackson	Interim Chief Executive	✓	A	A	✓	✓	✓	✓	✓		✓			
Rob Gillies	Medical Director	✓	✓	A	A	A	A	A	A		A	A	A	A
Arpan Guha	Interim Medical Director	✓	✓	✓	✓	✓	✓	A	A					
Jan Hornby	Interim Associate Director HR	A	✓											
Shelia Lloyd	Director of Nursing						✓	A	A		A	A	A	
Jugnu Mahajan	Interim Medical Director											A	A	A
Therese Patten	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Jane Royds	Associate Director of HR			A	✓	✓	✓	✓	✓		✓	✓	✓	✓
Steve Shanahan	Director of Finance	✓	✓	✓	✓	A	✓	✓	✓		✓	✓	✓	✓
In Attendance														
Audley Charles	Interim Company Secretary					✓	A	✓	A		✓	✓	✓	A
Jane Hindle	Interim Company Secretary	A	✓	✓	A									
Lee Threlfall	Contracts & Performance Manager						✓	✓	✓		A	✓	✓	
Kevin Walsh	Deputy Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
✓ = present; A = apologies; S = sickness absence; DNA = did not attend														

No Meeting Scheduled

Table 14

The ***Workforce Committee*** has delegated authority to:

- Review evidence relating to external standards, including NHS Resolution (formerly NHS Litigation Authority (NHSLA) (NHSR), Safe, Effective, Quality Occupational Health Service (SEQOHS), NHS Employers Guidance and CQC standards, raising any concerns regarding non-compliance in a timely manner and focusing on outcomes and improvements to the quality of patient and staff experience
- Review performance data and quality indicators covering key aspects of the Trust-wide workforce matters, identifying areas for action at a corporate and local level, ensuring follow up takes place:
    - Appraisal
    - Mandatory Training
    - Sickness
    - DBS
    - Staff Survey
    - Flu Vaccination
    - Recruitment & Staffing levels
    - CQUINs
    - Staff friends & family test
    - Bank & Agency
    - Volunteers

- Monitor the achievement of action plans covering key people management activities, including response to the annual Staff Survey, Staff Engagement Strategy, Recruitment & Retention Strategy, Equality Strategy (Equality Delivery Scheme (EDS2), Workforce Race Equality Standard (WRES) the Health Work and Well Being agenda and other strategic workforce priorities including national recommendations, e.g. the *Francis, Berwick, Cavendish, Saville and Keogh reports*
- Review and take appropriate action based on reports from the Workforce Committee sub-groups
- With delegated authority from the Trust Board ratify relevant policies and procedures approved by Workforce Committee sub-groups
- Provide a report on activities of the Committee to the Trust Board on a monthly basis.

- Ensure any areas of risk relating to HR practices and activities are highlighted and escalated as appropriate

Table 15 below shows membership and attendance of the committee for the reporting period:

Workforce Committee Attendance 2017/18													
	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Members:													
Carol Baxter (Chair to December 2017)	NED							✓	✓	No Meeting Scheduled			
Jim Birrell (Chair, January 2018)	NED										✓		
Pauline Gibson* (Chair from February 2018)	NED							A	✓		A	✓	
Julie Gorry	NED							A					
Shelia Lloyd	Director of Nursing							A	A		✓	A	
Gill Murphy	Acting Director of Nursing							✓	A		A	A	
Therese Patten	Chief Operating Officer							✓	✓		✓	A	
Jane Royds	Associate Director of HR							A	✓		✓	✓	
Helen Baythorpe	AD of Operations, Planned Care							✓	✓		A	A	
Audrey Cushion	Acting AD of HR Governance & Quality							A	✓		✓	✓	
John Flannery	Unison Officer							A	A		A	✓	
Laura Hilton	Acting Head of HR							✓	✓		✓	A	
Linda Lewis	Head of Health & Wellbeing							✓	✓		✓	✓	
Adam Ruddock	AD of Organisational Development, STHK							✓					
Simon Williams	Facilities Manager							✓	✓		✓	A	
In Attendance:													
✓ = present; A = apologies; S = sickness absence; DNA = did not attend													

Table 15

The Board has established a Committee of the Trust to be known as the ***Charitable Funds Committee***. The Board has the power to appoint and delegate functions in respect of charitable funds pursuant to *section 11 of the Trustee Act 2000.*

Table 16 below shows membership and attendance of the committee for the reporting period:

Charitable Funds Committee Attendance 2017/18													
	Role	Apr	May	Jun 26th	Jul	Aug	Sep	Oct	Nov 9th	Dec	Jan	Feb	Mar 22nd
Members:													
Richard Fraser (Chair)	NED			✓					✓				✓
Ged Clarke	NED			A					A				
Julie Gorry	NED								✓				
Steve Shanahan	Director of Finance			✓					A				✓
Kevin Walsh (Delegated Authority)	Deputy Director of Finance								✓				
In Attendance:													
Suzanne McGrath	Deputy Financial Accountant			✓					✓				✓
Mark Wilson	Assistant Director of Finance			✓					✓				✓
✓ = present; A = apologies; S = sickness absence; DNA = did not attend													

Table 16

The ***Remuneration and Nominations Committee*** has the delegated authority from the Board to:

a) seek any information it requires from any employee of the Trust in order to perform its duties as set out below

b) obtain, within the limits set out in the Trust's *Scheme of Delegation*, outside professional advice on any matter within its terms of reference

c) call any employee to be questioned at a meeting of the committee as and when required.

Table 17 below shows membership and attendance of the committee for the reporting period:

Remuneration & Nominations Committee Attendance 2017/18													
	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec VB	Jan	Feb	Mar
Members:													
Richard Fraser (Chair)	NED		✓			A		✓	✓	✓			✓
Carol Baxter	NED		A			A		A	A	A			
Jim Birrell	NED					✓		✓	✓	✓			
Paul Burns (Senior Independent Director)	NED		✓			✓		A					
Ged Clarke	NED		A			A		A	✓	A			✓
Su Fowler-Johnson*	NED		✓			✓							
Pauline Gibson *	NED					A		A	A	A			
Julie Gorry	NED					✓		✓	✓	A			✓
Ann Pennell	NED		A			✓		✓	A	✓			
Karen Jackson	Interim Chief Executive					✓		A					
Jane Royds	Associate Director of HR					✓		✓					✓
In Attendance:													
Audley Charles	Interim Company Secretary							✓		✓			✓
Jane Hindle	Interim Company Secretary		✓			✓							
✓ = present; A = apologies; S = sickness absence; DNA = did not attend													

Table 17

SUSAN MORTON HOUSEKEEPING ASSISTANT

The Trust Board

Chair and Non-Executive Directors

Richard Fraser

Chair of the Board of Directors; Chair of Remuneration and Nominations Committee, Chair of Charitable Funds

Appointed December 2016

Born in Glasgow, Richard studied civil and mechanical engineering at university. His first senior job was site manager during the construction of the landmark oil storage tanks at Stanlow, near Ellesmere Port.

He has more than 30 years' experience as a Board director at a number of large companies. He is also chair of St Helens and Knowsley Hospitals NHS Trust.

Carol Baxter

Non-Executive Director

Appointed February 2016 – January 2018

Professor Carol Baxter's career has embraced the public sector in a variety of roles, including as a nurse - advisor to central government departments, national and international agencies and as a professor of nursing.

She was Head of Equality, Diversity and Human Rights at NHS Employers from 2005 to 2014. She is also a Principal Research Fellow in the Department of Primary Care and Public Health at Imperial College London; a Trustee at the Employer's Network for Equality and Inclusion and a non-executive director at Centre for Better Ageing.

Carol was awarded a CBE in the Queen's 2009 Birthday Honours list for services to equal opportunities and was inducted into the Nursing Times Nursing Hall of Fame in 2010.

Jim Birrell

Non-Executive Director; Chair of Finance, Performance and Investment Committee

Appointed September 2017

Jim qualified as an accountant in local government before moving into the NHS in 1983. Following periods as the Finance Director at Alder Hey and then North West Regional Director of Finance, Jim spent 10 years as Chief Executive at Aintree University Hospitals NHS Foundation Trust.

In the latter role he developed a keen interest and commitment to improving quality. Since retiring from Aintree in 2011, Jim has undertaken a number of management consultancy assignments, including work for NHS Improvement.

He lives in Southport.

Paul Burns

Non-Executive Director
and Senior Independent Director

Appointed June 2010 – June 2017

Paul is a practising Barrister and Head of Local Government and Social Housing at Exchange Chambers which has bases in Liverpool, Manchester and Leeds.

Paul is widely acknowledged as a leader in his specialist fields of local government law and social housing law, which encompass areas as diverse as anti-social behaviour, landlord and tenant, human rights, mental health, public law, personal injury, risk management and governance.

He has extensive experience advising and representing large public and private sector organisations and is regularly instructed in high profile and test case litigation. Paul sits on the board of Exchange Chambers, holds a non-executive directorship on the Group Board of First Ark Limited and sits part-time as a Legally Qualified Chair in police gross misconduct cases

Ged Clarke

Non-Executive Director; Chair of Audit Committee

Appointed May 2016

Ged, who was educated in Southport, is a chartered accountant, having qualified with Price Waterhouse in Liverpool. He went on to form Kinsella Clarke Chartered Accountants in Bootle.

His health background is gleaned from seven years at the Walton Centre for Neurology and Neurosurgery Foundation Trust. At the Walton Centre he was non-executive director before becoming chair of the audit committee and then vice-chairman. He played a key role in the process of that Trust obtaining foundation Trust status.

Ged lives in Birkdale and has three grown up children. In his spare time he enjoys golf at the Royal Birkdale Golf Club.

Su Fowler-Johnson

Designate Non-Executive Director

Appointed July 2012 – June 2017

Su Fowler-Johnson has both a clinical and general management background and has worked in the NHS. She has held senior positions in academia, general practice, Department of Health and private sector consultancy. During her clinical career she specialised in the management of long-term conditions.

While working at Enfield and Haringey, and Greater Manchester Strategic Health Authorities as a nurse advisor, she worked closely with independent practitioners (GPs, dentists and optometrists) as part of developing services in community and primary care.

Su has lived in Burscough for more than 15 years. She also works with a local social enterprise focusing on developing child and adolescent mental health services.

Pauline Gibson

Designate Non-Executive Director; Chair of Workforce Committee

Appointed September 2017

Pauline is director of Staffordshire-based Excel Coaching and Consulting. She is a fellow of Chartered Institute of Personnel and Development.

She is an experienced board director specialising in executive coaching, strategic leadership development, transformational teams and culture change. She has spearheaded significant culture change programmes and is skilled in developing a high performing leadership cadre and driving catalytic team performance.

Julie Gorry

Non-Executive Director; Chair of Quality and Safety Committee

Appointed September 2017

Julie was chief executive of Wirral Hospice for 12 years and has more than 20 years' experience as an executive director in the independent sector and the NHS.

Previously, she was North West regional representative for the National Council for Palliative Care for more than 15 years before its merger with Hospice UK in summer 2017. She was also chair of the Hospice Chief Executive Advisory Group for the North West Strategic Clinical Network for Palliative and End of Life Care.

Julie, who is a practicing nurse, is a specialist advisor for Care Quality Commission. She has a Master of Arts in Strategic Human Resources and a passion for improving quality, patient safety and patient experience.

Ann Pennell
Non-Executive Director

Appointed December 2015 – December 2017

Ann Pennell has more than 15 years' experience at a senior director level in local government and has held a number of Board level management positions working closely with the NHS in:

- Children and young people's services
- Social care
- Housing, education and regeneration

She has led large-scale change and improvement programmes in public services working collaboratively with a range of partners.

Ann was an assistant chief executive in London where she graduated with a post- graduate degree in education and teaching qualifications. She re-located to Lancashire to be close to family. She has two sons and lives locally.

Executive Directors

Karen Jackson
Interim Chief Executive

April 2017 – January 2018

Karen Jackson joined the Trust on secondment from NHS Improvement, the national organisation which supports NHS providers and local health systems.

She was mostly recently working with NHS Improvement to lead work on improving urgent care service delivery across England.

Before this she was chief executive at North Lincolnshire and Goole NHS Foundation Trust and has a professional background in NHS finance.

She is a graduate in genetics from the University of Liverpool.

Ann Farrar
Interim Chief Executive

Appointed January 2018 – March 2018

Ann was interim Chief Executive of North Cumbria University Hospitals NHS Trust from 2012 until early 2016 when she returned to work with the NHS in North East.

Immediately before joining the Trust she was Executive Director of the Better Health Programme based at Northumbria Healthcare NHS Foundation Trust.

Silas Nicholls
Chief Executive

Appointed April 2018

Silas brings with him a wealth of experience to the Trust and a strong track record of achievement, most recently at Manchester University NHS Foundation Trust where he was Group Deputy Chief Executive.

Silas, who lives locally, is an experienced chief executive who began his NHS career as a graduate trainee. He is a former Director of Operations and Performance at Clatterbridge Cancer Centre NHS Foundation Trust, Wirral, and Deputy Chief Executive and Director of Strategy at Wrightington, Wigan and Leigh NHS Foundation Trust.

Stephen Shanahan
Executive Director of Finance

Appointed 2015

Steve Shanahan was Executive Director of Finance at North Cumbria University Hospitals NHS Trust before joining the Trust on secondment in November 2015. He was made substantive in August 2016. He had a career at Board level in the private sector before joining the NHS in 2005 when he was appointed Finance Director at Shrewsbury and Telford Hospital NHS Trust. He lives in West Lancashire.

Sheila Lloyd
Executive Director of Nursing

Appointed October 2016 – March 2018

Sheila has held senior nursing and managerial posts since 2004 in both specialist and large acute Trusts. Sheila qualified as a Registered General Nurse in 1991 at what was then Walton and Fazakerley hospitals, now Aintree University Hospital NHS Foundation Trust.

Sheila specialised in heart and chest nursing in Liverpool and has held various clinical posts at ward and nurse specialist level. In addition, Sheila was a cancer manager within a regional gynaecological cancer centre and was Assistant Director of Nursing, Quality and Commissioning within the former North West Strategic Health Authority.

More recently she has undertaken turnaround work with Children and Young People's Services focusing on clinical governance, safety, effectiveness and patient and staff experience. Sheila was successful in completing the national Breaking Through Top Talent Leadership Programme in 2012.

She was most recently Executive Director of Nursing and Quality at the Black Country Partnership NHS Foundation Trust.

Sheila is a member of the Royal College of Nursing Executive Nurse Network.

Therese Patten
Chief Operating Officer

Appointed October 2016

Therese joined the Trust from Liverpool's Alder Hey Children's Hospital NHS Foundation Trust in Liverpool where she was Associate Director Strategic Development and Partnership. This was an executive role leading on the delivery of the strategic plan which included delivering strategic local and international partnerships.

Therese has worked in the NHS, private health and international aid sectors. She has more than 20 years' experience in healthcare, more recently in board positions as Chief Operating Officer and Commercial Director.

Before that she worked in Liverpool, including a community Trust, and for a time in the private healthcare sector. In the 1990s, she worked in Somaliland and Zimbabwe in health education and nutrition, and later for the Department for International Development in Pakistan.

Rob Gillies
Executive Medical Director

Appointed June 2013 – (currently absent from work)

Rob Gillies was formerly Deputy Medical Director at Pennine Acute Hospitals NHS Trust in Manchester.

He graduated from Liverpool University in 1982 doing basic surgical training in Liverpool and higher surgical training in the North East, West Midlands and a knee surgery fellowship in Toronto during 1993. He was appointed as a consultant orthopaedic knee surgeon at Mid-Cheshire Hospitals NHS Foundation Trust in 1995.

In 2004 Rob was appointed as Associate Postgraduate Dean in Mersey Deanery and Honorary Senior Lecturer at the University of Liverpool

Paul Mansour

Acting Medical Director

August 2017 – Oct 2017
December 2017 – January 2017

Prof Arpan Guha

Interim Executive Medical Director

Appointed September 2017 – December 2017

Prof Arpan Guha was formerly Deputy Medical Director at the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Prof Guha joined the Royal in 2005 as a critical care consultant and is still clinically active. He has been deputy medical director since December. His responsibilities have included supporting clinical quality and cost effectiveness, improvement and medical education. He has a number of national roles, which include memberships of the Department of Health Education Costing Group, north of England member for the NHS England Critical Care Clinical Reference Group, and until recently was a member of the National Organ Donation Committee.

His academic roles have included being the immediate past Head of the Post-graduate School of Medicine at the University of Liverpool. He has professorial appointments in the universities of Liverpool and Chester as well as overseas in universities in Taiwan and India, in recognition of his contributions to academic activities in medicine. His research is in the areas of leadership and team working in medicine, patient safety and education.

His leadership in medicine is recognised by many awards, including the NHS Northwest Leadership Award 2015 as Mentor/Coach of the Year

Dr Jugnu Mahajan
Interim Medical Director

Appointed January 2018

A paediatrician by profession, Dr Mahajan is a highly experienced medical director. She was formerly Medical Director for the Isle of Man and before that Barnsley Hospital NHS Foundation Trust.

Jane Royds
Associate Director of Strategic HR

Appointed June 2017

Jane was previously Executive Director of Non-clinical Services at Queenscourt Hospice in Southport.

She has worked 27 years in human resources (HR) for the NHS across community, primary care and mental health organisations prior to joining the hospice.

She is a Fellow of the CIPD and has a MA in Strategic HR.

Table 18: Appointments and Attendance at Board of Directors-1 April 2017- 31 March 2018 (The Appointments and attendance of the Board Committees can be found in the AGS)

Board of Directors Attendance 2017/18														
		Apr 5th	May 4th	Jun 7th	Jul 5th	July 27th	Sep 6th	Sep 20th AGM	Oct 4th	Nov 1st	Dec 6th	Jan 10th	Feb 7th	Mar 7th
Non-Executive														
Carol Baxter	Non-Executive Director	✓	A	A		✓	A	A	✓	✓	✓	✓	A	
Jim Birrell	Non-Executive Director					✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Burns	Non-Executive Director/ Senior Independent Director	✓												
Ged Clarke	Non-Executive Director	✓	✓	✓	✓	A	✓	A	✓	✓	A	✓	A	✓
Su Fowler-Johnson	Non-Executive Director	✓	✓	✓										
Richard Fraser (Chair)	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pauline Gibson*	Non-Executive Director						✓	A	✓	✓	A	A	✓	✓
Julie Gorry	Non-Executive Director								✓	✓	✓	✓	✓	✓
Ann Pennell	Non-Executive Director	✓	✓	✓	✓	A	✓	A	A	✓	✓			
Executives														
Ann Farrar	Interim Chief Executive											✓	✓	A
Robert Gillies	Medical Director	A	✓	✓	✓	✓	A	A	A	A	A	A	A	A
Arpan Guha	Interim Medical Director								✓	✓	A			
Jan Hornby*	Interim Associate Director of Human Resources	✓	✓	✓										
Karen Jackson	Interim Chief Executive		✓	✓	✓	✓	A	✓	A	✓	✓			
Shelia Lloyd	Director of Nursing	✓	✓	✓	✓	A	✓	✓	A	✓	✓	✓	✓	A
Iain McInnes	Interim Chief Executive	✓												
Jugnu Mahajan	Medical Director												✓	✓
Paul Mansour	Acting Medical Director						✓	✓			✓			
Therese Patten	Chief Operating Officer	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Jane Royds*	Assistant Director of Human Resources			✓	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Steve Shanahan	Director of Finance	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓
In Attendance:														
Audley Charles	Interim Company Secretary						✓	✓	✓	✓	✓	✓	✓	✓
Jane Hindle	Interim Company Secretary	A	✓	✓	✓									
✓ = present; A = apologies; S = sickness absence; DNA = did not attend														

Table 18

Details of company directorships and other significant interest held by directors

Details of Interest declared by members of the Board of Directors including Company Directorships are set out in the Table below and the register of Directors' interests is available on the Trust's website or from the Company Secretary at: Southport and Ormskirk NHS Trust, Ormskirk and District General Hospital, Town Lane Kew, Southport PR8 6PN. Telephone 01704 704769

There are no company directorships held by the Directors where such companies are likely to do business with or are seeking to do business with, the Trust.

See the Register of Interests in Table 19 below:

Southport and Ormskirk Hospital NHS Trust

REGISTER OF INTERESTS DECLARED BY BOARD OF DIRECTORS 2017/18

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	Other	Date of entry on register or amendment
BAXTER, Mrs Carol	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee Employers Network for Equality & Inclusion** **Trustee – Centre for Aging Better**	**4 February 2016**
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Senior Adviser to Newton providing consultancy services to Private & Public Sector**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 July 2017** **Updated 25 September 2017**
BURNS Mr Paul	Non-Executive Director & Senior Independent Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**June 2010**

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	Other	Date of entry on register or amendment
CLARKE, Mr Ged	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Kinsella Clarke Chartered Accountants. A number of Trust's Medical Consultants are clients.**	**1 May 2016**
FARRAR, Mrs Ann	Interim Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**18 January 2018**
FRASER, Mr Richard	Chairman	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trust Chairman of St Helens & Knowsley Hospital NHS Trust**	**1 December 2016** **Updated 2 April 2018**
GIBSON, Mrs Pauline	Non-Executive Director	**Nil**	**Director, Excel Coaching & Consultancy** Provision of coaching services to Directorate and senior NHS Management personnel	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GILLIES, Mr Rob	Executive Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**June 2013**

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	Other	Date of entry on register or amendment
GORRY, Mrs Julie	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**2 August 2017**
GUHA Mr Arpan	Interim Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**September 2017**
JACKSON, Mrs Karen	Interim Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**April 2017**
LLOYD, Mrs Sheila	Executive Director of Nursing	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**November 2016**
JUGNU, Dr Mahajan	Interim Medical Director	**Nil**	**Director of M&M Professional Consultancy Services**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**22 January 2018**
MANSOUR Dr Paul	Acting Medical Director	**Nil**	**Nil**	**Nil**	**Responsible Officer for Queenscourt Hospice**	**Nil**	**Nil**	**Nil**	**October 2016**
PATTEN, Mrs Therese	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
PENNELL, Mrs Ann	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Governor – Burscough Primary Science College**	**1 February 2016**

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	Other	Date of entry on register or amendment
ROYDS, Mrs Jane	Associate HR Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**30 May 2017** **Updated 25 September 2017**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust**	**Nil**	**Nil**	**9th November 2016**

Table 19

Statement of compliance with cost allocation and charging guidance

We have complied with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information Guidance.

Details of political donations

There were no political donations made by the Trust during the reporting period.

How the Trust has regard to the quality Governance Framework

Quality governance is the combination of structures and processes at and below board level to lead on Trust-wide quality performance including:

- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best practice and
- identifying and managing risks to quality of care.

Material inconsistencies in reporting

There are no material inconsistencies in reporting (to include any material inconsistencies between AGS, annual and quarterly Board Statements, Corporate Governance Statement, Annual Plan, Quality Report, CQC reports and Associated action plans)

Summary of stakeholder relations

SOHT operates within the Cheshire and Mersey STP footprint and have positive and developing relations with all key stakeholders within that Partnership. SOHT itself is leading or undertaking a supportive role across a number of work streams, including the STP wide mental health work stream.

During 2017/18 the Sefton Transformation Board was formed with Sefton CCGs. The Trust has identified a number of areas where through working together we can potentially deliver better services and outcomes for the people of Southport and Ormskirk. This work will be taken forward during 2018/19.

Income Disclosures

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) states that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. We have met this requirement.

Statement of disclosure of information to auditors

The Directors of the Trust are responsible for preparing the Annual Report and Financial Statements (annual accounts) in accordance with applicable law and regulations.

Each of the Directors, whose name and functions are listed in the Board of Directors section of this Annual Report and Accounts and was a director at the time the report is approved, confirms that, to the best of each person's knowledge and belief:

- So far as the Director is aware, there is no relevant audit information of which the Company's auditors are unaware; and
- The Director has taken all the steps that ought to have been taken as a Director in order to make himself or herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information, as set out in a Letter of Representation to the external auditors.

THE REMUNERATION AND STAFF REPORT

The Remuneration Report

Annual Statement on Remuneration

Substantial changes related to senior managers' remuneration (including details of the context in which those charges occurred)

The remuneration of the Executive Team does not include a deferred performance pay scheme, based on a two year cycle. The principles of the performance framework focus on reinforcing the collective performance of the organisation rather than that of individual director.

Senior Managers' Remuneration Policy

Service contract obligations

The Trust is obliged to give Directors six months' notice of termination of employment, which matches the notice period, expected of Executive Directors from the Trust. The Trust does not make termination payments beyond its contractual obligations which are set out in the contract of employment and related terms and conditions. Executive Directors' terms and conditions, with the exception of salary shadow the national arrangements, inclusive of sick pay and redundancy arrangements and do not contain any obligations above the national level.

Policy on payment for loss of office

The principles of the determination of payments for loss of office are in accordance with the national agenda for change guidance and in accordance with employment legislation.

Statement of consideration of employment conditions

The Trust adheres to the national agenda for change guidelines for the setting of notice periods. Director contracts, however, are subject to six months' notice periods.

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ANNUAL REPORT ON REMUNERATION

Service contracts

All directors are subject to six months' notice period. **Table 3 below** shows their start and finishing dates, where applicable or if their role is current:

Remuneration Committee

The Trust has a Remuneration and Nominations Committee. The Committee reviews and makes recommendations to the Board on the composition, skills mix and succession planning of the Executive Directors of the Trust and is chaired by the Trust Chair.

All Non-Executive Directors are members of the Committee and the Chief Executive, Company Secretary, and the Associate Director of Human Resources are normally in attendance.

Remuneration & Nominations Committee Attendance 2017/18													
	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec VB	Jan	Feb	Mar
Members:													
Richard Fraser (Chair)	NED		✓			A		✓	✓	✓			✓
Carol Baxter	NED		A			A		A	A	A			
Jim Birrell	NED					✓		✓	✓	✓			
Paul Burns (Senior Independent Director)	NED		✓			✓		A					
Ged Clarke	NED		A			A		A	✓	A			✓
Su Fowler-Johnson*	NED		✓			✓							
Pauline Gibson *	NED					A		A	A	A			
Julie Gorry	NED					✓		✓	✓	A			✓
Ann Pennell	NED		A			✓		✓	A	✓			
Karen Jackson	Interim Chief Executive					✓		A					
Jane Royds	Associate Director of HR					✓		✓					✓
In Attendance:													
Audley Charles	Interim Company Secretary							✓		✓			✓
Jane Hindle	Interim Company Secretary		✓			✓							
✓ = present; A = apologies; S = sickness absence; DNA = did not attend													

Table 20

The Remuneration and Nominations Committee made recommendations to the Board of Directors on the following appointments:

- Appointment and remuneration of two Non-Executive Directors
- Appraisal of the Chair
- Approval of Appointment of the Interim Chief Executive
- Approval of appointment of the substantive Chief Executive

Disclosures required by the Health and Social Care Act

Senior Managers' Remuneration

Senior Managers remuneration details and pension benefits for 2016-17 are set out at **Table 21** below:

Salary and pension entitlements of senior managers (subject to audit):

Table 21

		2017-2018					
Name & Title	**Note**	**Salary (bands of £5,000)** £000	**Expense Payments (Taxable) to nearest £100** £	**Performance Pay and Bonuses (bands of £5,000)** £000	**Long Term Performance Pay and Bonuses (bands of £5,000)** £000	**All pension-related benefits (bands of £2,500)** £000	**TOTAL (bands of £5.000)** £000
K.Jackson - Interim CEO	1	0-5					0-5
A Farrar - Interim CEO	2	50-55					50-55
TA.Patten - Chief Operating Officer		100-105				22.5-25	125-130
R.Fraser - Chair		25-30					25-30
S.Shanahan - Finance Director		130-135				35-37.5	165-170
CE.Baxter - Non-Executive Director		5-10					5-10
GJ.Clarke - Non-Executive Director		5-10					5-10
AC.Pennell-Johnson - Non-Executive Director	3	0-5					0-5
PA.Burns - Non-Executive Director	4	0-5					0-5
J Birrell - Non-Executive Director	5	0-5					0-5
J Gorry - Non-Executive Director	6	0-5					0-5
P Gibson - Non-Executive Director	7	0-5					0-5
S.Fowler-Johnson - Non-Executive Director	8	0-5					0-5
S.Lloyd - Nursing Director		100-105				0-2.5	100-105
R.Gillies - Medical Director	9	175-180					175-180
Professor A.Guha - Interim Medical Director	10	45-50					45-50
J Mahajan - Interim Medical Director	11	25-30					25-30

(1) April 17 until Jan 18. Seconded from North Lincolnshire & Goole NHS Foundation Trust at no cost to Southport & Ormskirk Hospital NHS Trust.

(2) Figure represents the recharge value from Northumberland Healthcare including on-costs - employers national insurance & Superannuation and is for the period Jan to Mar 18.

(3) Left 21.12.17

(4) Left 30.04.17

(5) Started 04.07.17

(6) Started 02.08.17

(7) Started 05.07.17

(8) Left 30.06.17

(9) Excluded Aug 17

(10) Figure represents the recharge value from Royal Liverpool & Broadgreen including on-costs - employers national insurance & superannuation for the period Oct to Dec 17.

(11) Started 22.01.18

-	-	2016-2017					
Name & Title	Note	Salary (bands of £5,000) £000	Expense Payments (Taxable) to nearest £100 £	Performance Pay and Bonuses (bands of £5,000) £000	Long Term Performance Pay and Bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5.000) £000
K.Hodgson - Interim CEO	1	80-85					80-85
J.Parry - Chief Executive	2	90-95				25-27.5	115-120
A.Marr - Interim Chief Executive	3	15-20					15-20
S.Finnegan - Chief Operating Officer	4	30-35				7.5-10	40-45
L.Hunt - Interim Chief Operating Officer	5	40-45					40-45
P.Johnson - Interim Chief Operating Officer	6	140-145					140-145
TA.Patten - Chief Operating Officer	7	50-55				32.5-35	80-85
R.Fraser - Chair	8	10-15					10-15
S.Musson - Chair	9	20-25					20-25
L.Ludgrove - Interim HR Director	10	60-65					60-65
S.Partington - Director of HR	11	50-55				15-17.5	65-70
R.Jones - Interim HR Director	12	35-40					35-40
J.Royds - Interim HR Director	13	10-15					10-15
S.Shanahan - Finance Director	14	125-130				25-27.5	150-155
CE.Baxter - Non-Executive Director	15	5-10					5-10
G.Slee - Non-Executive Director	16	0-5					0-5
GJ.Clarke - Non-Executive Director	17	5-10					5-10
AC.Pennell-Johnson - Non-Executive Director		5-10					5-10
PA.Burns - Non-Executive Director		5-10					5-10
J.Newman - Non-Executive Director	18	5-10					5-10
S.Fowler-Johnson - Non-Executive Director		5-10					5-10
S. Featherstone - Director of Nursing	19	35-40				27.5-30	65-70
AJ.Kelly - Acting Director of Nursing	20	30-35					30-35
S.Lloyd - Nursing Director	21	35-40				110-112.5	150-155
R.Gillies - Medical Director		175-180				40-42.5	215-220

Notes

(1) May'16 - Aug'16

(2) Left on 24.10.16

(3) Left 10.05.16.

(4) Left 31.07.16
(5) Left May'16.
(6) Left 30.10.16.
(7) Started 01.10.16
(8) Started 01.12.16
(9) Left 30.11.16
(10) Left June'16.
(11) Left 05.09.16

(12) Interim Director 04.07.16 - 31.10.16 then 6.12.16 - 31.03.17. Currently an Associate HR Director with the Trust (from 31.05.17) and therefore not a Board member for 17/18.

(13) Originally
interim
director left
Nov 16.

(14) Started 09.11.15 - 31.08.16 as Interim Finance Director then made permanent 01.09.16.

(15) Started 01.02.16
(16) Left 30.04.16
(17) Started 01.05.16
(18) Left 31.03.17
(19) Left 21.08.16
(20) Aug 16 to Nov 16
(21) Started Nov 16

Additional notes

Expense payments only relate to taxable mileage. All of these were less than £50 so show as zero in the above table.

The pension related benefits column reflects the annual increase in pension entitlement. It is not a cash payment but a figure calculated from pension information.

Total remuneration includes salary, non-consolidated performance-related pay, taxable expense payments as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Southport & Ormskirk Hospital NHS Trust in the financial year 2017-18 was between £175,000 and £180,000 (2016-17, £175,000 to £180,000). This was 7.5 times the median remuneration of the workforce (2016-17, 7.3 times). The median value is £23,597 (2016-17, £24,304).

In 2017-18, 15 (2016-17, 12) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £15,404 to £266,416 (2016-17: £15,251 to £252,755).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

There are no off-payroll engagements of Board members for 2017/18. Please note the figures for Ann Farrar (Interim CEO) and Jane Royds (HR Director) are the recharge costs from their employer organisations and include employers' national insurance and superannuation.

a) Pension benefits

Name & title	Real increase (decrease) in pension at pension age (bands of £2,500)	Real increase (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)
	£'000s	£'000s	£'000s	£'000s
T Patten (Chief Operating Officer)	2.5-5	2.5-5	20-25	50-55
S Shanahan (Director of Finance)	0-2.5	2.5-5	15-20	55-60
S.Lloyd (Nursing Director)	0-2.5	(2.5-5)	35-40	100-105
Dr J Mahajan (Interim medical Director)	0-2.5	0-2.5	35-40	110-115

Table 22

Name & title	Cash Equivalent Transfer Value at 1 April 2017	Real increase/(decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension (to nearest hundred £s)
	£'000s	£'000s	£'000s	£'00s
T Patten (Chief Operating Officer)	305	56	363	0
S Shanahan (Finance Director)	385	N/A**	N/A**	0
S Lloyd (Nursing Director)	615	42	663	0
Dr J Mahajan (Interim Medical Director)	765	12	836	0

Table 23

** Member is above the scheme retirement age and therefore a Cash Equivalent Transfer Value (CETV – explained below) is not applicable.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Members of the Remuneration and Nominations Committee:

All Non-Executive Directors are members of the Remuneration and Nominations Committee. The members are:

R Fraser (Trust Chair) – Started 01/02/16
P Burns (Non-Executive Director) - Left 30/04/2017
S Fowler-Johnson (Non-Executive Director) - Left 30/06/2017
A Pennell-Johnson (Non-Executive Director) - Left 21/12/2017
C Baxter (Non-Executive) - Left 31/01/2018
G Clarke (Non-Executive Director) – Started 01/05/16
J Birrell (Non-Executive Director) - Started 04/07/2017
J Gorry (Non-Executive Director) - Started 02/08/2017
P Gibson (Non-Executive Director) - Started 05/07/2018

Remuneration policy

The key principles from the Remuneration framework developed and approved by the Remuneration Committee are as follows:

(a) The level of remuneration should be reflective of the responsibility of the role to which the remuneration applies;
(b) The level of remuneration should be sufficient to recruit, retain and fairly reward directors of the quality and with the skills and experience required to lead Southport & Ormskirk NHS Trust successfully;
(c) The Committee should avoid remuneration which is more than necessary for the purposes set out at (a) and (b) above;
(d) The Committee must be sensitive to pay and employment conditions elsewhere in the Trust and external to the Trust;
(e) The Committee must ensure that any decisions as to remuneration are affordable and provide value for money having regard to the full cost of remuneration (including pension effects);
(f) The Committee must be able to justify any salary higher than the Prime Minister's salary of £150,402.
(g) The Committee will have regard to The UK Corporate Governance Code and The Monitor NHS Foundation Trust Code of Governance as it pertains to Director Remuneration (as amended from time to time), any guidance issued by the Trust Development Authority and such other principles and guidance as may be applicable and brought to its attention from time to time.
(h) No director shall be involved in deciding his or her own remuneration;
(i) Where any director is involved in advising or supporting the Committee care must be taken to recognise and avoid conflicts of interest;
(j) Where performance related pay and/or any cost of living rise awarded and/or other benefits are awarded as part of remuneration then the extent to which these elements (or any one of them) affect the total remuneration for any individual shall be considered and taken into account as part of the determination of appropriate total remuneration for that individual;
(k) Where the Chief Executive or any Executive Director is released by the Trust in order to carry out a role elsewhere (for example as a non-executive director elsewhere) then subject to the terms of the contract of employment the Committee may determine whether the Chief Executive or Executive Director will retain any or all of the earnings arising from that role;
(l) The Committee is accountable to the Board and will comply with the standards of integrity and transparency consistent with its function within the NHS as a public authority.

Methodology

The Annual Review peer group comparison data will principally be the Capita Median for F.T.s (as amended from time to time) for Trusts with a turnover within a band in which the Trust falls. At the time of this policy coming into force the benchmark is Trusts with annual total revenue of between £101m and £200m.

However it is emphasised that the FT Capita Median data represents no more than a reference point for the consideration and determination of remuneration since the Committee must use such comparison data with caution to avoid any risk of an increase in remuneration levels with no corresponding improvement in performance as set out in Section 6 below. However the Committee will take into account all relevant matters as shall apply at the time of any consideration or determination of remuneration.

In consequence the Committee may at its discretion, and subject to the contractual employment terms of any individual to which this Framework applies, determine the remuneration of the Chief Executive and each Executive Director.

The Committee will consider the individual circumstances of the Chief Executive and each Executive Director when reviewing remuneration. Accordingly a determination of remuneration in respect of one Executive Director will not necessarily impact upon the remuneration of any other Executive Director.

Service contracts

Directors' contracts are not time limited and the required notice period for new Executive Directors is six months.

Accountable Officer's Approval

Signed as Accountable Officer of the Trust

Chief Executive: Silas Nicholls

Signed: …….

Date: …….


SARAH CURRIE PHYSIOTHERAPIST

THE STAFF REPORT

Staff Costs Analysis

Staff numbers and costs

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	282	30	**312**	257
Ambulance staff	-	-	-	-
Administration and estates	522	18	**540**	637
Healthcare assistants and other support staff	655	90	**745**	875
Nursing, midwifery and health visiting staff	787	95	**882**	1,178
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	354	8	**362**	401
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	-	-	-	10
Total average numbers	**2,600**	**241**	**2,841**	**3,358**
Of which:				
Number of employees (WTE) engaged on capital projects	9	2	**11**	15

Table 24

The numbers above are subject to audit and are based on whole time equivalents not headcount.

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	98,747	-	**98,747**	105,444
Social security costs	8,484	-	**8,484**	9,424
Apprenticeship levy	465	-	**465**	-
Employer's contributions to NHS pensions	10,440	-	**10,440**	11,993
Pension cost - other	14	-	**14**	79
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	4	-	**4**	-
Temporary staff		13,772	**13,772**	16,259
Total gross staff costs	**118,154**	**13,772**	**131,926**	**143,199**
Recoveries in respect of seconded staff	-	(4,127)	**(4,127)**	(398)
Total staff costs	**118,154**	**9,645**	**127,799**	**142,801**
Of which				
Costs capitalised as part of assets	215	37	**252**	611

Table 25

Staff number analysis

The tables below show the number of staff (headcount) employed by gender against their pay bands. Most staff are paid according to the NHS Agenda for Change bandings ranging from 1 to 9. 2017/18 Composition by gender (headcount):

Gender	AFC Band 1	AFC Band 2	AFC Band 3	AFC Band 4	AFC Band 5	AFC Band 6	AFC Band 7	AFC Band 8 **	AFC Band 9**	Medical Staff	Trust Scale	Grand Total
Female	160	368	340	175	480	405	204	87	1	77	4	2,301
Male	58	117	54	35	73	65	29	27		150	7	615
Grand Total	218	485	394	210	553	470	233	114	1	227	11	2,916

Table 26

2016/17 Composition by gender (headcount)

Gender	AFC Band 1	AFC Band 2	AFC Band 3	AFC Band 4	AFC Band 5	AFC Band 6	AFC Band 7	AFC Band 8 **	Medical Staff	Trust Scale	Grand Total
Female	170	429	404	212	642	526	279	94	79	3	2,838
Male	58	132	57	38	85	61	42	30	157	6	666
Grand Total	228	561	461	250	727	587	321	124	236	9	3,504

Table 27

** Senior managers

Sickness absence data

Table 28

	2017/18	**2016/17**
Staff group	**% Full-time equivalent days sickness**	**% Full-time equivalent days sickness**
Medical and Dental	1.36	1.67
Administrative and Clerical	4.51	4.84
Estates and Ancillary	7.45	6.01
Additional Clinical Services	7.37	7.66
Nursing and Midwifery Registered	6.12	5.95
Students	19.43	0.00
Allied Health Professionals	3.17	3.61
Professional Scientific and Technical	5.54	5.83
Healthcare Scientists	3.17	2.98

Average	**5.51**	**5.47**

Staff policies applied during the financial year

The appropriate staff policies are applied as required and where appropriate. They are regularly reviewed in accordance with Trust policy.

Staff Survey Results

NHS Staff Survey 2017, Response Rate

Response Rate: Acute and Community Trusts	
Trust 2017/18	**45%**
National	**43%**
Trust 2016/17	**19%**
National	**44%**

Table 29

Top 5 Ranking Scores

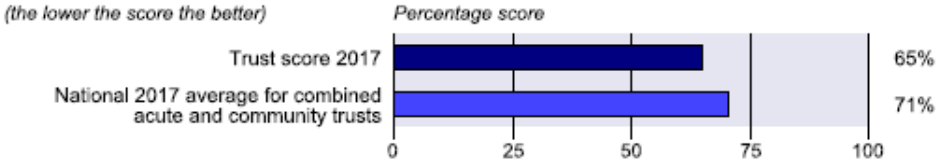
3. Summary of 2017 Key Findings for Southport and Ormskirk Hospital NHS Trust

3.1 Top and Bottom Ranking Scores

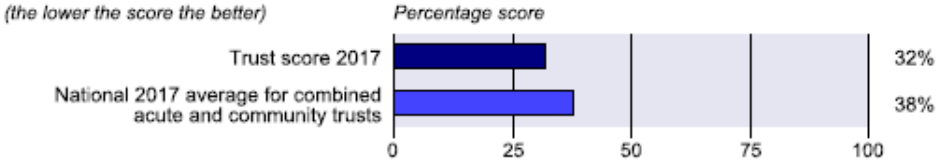
This page highlights the five Key Findings for which Southport and Ormskirk Hospital NHS Trust compares most favourably with other combined acute and community trusts in England.

TOP FIVE RANKING SCORES

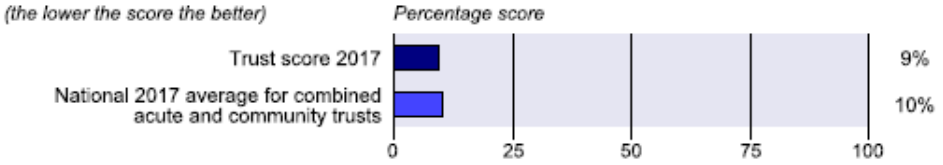
✓KF16. Percentage of staff working extra hours



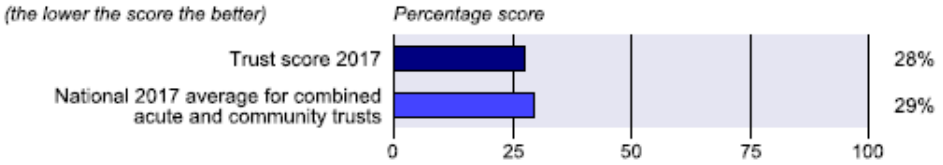
✓KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months



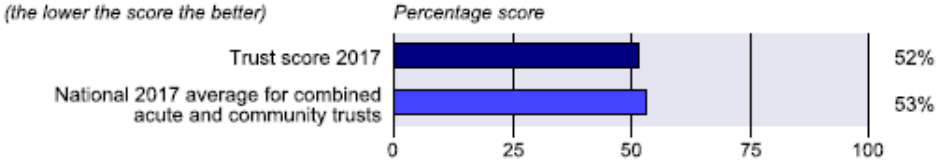
✓KF20. Percentage of staff experiencing discrimination at work in the last 12 months



✓KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



✓KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves



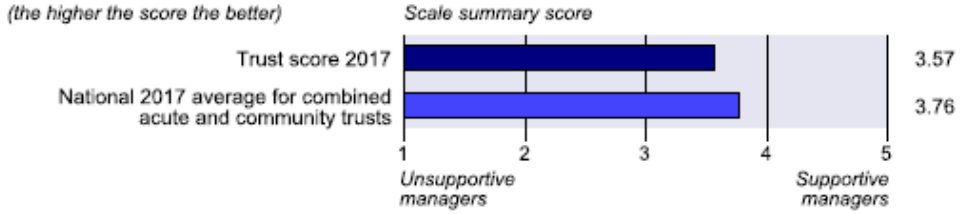
For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). Southport and Ormskirk Hospital NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

Bottom 5 Ranking Scores

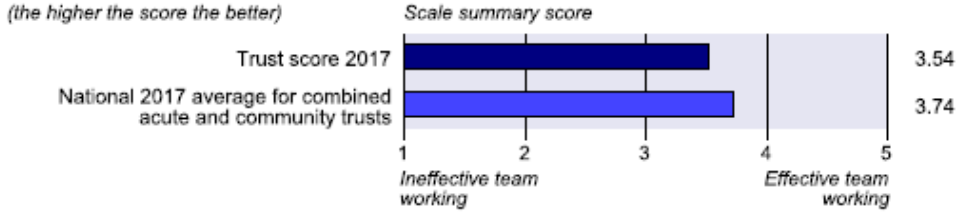
This page highlights the five Key Findings for which Southport and Ormskirk Hospital NHS Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

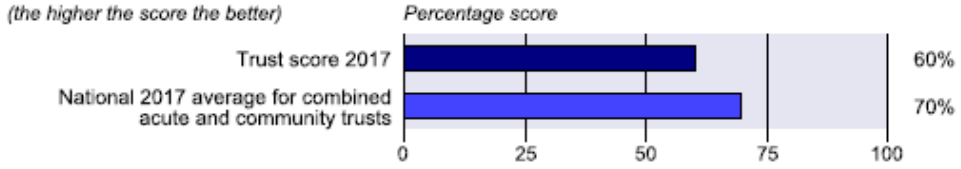
! KF10. Support from immediate managers



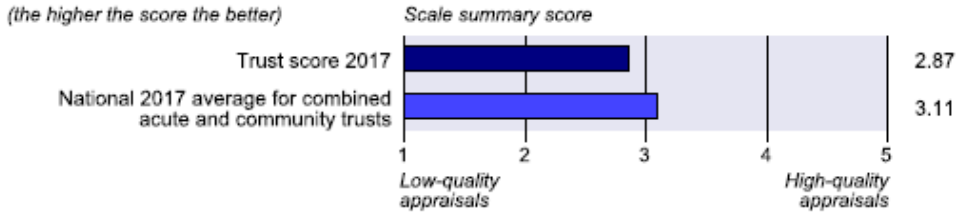
! KF9. Effective team working



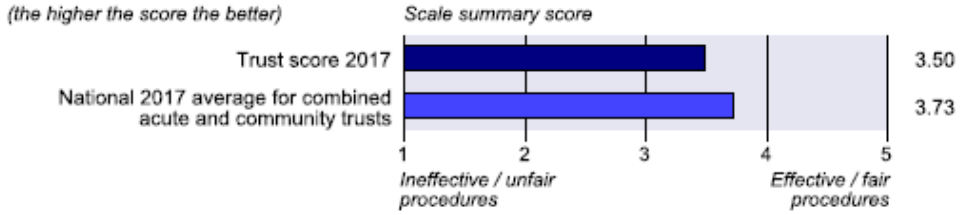
! KF7. Percentage of staff able to contribute towards improvements at work



! KF12. Quality of appraisals



! KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents



For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). Southport and Ormskirk Hospital NHS Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 43. Further details about this can be found in the document ***Making sense of your staff survey data***.

Expenditure on consultancy

Consultancy expenditure was £1,500,000 (prior year £116,000). The majority of this work was in service improvement and has been funded in the main by NHS Improvement. Other areas include procurement and support in the Trust's cost improvement programme.

Off-payroll engagements

The Trust is required to report an off-payroll arrangements as of 31st March 2018, for more than £245 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 30

New off-payroll arrangements where the reformed public sector rules apply. These are for off-payroll arrangements as of 31st March 2018, for more than £245 per day and that last longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**Number**
Of which:	
number assessed as caught by IR35	1
number assessed as not caught by IR35	3
number engaged directly (via PSC contracted to department) and are on the departmental payroll	4
number of engagements reassessed for consistency/assurance purposes during the year	8
number of engagements that saw a change in IR35 status following the consistency review	0

Table 31

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure should include both on payroll and off-payroll engagements.	16

Table 32

Exit packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages compulsory redundancies	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
<£10,000	1	4,089			1	4089		
£10,001 - £25,000								
£25,001 - 50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Totals	**1**	**4,089**	**-**	**-**	**1**	**4,089**	**-**	**-**

Table 33

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS redundancy scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Analysis of other departures:

	Agreements	Total value of agreements
	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	**-**	**-**

Table 34

Signed as Accountable Officer of the Trust

CHIEF EXECUTIVE …**S Nicholls**……

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed..... *S Nicholls*.....Chief Executive

Date.....24/05/18.....

Independent auditor's report to the Directors of Southport and Ormskirk Hospital NHS Trust

Opinion

We have audited the financial statements of Southport and Ormskirk Hospital NHS Trust ('the Trust') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the NHS Trusts in England ("the Accounts Direction").

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of the audit report

This report is made solely to the Board of Directors of Southport and Ormskirk Hospital NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Material Uncertainty Related to Going Concern

We draw attention to Note 1.1.2 in the financial statements, which indicates that the Trust incurred a deficit during the year ended 31 March 2018 of £33.601 million resulting in an accumulated deficit of £66.233 million. As stated in Note 1.1.2, cash funding loan finance from the Department of Health is expected to continue without interruption. The Trust is expecting to incur a deficit during the next 12 months of £28.8 million and as a result will continue to require substantial additional working capital support from the Department of Health. The material uncertainty remains because there is no medium term plan in place to repay the accumulated deficit or return the Trust to a break-even position. Our opinion is not modified in respect of this matter.

Other information

The directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 25 May 2018, we issued a referral to the Secretary of State under section 30b) of the Local Audit and Accountability Act 2014 in relation to the breach of the Trust's statutory financial duty at 31 March 2018 under Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 that:

'Each NHS trust must ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to revenue account'.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required to report by exception if we are not satisfied that the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, we are not satisfied that, in all significant respects, Southport and Ormskirk Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

In considering the Trust's arrangements for securing sustainable resource deployment, we identified the following matters:

- The Trust incurred a deficit of £33.6 million in 2017/18 against an original planned deficit of £18.1 million. In December 2017, the Trust amended its planned deficit to £31.7 million, but due to adverse determinations and financial sanctions the Trust was unable to deliver this revised plan. The final outturn for 2017/18 resulted in an underlying cumulative deficit of £66.2 million as at 31 March 2018 - representing a breach of the Trust's statutory 'break-even' duty.
- The Trust did not meet its original Cost Improvement Programme (CIP) target for 2017/18. The target set at the beginning of the year was £5.6m, of which only £3.65m was delivered.
- The Trust has yet to develop a service delivery model, and organisational configuration, that is able to deliver sustainable services in the future. These have not yet been formalised into a comprehensive strategy, with accompanying detailed operational plans.
- The Trust's 2018/19 Plan, submitted to NHS Improvement in April 2018, shows a deficit of £28.8 million after cost improvement plans of £7m. If the 2018/19 Financial Plan is delivered, it will take the Trust's cumulative deficit to £95m - over 58% of the Trust's operating income. As at April 2018, only 44% of the required £7m CIP / saving schemes have been identified.
- The Trust was reliant on significant cash support of £30.8m from the Department of Health in 2017/18, and the 2018/19 plan includes significant further interim revenue support loans from the Department of Health.
- The Care Quality Commission 2018 inspection report (issued in March 2018) provided an overall rating of 'Requires Improvement' and 'inadequate' in the Well Led domain. Whilst some improvements were noted from the previous 2015 and 2016 CQC reports, the Trust's overall CQC rating remained Requires Improvement in 2017/18.

These issues are evidence of significant weaknesses in the Trust's arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we issue a report in the public interest under schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under schedule 7(2) of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in these respects.

Respective responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Chief Executive is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

As explained in the Annual Governance Statement, the Accountable Officer is also responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by schedule 13(10)(a) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

We certify that we have completed the audit of the financial statements of Southport and Ormskirk Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

25th May 2018

Accounts 2017/18

CLARE HUNTER CARIDAC REHABILITATION NURSE

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

.....24/05/18.....Date..... *S Nicholls*.....Chief Executive

..... 24/05/18.....Date..... *S Shanahan*.....Finance Director

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	**145,309**	174,458
Other operating income	4	**12,968**	12,237
Operating expenses	5, 7	**(185,545)**	(204,015)
Operating surplus/(deficit) from continuing operations		**(27,268)**	(17,320)
Finance income	10	**21**	18
Finance expenses	11	**(4,647)**	(2,067)
PDC dividends payable		**(1,085)**	(1,828)
Net finance costs		**(5,711)**	(3,877)
Other gains / (losses)	12	**42**	1
Gains / (losses) arising from transfers by absorption		**(693)**	-
Surplus / (deficit) for the year from continuing operations		**(33,630)**	(21,196)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	15	**3,135**	5,455
Total comprehensive income / (expense) for the period		**(30,495)**	(15,741)

Financial performance for the year

Surplus / (deficit) for the period	**(33,630)**	(21,196)
Impairments (excluding IFRIC 12 impairments)	**-**	393
Adjust (gains) / losses on transfers by absorption	**693**	
Remove capital donations / grants I&E impact	**(66)**	94
CQUIN Risk Reserve - 1617 CT non achievement adjustment	**(598)**	
Adjusted financial performance surplus / (deficit)	**(33,601)**	(20,709)

The Trust reported a deficit of £33,601k in 2017/18 after technical adjustments for donated asset reserve elimination, absorption transfer loss and a CQUIN income adjustment.

The adjustment in respect of donated assets removes the benefit of donated income at £206k being higher than depreciation at £140k. The loss on transfer by absorption relates to the transfer of Community properties to NHS Property Services Ltd. CQUIN is a quality payment from commissioners. Owing to the Trust not achieving its financial targets in 16/17, the Trust was not permitted to show an element of its CQUIN monies (£598k) in its adjusted position.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	**5,407**	6,784
Property, plant and equipment	14	**121,383**	117,207
Trade and other receivables	17	**1,382**	1,267
Total non-current assets		**128,172**	125,258
Current assets			
Inventories	16	**2,454**	2,586
Trade and other receivables	17	**9,591**	8,042
Cash and cash equivalents	18	**1,079**	1,623
Total current assets		**13,124**	12,251
Current liabilities			
Trade and other payables	19	**(25,231)**	(20,686)
Borrowings	21	**(6,366)**	(1,959)
Provisions	23	**(131)**	(164)
Other liabilities	20	**(471)**	(397)
Total current liabilities		**(32,199)**	(23,206)
Total assets less current liabilities		**109,097**	114,303
Non-current liabilities			
Borrowings	21	**(81,822)**	(57,547)
Provisions	23	**(278)**	(303)
Total non-current liabilities		**(82,100)**	(57,850)
Total assets employed		**26,997**	56,453
Financed by			
Public dividend capital		**97,241**	96,202
Revaluation reserve		**13,240**	10,228
Income and expenditure reserve		**(83,484)**	(49,977)
Total taxpayers' equity		**26,997**	56,453

The financial statements were approved by the Board on 24th May 2018 and signed on its behalf by:

Chief Executive: *S Nicholls* **Date:** 24/05/2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**96,202**	**10,228**	**(49,977)**	**56,453**
Surplus/(deficit) for the year	**-**	**-**	**(33,630)**	**(33,630)**
Transfers by absorption: transfers between reserves	**-**	**(123)**	**123**	**-**
Revaluations	**-**	**3,135**	**-**	**3,135**
Public dividend capital received	**1,039**	**-**	**-**	**1,039**
Taxpayers' equity at 31 March 2018	**97,241**	**13,240**	**(83,484)**	**26,997**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	95,852	4,773	(28,781)	71,844
Prior period adjustment	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	95,852	4,773	(28,781)	71,844
Surplus/(deficit) for the year	-	-	(21,196)	(21,196)
Revaluations	-	5,455	-	5,455
Public dividend capital received	350	-	-	350
Taxpayers' equity at 31 March 2017	96,202	10,228	(49,977)	56,453

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**(27,268)**	(17,320)
Non-cash income and expense:			
Depreciation and amortisation	5	**5,890**	5,708
Net impairments	6	**-**	393
Income recognised in respect of capital donations	4	**(206)**	(67)
(Increase) / decrease in receivables and other assets		**(1,664)**	(1,617)
(Increase) / decrease in inventories		**132**	(300)
Increase / (decrease) in payables and other liabilties		**3,385**	3,485
Increase / (decrease) in provisions		**(58)**	(110)
Other movements in operating cash flows		**(2,545)**	25
Net cash generated from / (used in) operating activities		**(22,334)**	(9,803)
Cash flows from investing activities			
Interest received		**21**	19
Purchase of intangible assets		**(594)**	(1,624)
Purchase of property, plant, equipment and investment property		**(3,772)**	(3,885)
Sales of property, plant, equipment and investment property		**65**	11
Receipt of cash donations to purchase capital assets		**206**	67
Net cash generated from / (used in) investing activities		**(4,074)**	(5,412)
Cash flows from financing activities			
Public dividend capital received		**1,039**	350
Movement on loans from the Department of Health and Social Care		**30,404**	20,300
Capital element of finance lease rental payments		**(984)**	(962)
Capital element of PFI, LIFT and other service concession payments		**(605)**	(577)
Interest paid on finance lease liabilities		**(479)**	(519)
Interest paid on PFI, LIFT and other service concession obligations		**(1,100)**	(687)
Other interest paid		**(1,284)**	(806)
PDC dividend (paid) / refunded		**(1,127)**	(1,283)
Net cash generated from / (used in) financing activities		**25,864**	15,816
Increase / (decrease) in cash and cash equivalents		**(544)**	601
Cash and cash equivalents at 1 April - brought forward		**1,623**	1,022
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**1,623**	1,022
Cash and cash equivalents at 31 March	18.1	**1,079**	1,623

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis.

The basis of management's going concern assessment is the continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents.

There are future uncertainties, however, like other NHS providers the Trust is working with local and regional NHS organisations to return to a financially sustainable organisation within the five year forward time-frame of 2020/21. Cash support is being given by the Department of Health via interest-bearing loans and NHS Improvement is providing support specialised resources to aid efficiency and productivity. In addition the Trust has successfully appointed a permanent Chief Executive to lead the organisation with a clear vision of what needs to be done.

Final financial plans for 2018/19 were submitted to NHS Improvement (NHSI) on 30th April 2018 and show a forecast deficit of £28.8m. This is an improvement on 2017/18, however, this does not return the organisation back into balance. The new Chief Executive has made some senior management changes with the appointment of a Director of Strategy. In addition NHSI are providing support in the recruitment of a Turnaround Director. A new Director of Nursing has taken up her post and a new permanent Medical Director will be appointed later in the year. The organisation will finally have a stable leadership with a long-term view to work with our local commissioners and other stakeholders to deliver safe, high quality, affordable healthcare to the local population.

In accordance with IAS 1, management have made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Our external auditors, Mazars LLP have made a Section 30 referral letter to the Secretary of State as the Trust has made a cumulative deficit over a 3 year period. This is a legal requirement for the auditors, however, given that the Trust has plans for the future and cash support, the Trust does not believe that this referral letter undermines management's view that the Trust is a going concern.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Managed service contracts with GE Medical Systems Ltd (radiological equipment facility) and Veolia (Energy Centre and Facilities Management workshops facility) have been accounted for under IFRIC 12 (service concession arrangements). Both contracts were deemed to be on-SOFP (Statement of Financial Position). The Group Accounting Manual specifies that on-SOFP assets under IFRIC 12 must be shown under PFI disclosures.

The Trust accounted for its share of profits over a number of years with West Lancashire Health Partnership Ltd which was set up as a Community Interest Company (CIC). This company dissolved in April 2017 and the share of the profits transferred to Southport & Ormskirk Hospital NHS Trust Charitable Fund. The CIC regulator insisted that these monies could only transfer to either another CIC or a charity. As such these prior year profits (£197k) should never have been recognised. The Group Accounting Manual states that where a prior year error is not material and does not require statement, it must adjust for the cumulative effect of the error in the current year, reflecting any impact for income and expenditure as appropriate. It may not take income and expenditure adjustments directly to retained earnings.

Radiology equipment assets under the GE managed equipment service are valued excluding VAT as the contract payments are fully VAT recoverable.

The Energy Centre at Ormskirk is valued excluding VAT as the contract payments under this managed service are fully recoverable.

One of the Trust' modular buildings is valued applying 50% VAT recovery as under its finance lease payments, 50% of the charge is recoverable.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The Trust's latest asset valuation was 1st January 2018. This was a desktop valuation using a modern equivalent asset value approach. The value is not materially different to one at 31st March 2018 as the January valuation is based on a BCIS TPI (Building Cost Index) of 318 which is unchanged at March.

A revised model has been used to apportion the unitary charges for the two IFRIC 12 contracts with GE and Veolia. This apportions costs between service charges, interest payable, contingent rent and repayment of the lease liability. This has resulted in prior year changes which as it is not material and does not require restatement, the cumulative effect of the change has been reflected in in the current year.

Note 1.3 Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue relating to patient care spells that are part-completed at the year end is calculated using actual coded patient data from April 2017 to January 2018. The value at the end of each month is calculated based on the patients' length of stay at the end of the month compared to the total length of stay for that spell. An average of all the months is taken and used to calculate the year end value.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• Collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. The Trust has a rolling programme of valuations of properties with an annual desktop revaluation and a full revaluation every 5 years. The last full revaluation took place as at 1st January 2015 and the last desktop valuation was 1st January 2018. The valuers are Cushman & Wakefield who are regulated by the Royal Institute of Chartered Surveyors (RCIS). All valuations are undertaken by an RCIS qualified valuer.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

In applying this, the Trust compares the new value of the whole site (split between land and buildings) to the existing value. Where the total value of the land or buildings on a site has increased this goes to the revaluation reserve. Where the valuation has reduced this is an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the class of asset and, thereafter, to expenditure.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.6.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	-	99
Dwellings	80	80
Plant & machinery	-	15
Transport equipment	7	7
Information technology	-	40
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	-	5

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivables. Financial liabilities are classified as other financial liabilities.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

Note 1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 23.2 but is not recognised in the trust’s accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM* .

Note 1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.18 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted
As required by IAS 8, trusts should disclose any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector and an assessment subsequent application will have on the financial statements.

IFRS 9 Financial instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.

IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration - Application required for accounting periods beginning on or after 1 January 2018.

IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The Trust has an internal divisional structure based on specialties and functions.

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. The Trust Board review the financial position of the whole organisation in their decision making process, rather than individual divisions included in the totals.

Under IFRS8 segmental reporting, the Trust is required to report separate segments only where one of the quantitative thresholds is reached: 10% of revenue, profit/loss or assets; unless this would result in less than 75% of the body's revenue being included in reportable segments.

The Trust has reviewed the thresholds at its Board meeting on 7th March 2018. The Board concluded that as all the contractual income for the Trust is held within the Corporate Division and that as this accounts for 90% of total revenue that only one division exceeds the 10% revenue threshold and therefore only one operating segment needs to be reported. In addition the Board agreed to review the operating segment requirement on an annual basis particularly as a change may be necessary if the organisation adopts service line management whereby income and expenditure budgets are devolved down to service lines and decisions made at the divisional level.

Currently the Trust is viewed as having one segment which is healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	**17,752**	21,430
Non elective income	**60,490**	59,370
First outpatient income	**8,336**	8,476
Follow up outpatient income	**17,502**	19,014
A & E income	**10,704**	11,548
High cost drugs income from commissioners (excluding pass-through costs)	**5,032**	4,816
Other NHS clinical income	**18,961**	20,429
Community services		
Community services income from CCGs and NHS England	**1,757**	21,692
Income from other sources (e.g. local authorities)	**2,978**	2,724
All services		
Private patient income	**70**	50
Other clinical income	**1,727**	4,909
Total income from activities	**145,309**	174,458

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	**19,677**	18,341
Clinical commissioning groups	**119,796**	149,603
Other NHS providers	**812**	1,053
NHS other	**84**	687
Local authorities	**3,095**	2,879
Non-NHS: private patients	**70**	50
Non-NHS: overseas patients (chargeable to patient)	**176**	13
NHS injury scheme	**1,208**	1,652
Non-NHS: other	**391**	180
Total income from activities	**145,309**	174,458
Of which:		
Related to continuing operations	**145,309**	174,458

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	**176**	13
Cash payments received in-year	**23**	9
Amounts added to provision for impairment of receivables	**1**	-
Amounts written off in-year	**97**	1

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	**224**	269
Education and training	**6,027**	6,009
Receipt of capital grants and donations	**206**	67
Charitable and other contributions to expenditure	**30**	30
Non-patient care services to other bodies	**2,531**	2,716
Rental revenue from operating leases	**25**	25
Other income	**3,925**	3,121
Total other operating income	**12,968**	12,237
Of which:		
Related to continuing operations	**12,968**	12,237

Other income breakdown

	2017/18	2016/17
	£000	£000
Car parking income	**1,632**	1,608
Catering	**799**	747
Property rental (not lease income)	**88**	44
Staff accommodation rental	**64**	71
Staff contribution to employee benefit schemes	**1**	20
Other income generation schemes	**1,341**	631
	3,925	3,121

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**898**	687
Purchase of healthcare from non-NHS and non-DHSC bodies	**1,458**	1,459
Staff and executive directors costs	**127,226**	141,694
Remuneration of non-executive directors	**66**	70
Supplies and services - clinical (excluding drugs costs)	**17,950**	22,267
Supplies and services - general	**2,268**	2,342
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**9,060**	9,285
Consultancy costs	**1,500**	116
Establishment	**1,949**	1,950
Premises	**5,395**	9,163
Transport (including patient travel)	**499**	911
Depreciation on property, plant and equipment	**4,075**	3,917
Amortisation on intangible assets	**1,815**	1,791
Net impairments	**-**	393
Increase/(decrease) in provision for impairment of receivables	**356**	236
Increase/(decrease) in other provisions	**41**	-
Change in provisions discount rate(s)	**3**	25
Audit fees payable to the external auditor		
audit services- statutory audit	**47**	75
other auditor remuneration (external auditor only)	**11**	-
Internal audit costs	**121**	121
Clinical negligence	**4,925**	3,518
Legal fees	**35**	204
Insurance	**156**	168
Research and development	**289**	294
Education and training	**606**	798
Rentals under operating leases	**264**	250
Redundancy	**4**	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	**1,568**	1,453
Car parking & security	**344**	30
Hospitality	**31**	4
Losses, ex gratia & special payments	**3**	17
Other services, eg external payroll	**1,938**	-
Other	**644**	777
Total	**185,545**	204,015
Of which:		
Related to continuing operations	**185,545**	204,015

Note that the 2016/17 figures have been re-mapped to revised descriptions. The total value of £204,015k is the same as is in the audited 16/17 accounts.

Note 5.1 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust		
2. Audit-related assurance services		
3. Taxation compliance services		
4. All taxation advisory services not falling within item 3 above		
5. Internal audit services		
6. All assurance services not falling within items 1 to 5		
7. Corporate finance transaction services not falling within items 1 to 6 above		
8. Other non-audit services not falling within items 2 to 7 above	**11**	
	11	**-**

Note 5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	-	393
Total net impairments charged to operating surplus / deficit	**-**	393

Note 7 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	**94,952**	105,444
Social security costs	**8,484**	9,424
Apprenticeship levy	**465**	-
Employer's contributions to NHS pensions	**10,440**	11,993
Pension cost - other	**14**	79
Termination benefits	**4**	-
Temporary staff (including agency)	**13,772**	16,259
Total gross staff costs	**128,131**	143,199
Recoveries in respect of seconded staff	**(332)**	(398)
Total staff costs	**127,799**	142,801
Of which		
Costs capitalised as part of assets	**252**	611

Note 7.1 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £296k (£153k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 Southport And Ormskirk Hospital NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Southport And Ormskirk Hospital NHS Trust is the lessor.

This lease relates to land on the Southport site used by Fresenius to run the Renal Unit.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	**25**	25
Total	**25**	25

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**25**	25
- later than one year and not later than five years;	**100**	100
- later than five years.	**125**	150
Total	**250**	275

Note 9.2 Southport And Ormskirk Hospital NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Southport And Ormskirk Hospital NHS Trust is the lessee.

Operating leases only relate to lease cars and multi function devices (printers/scanners/photocopiers).

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	**264**	250
Total	**264**	250

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**110**	96
- later than one year and not later than five years;	**377**	5
Total	**487**	101

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	**21**	18
Total	**21**	18

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	**1,619**	884
Finance leases	**486**	496
Main finance costs on PFI and LIFT schemes obligations	**844**	686
Contingent finance costs on PFI and LIFT scheme obligations	**1,698**	-
Total interest expense	**4,647**	2,066
Unwinding of discount on provisions	**-**	1
Total finance costs	**4,647**	2,067

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

There were no relevant amounts included in finance costs or compensation paid under this legislation in either the current or prior years.

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	**42**	1
Total gains / (losses) on disposal of assets	**42**	1

Note 13.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**14,919**	**-**	**14,919**
Transfers by absorption	**(9)**	**-**	**(9)**
Additions	**411**	**33**	**444**
Reclassifications	**29**	**(29)**	**-**
Disposals / derecognition	**(9)**	**-**	**(9)**
Gross cost at 31 March 2018	**15,341**	**4**	**15,345**
Amortisation at 1 April 2017 - brought forward	**8,135**	**-**	**8,135**
Transfers by absorption	**(6)**	**-**	**(6)**
Provided during the year	**1,815**	**-**	**1,815**
Disposals / derecognition	**(6)**	**-**	**(6)**
Amortisation at 31 March 2018	**9,938**	**-**	**9,938**
Net book value at 31 March 2018	**5,403**	**4**	**5,407**
Net book value at 1 April 2017	**6,784**	**-**	**6,784**

Note 13.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	14,203	-	14,203
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2016 - restated	14,203	-	14,203
Additions	1,138	-	1,138
Reclassifications	353	-	353
Disposals / derecognition	(775)	-	(775)
Valuation / gross cost at 31 March 2017	14,919	-	14,919
Amortisation at 1 April 2016 - as previously stated	7,119	-	7,119
Prior period adjustments	-	-	-
Amortisation at 1 April 2016 - restated	7,119	-	7,119
Provided during the year	1,791	-	1,791
Disposals / derecognition	(775)	-	(775)
Amortisation at 31 March 2017	8,135	-	8,135
Net book value at 31 March 2017	6,784	-	6,784
Net book value at 1 April 2016	7,084	-	7,084

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**6,899**	**117,402**	**1,191**	**536**	**41,310**	**637**	**6,906**	**4,421**	**179,302**
Transfers by absorption	**(204)**	**(476)**	**-**	**-**	**(19)**	**-**	**-**	**-**	**(699)**
Additions	**-**	**1,119**	**-**	**1,294**	**2,849**	**-**	**457**	**107**	**5,826**
Revaluations	**973**	**(18,069)**	**(525)**	**-**	**-**	**-**	**-**	**-**	**(17,621)**
Reclassifications	**342**	**907**	**19**	**(1,218)**	**8**	**-**	**6**	**(64)**	**-**
Disposals / derecognition	**-**	**-**	**-**	**-**	**(425)**	**-**	**-**	**(16)**	**(441)**
Valuation/gross cost at 31 March 2018	**8,010**	**100,883**	**685**	**612**	**43,723**	**637**	**7,369**	**4,448**	**166,367**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**18,631**	**544**	**-**	**33,290**	**449**	**4,989**	**4,192**	**62,095**
Transfers by absorption	**-**	**(5)**	**-**	**-**	**(4)**	**-**	**-**	**-**	**(9)**
Provided during the year	**-**	**2,120**	**15**	**-**	**1,367**	**42**	**493**	**38**	**4,075**
Revaluations	**-**	**(20,201)**	**(555)**	**-**	**-**	**-**	**-**	**-**	**(20,756)**
Disposals / derecognition	**-**	**-**	**-**	**-**	**(405)**	**-**	**-**	**(16)**	**(421)**
Accumulated depreciation at 31 March 2018	**-**	**545**	**4**	**-**	**34,248**	**491**	**5,482**	**4,214**	**44,984**
Net book value at 31 March 2018	**8,010**	**100,338**	**681**	**612**	**9,475**	**146**	**1,887**	**234**	**121,383**
Net book value at 1 April 2017	**6,899**	**98,771**	**647**	**536**	**8,020**	**188**	**1,917**	**229**	**117,207**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	6,899	114,103	1,317	1,126	39,822	632	6,906	4,528	175,333
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	6,899	114,103	1,317	1,126	39,822	632	6,906	4,528	175,333
Additions	-	1,735	-	258	1,870	77	669	21	4,630
Impairments	-	(408)	-	-	-	-	-	-	(408)
Revaluations	-	1,759	(126)	-	-	-	-	-	1,633
Reclassifications	-	213	-	(848)	-	-	282	-	(353)
Disposals / derecognition	-	-	-	-	(382)	(72)	(951)	(128)	(1,533)
Valuation/gross cost at 31 March 2017	6,899	117,402	1,191	536	41,310	637	6,906	4,421	179,302
Accumulated depreciation at 1 April 2016 - as previously stated	-	20,480	561	-	32,275	472	5,469	4,282	63,539
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	20,480	561	-	32,275	472	5,469	4,282	63,539
Provided during the year	-	1,955	16	-	1,397	40	471	38	3,917
Impairments	-	(15)	-	-	-	-	-	-	(15)
Revaluations	-	(3,789)	(33)	-	-	-	-	-	(3,822)
Disposals/ derecognition	-	-	-	-	(382)	(63)	(951)	(128)	(1,524)
Accumulated depreciation at 31 March 2017	-	18,631	544	-	33,290	449	4,989	4,192	62,095
Net book value at 31 March 2017	6,899	98,771	647	536	8,020	188	1,917	229	117,207
Net book value at 1 April 2016	6,899	93,623	756	1,126	7,547	160	1,437	246	111,794

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	**8,010**	**83,744**	**681**	**612**	**6,747**	**146**	**1,869**	**166**	**101,975**
Finance leased	**-**	**10,963**	**-**	**-**	**789**	**-**	**-**	**-**	**11,752**
On-SoFP PFI contracts and other service concession arrangements	**-**	**4,114**	**-**	**-**	**1,460**	**-**	**-**	**-**	**5,574**
Owned - donated	**-**	**1,517**	**-**	**-**	**479**	**-**	**18**	**68**	**2,082**
NBV total at 31 March 2018	**8,010**	**100,338**	**681**	**612**	**9,475**	**146**	**1,887**	**234**	**121,383**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	6,899	82,407	647	536	5,808	188	1,898	182	98,565
Finance leased	-	10,833	-	-	933	-	-	-	11,766
On-SoFP PFI contracts and other service concession arrangements	-	4,041	-	-	777	-	-	-	4,818
Owned - donated	-	1,490	-	-	502	-	19	47	2,058
NBV total at 31 March 2017	6,899	98,771	647	536	8,020	188	1,917	229	117,207

Note 15 Revaluations of property, plant and equipment

The Trust's land and building assets were revalued effective at 1st January 2018. The valution was carried out by an independent valuer using a modern equivalent asset valuation approach.

The result was an increase in the value of land and buildings by £3.135m.

Note 16 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	**587**	665
Energy	**68**	72
Other	**1,799**	1,849
Total inventories		
of which:	-	-
Held at fair value less costs to sell	**2,454**	2,586

Inventories recognised in expenses for the year were £10,606k (2016/17: £10,283k).

Note 17.1 Trade receivables and other receivables

	2018 £000	2017 £000
Current		
Trade receivables	**6,558**	5,306
Accrued income	**550**	114
Provision for impaired receivables	**(159)**	(109)
Prepayments (non-PFI)	**1,160**	1,144
VAT receivable	**500**	430
Other receivables	**982**	1,157
Total current trade and other receivables	**9,591**	8,042
Non-current		
Provision for impaired receivables	**(194)**	(208)
Other receivables	**1,576**	1,475
Total non-current trade and other receivables	**1,382**	1,267
Of which receivables from NHS and DHSC group bodies:		
Current	**5,673**	4,308

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**317**	287
Prior period adjustments	**-**	-
At 1 April - restated	**317**	287
Increase in provision	**356**	236
Amounts utilised	**(320)**	(206)
At 31 March	**353**	317

Note 17.3 Credit quality of financial assets

	2017/18 Trade and other receivables	2016/17 Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
30-60 Days	**22**	61
60-90 days	**139**	27
90- 180 days	**179**	108
Over 180 days	**257**	118
Total	**597**	314
Ageing of non-impaired financial assets past their due date		
0 - 30 days	**2,196**	777
30-60 Days	**311**	120
60-90 days	**73**	148
90- 180 days	**275**	165
Over 180 days	**1,335**	714
Total	**4,190**	1,924

Note 18.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**1,623**	1,022
Prior period adjustments	-	-
At 1 April (restated)	**1,623**	1,022
Net change in year	**(544)**	601
At 31 March	**1,079**	1,623
Broken down into:		
Cash at commercial banks and in hand	**51**	59
Cash with the Government Banking Service	**1,028**	1,564
Total cash and cash equivalents as in SoFP	**1,079**	1,623
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**1,079**	1,623

Note 18.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	**2**	1
Total third party assets	**2**	1

Note 19.1 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	**12,307**	10,748
Capital payables	**2,021**	1,001
Accruals	**6,541**	4,302
Social security costs	**1,245**	1,406
Other taxes payable	**1,101**	1,193
PDC dividend payable	**44**	86
Accrued interest on loans	**333**	77
Other payables	**1,639**	1,873
Total current trade and other payables	**25,231**	20,686
Of which payables from NHS and DHSC group bodies:		
Current	**9,636**	6,164

Note 19.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018	31 March 2017
	£000	£000
- outstanding pension contributions	**1,444**	1,630

Note 20 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	**471**	397
Total other current liabilities	**471**	397

Note 21 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	**4,620**	400
Obligations under finance leases	**990**	990
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	**756**	569
Total current borrowings	**6,366**	1,959
Non-current		
Loans from the Department of Health and Scoial Care	**68,015**	41,831
Obligations under finance leases	**9,027**	10,018
Obligations under PFI, LIFT or other service concession contracts	**4,780**	5,698
Total non-current borrowings	**81,822**	57,547

Note 22 Finance leases

Note 22.1 Southport And Ormskirk Hospital NHS Trust as a lessee

Obligations under finance leases where Southport And Ormskirk Hospital NHS Trust is the lessee.

	2018 £000	2017 £000
Gross lease liabilities	**10,017**	11,008
of which liabilities are due:		
- not later than one year;	**990**	990
- later than one year and not later than five years;	**3,935**	3,928
- later than five years.	**5,092**	6,090
Net lease liabilities	**10,017**	11,008
of which payable:		
- not later than one year;	**990**	990
- later than one year and not later than five years;	**3,935**	3,928
- later than five years.	**5,092**	6,090

The main finance lease obligations relate to the 2 modular buildings on the Southport site.

Note 23.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other	Total
	£000	£000	£000
At 1 April 2017	**382**	**85**	**467**
Change in the discount rate	**3**	**-**	**3**
Arising during the year	**52**	**40**	**92**
Utilised during the year	**(62)**	**(40)**	**(102)**
Reversed unused	**(29)**	**(22)**	**(51)**
Unwinding of discount	**-**	**-**	**-**
At 31 March 2018	**346**	**63**	**409**
Expected timing of cash flows:			
- not later than one year;	**68**	**63**	**131**
- later than one year and not later than five years;	**272**	**-**	**272**
- later than five years.	**6**	**-**	**6**
Total	**346**	**63**	**409**

The other provision relates to public/employer liabilities.

Note 23.2 Clinical negligence liabilities

At 31 March 2018, £70,761k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Southport And Ormskirk Hospital NHS Trust (31 March 2017: £62,436k).

Note 24 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	**(53)**	(34)
Other	**(500)**	(600)
Gross value of contingent liabilities	**(553)**	(634)
Amounts recoverable against liabilities	**-**	-
Net value of contingent liabilities	**(553)**	(634)
Net value of contingent assets	-	-

Contingent Liabilities consists of £500k in relation to the contract with the Marina Dalglish Appeal and the West Lancashire Community Hospice Association. This contract deals with the donation for the Medical Day Unit Extension. If the Trust ceased to provide or moved the services provided in the Medical Day Unit within the next 6 years then the Trust would be liable to refund the donation on a pro rata basis (£100k per year of the contract remaining).

The other element of contingent liabilities is for public/employer liabilities and the figure is the one notified to the Trust byNHS Resolution.

Note 25 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	**180**	871
Total	**180**	871

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has 2 managed service contracts. One for energy management and the other for radiology equipment. Both of these contracts are accounted for as On-SOFP service concession arrangements.

Note 26.1 Imputed finance lease obligations

Southport And Ormskirk Hospital NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**5,536**	6,267
Of which liabilities are due		
- not later than one year;	**756**	569
- later than one year and not later than five years;	**2,301**	2,566
- later than five years.	**2,479**	3,132
Net PFI, LIFT or other service concession arrangement obligation	**5,536**	6,267
- not later than one year;	**756**	569
- later than one year and not later than five years;	**2,301**	2,566
- later than five years.	**2,479**	3,132

Note 26.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**55,896**	45,634
Of which liabilities are due:		
- not later than one year;	**3,378**	2,718
- later than one year and not later than five years;	**14,232**	11,557
- later than five years.	**38,286**	31,359

Note 26.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	**5,726**	2,716
Consisting of:		
- Interest charge	**844**	686
- Repayment of finance lease liability	**1,616**	577
- Service element and other charges to operating expenditure	**1,568**	1,453
- Contingent rent	**1,698**	-
Total amount paid to service concession operator	**5,726**	2,716

The Trust has revised the models it uses to account for its two PFI schemes following a review of the previous models. The new models provide a more accurate split of unitary payments between the component elements and as a result the profile for the write-down of the PFI liability also changes. In line with the requirements of the Group Accounting Manual (GAM), the Trust has made adjustments in the 2017/18 accounting entries to correct the cumulative non-material errors in prior years. The actual amount paid to the service operator in 2017/18 was £3,273k.

Note 27 Financial instruments

Note 27.1 Financial risk management

[In accordance with IFRS 7, trusts should disclose information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the entity is exposed at the end of the reporting period. These risks typically include, but are not limited to:

i) credit risk,
ii) liquidity risk and
iii) market risk,
iv) foreign currency risk.

For each type of risk trusts should disclose:

a) the exposures to risk and how they arise;
b) policies and processes for managing the risk and the methods used to measure the risk.
c) any changes in (a) or (b) since the previous period.

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust treasury activity is subject to review by its internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust borrows from government for capital expenditure, subject to approval by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets. Interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

Since the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2017 are in receivables from customers, as disclosed in the trade and other receivables note (Note 17).

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS commissioning organisations, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	**7,108**	**7,108**
Cash and cash equivalents at bank and in hand	**1,079**	**1,079**
Total at 31 March 2018	**8,187**	**8,187**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	**5,306**	**5,306**
Cash and cash equivalents at bank and in hand	**1,623**	**1,623**
Total at 31 March 2017	**6,929**	**6,929**

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	**72,635**	**72,635**
Obligations under finance leases	**10,017**	**10,017**
Obligations under PFI, LIFT and other service concession contracts	**5,536**	**5,536**
Trade and other payables excluding non financial liabilities	**24,086**	**24,086**
Total at 31 March 2018	**112,274**	**112,274**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	**42,231**	**42,231**
Obligations under finance leases	**11,008**	**11,008**
Obligations under PFI, LIFT and other service concession contracts	**6,267**	**6,267**
Trade and other payables excluding non financial liabilities	**16,051**	**16,051**
Total at 31 March 2017	**75,557**	**75,557**

Note 27.4 Fair values of financial assets and liabilities

The book value (carrying value) is a reasonable approximation of fair value.

Note 27.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	**30,452**	18,010
In more than one year but not more than two years	**17,215**	6,272
In more than two years but not more than five years	**57,035**	41,842
In more than five years	**7,572**	9,433
Total	**112,274**	75,557

Note 28 Losses and special payments

	2017/18		2016/17	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	**1**	**-**	-	-
Bad debts and claims abandoned	**442**	**319**	398	206
Stores losses and damage to property	**6**	**78**	10	82
Total losses	**449**	**397**	408	288
Special payments				
Ex-gratia payments	**34**	**70**	34	60
Total special payments	**34**	**70**	34	60
Total losses and special payments	**483**	**467**	442	348

Note 29 Related parties

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Southport & Ormskirk Hospital NHS Trust.

The Department of Health is regarded as a related party. During the year Southport & Ormskirk Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

	Income		**Receivables**		**Payables**	
	31 March 2018 £000	**31 March 2017 £000**	**31 March 2018 £000**	**31 March 2017 £000**	**31 March 2018 £000**	**31 March 2017 £000**
Southport & Formby CCG	**63,459**	78,534	**385**	409	**3,718**	1,012
West Lancashire CCG	**44,280**	56,312	**1,208**	1,222	**2,565**	1,911
NHS England	**19,612**	18,341	**321**	381	**140**	198
South Sefton CCG	**6,579**	8,373	**273**	-	**1,085**	307

The Trust has also received revenue and capital payments from Southport & Ormskirk Hospital NHS Trust Charitable Fund, trustees for which are also members of the Trust board. The summary financial statements of the Funds Held on Trust are included in the charitable fund.

The value of transactions with Southport & Ormskrik Hospital NHS Trust Charitable Fund amounted to £377,596 in 2017/18 (£141,545 2016/17). The majority of transactions were pure recharges for equipment bought using the Trust's finance system. Only £30,386 (£30,086 2016/17)has been recorded as income (shown in note 4) and this is for a service level agreement to provide financial services to the charity.

There is a related party declaration (recorded on the Declaration of Interests) between a Trust Board member and a current supplier, Ernst & Young LLP. The value of invoices in 2017/18 is £235,260.

Note 30 Prior period adjustments

There are no material prior period adjustments that have required the restatement of prior year accounts. Changes in accounting estimates around the managed service contracts have impacted on prior periods but the adjustments for these have been reflected in year due to materiality.

Note 31 Events after the reporting date

There are no adjusting or non-adjusting events after the end of the reporting period.

Note 32 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	**36,688**	**57,525**	43,431	63,459
Total non-NHS trade invoices paid within target	**23,391**	**31,449**	23,297	29,893
target	**63.76%**	**54.67%**	53.64%	47.11%
NHS Payables				
Total NHS trade invoices paid in the year	**1,583**	**19,367**	1,775	17,143
Total NHS trade invoices paid within target	**776**	**9,622**	722	5,775
Percentage of NHS trade invoices paid within target	**49.02%**	**49.68%**	40.68%	33.69%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 33 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	**30,398**	18,510
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**30,398**	18,510
External financing limit (EFL)	**30,473**	18,571
Undespend against EFL	**75**	61

Note 34 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	**6,270**	5,768
Less: Disposals	**(23)**	(9)
Less: Donated and granted capital additions	**(206)**	(67)
Charge against Capital Resource Limit	**6,041**	5,692
Capital Resource Limit	**6,048**	5,708
Under spend against CRL	**7**	16

Note 35 Breakeven duty financial performance

	2017/18 £000	2016/17 £000
Breakeven duty financial performance (deficit)	**(33,003)**	(20,709)

Note 36 Breakeven duty rolling assessment

	1999/00 to 2008/09 total £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Adjusted financial performance surplus/(deficit)		500	853	204	1,258	1,950	(896)	(17,202)	(20,709)	**(33,601)**
Remove CQUIN risk reserve adjustment										**598**
Breakeven duty in-year financial performance		500	853	204	1,258	1,950	(896)	(17,202)	(20,709)	**(33,003)**
Breakeven duty cumulative position	812	1,312	2,165	2,369	3,627	5,577	4,681	(12,521)	(33,230)	**(66,233)**
Operating income		146,757	153,368	178,182	181,098	189,224	188,905	182,236	186,695	**158,277**
Cumulative breakeven position as a percentage of operating income		0.89%	1.41%	1.33%	2.00%	2.95%	2.48%	-6.87%	-17.80%	**-41.85%**

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty should be 2009/10. Southport & Ormskirk Hospital NHS Trust is subject to a three year period for recovery of any deficit incurred. With cumulative deficits recorded from 2015/16 the Trust has failed its breakeven duty.

It is recognised that a longer-term recovery plan is required regardless of the three year recovery period defined in the breakeven duty.

The regulator, NHS Improvement recognises the Trust's performance as the adjusted financial performance (deficit of £33,601k for 2017/18), however in terms the breakeven duty there is a further adjustment around the CQUIN risk reserve in 17/18 which reduces the deficit to £33,003k.

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Quality Account 2017/2018

A précis version of this account is available on requests following feedback from members of the Healthwatch groups. Please call the Communications Department on 01704 704714.

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-National Children's Survey 2017
-Complaints

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PART 4 ANNEX

STATEMENTS OF ASSURANCE

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If you require this document in an alternative format, please contact our Communications Team on 01704 704714

PART 1

1.1 Statement on quality from Chief Executive on behalf of Board

Welcome to Southport & Ormskirk Hospital's Quality Account (QA). The Trust provides both inpatient and community healthcare to approximately 258,000 people across Southport, Formby and West Lancashire, with the eldest population in the country. Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk and District Hospital.

The Trust also provides sexual health services for the metropolitan borough of Sefton. The North West Regional Spinal Injuries Centre is at Southport hospital and provides specialist care for spinal patients across the North West and the Isle of Man. Services at the trust are commissioned by NHS West Lancashire and NHS Southport and Formby clinical commissioning groups.

Our Quality Account for 2017/18 has been developed with our staff, stakeholders and partner organisations, including clinicians and senior managers. The report gives an insight into the care provided for patients by the Trust.

The past year has been an uncertain one for the Trust with regards to our senior executive team and we acknowledge the impact this has had on staff morale and outside confidence in the organisation.

However, we now have a permanent chief executive in Silas Nicolls who started in April 2018 and is leading the organisation to develop a clear vision of quality improvement, staff engagement and communication. In addition in May 2018 we have welcomed Juliette Cosgrove as our new Director of Nursing, Midwifery, Therapies and Governance.

The CQC visited the Trust for an unannounced Core Services inspection between 20th–23rd November 2017 and an announced Well-Led inspection was between 5th - 7th December 2017. During the inspection the CQC rated six of the Trust's seven services as Requires Improvement and one as Good. Overall the Trust was rated as Requires Improvement.

The Trust has developed a robust Quality Improvement Plan to monitor and embed progress against recommendations. We have worked with our clinicians, managers and local partners to identify the priorities to improve quality and safety throughout our hospitals.

We have continued to make improvements in quality and safety whilst facing a significant financial challenge, but mindful of the need to provide high quality services which are sustainable in the future.

The Trust and its stakeholders have therefore committed to developing a transformation strategy which provides a coherent and clinically sustainable plan for the future of hospital and related community services in Southport and Ormskirk. In particular it is clear from discussions with local clinicians and our staff that a significant amount of effort should be

dedicated to improving patient flow and the provision of services for the frail elderly population.

Like many NHS providers we continue to experience pressures relating to emergency admissions and capacity within our hospital. We have worked with our partners in health and social care to improve the flow of patients and facilitate timely discharge.

Our improvement programme to “cool down” A&E for the benefit of both patients and staff has begun with the grand opening of the Clinical Decision Unit (CDU) in May 2018. Congratulations and thanks to everyone who worked so hard to make this possible. The new CDU is the first completed element of the £1.25m investment in A&E. Upgrades to the rest of the department should be completed by August 2018.

There are some important clinical indicators which help us monitor how we are delivering in terms of clinical outcomes. Mortality rate is an important clinical quality indicator, and the SHMI and HSMR figures for the Trust remain higher than expected. Our two highest local mortality-related diagnoses are for pneumonia and stroke.

The Trust is committed to reducing avoidable mortality, as evidenced by a reduction standardised mortality ratios to within statistical norms by April 2019. All deaths within the hospital are reviewed by a group of clinicians to identify any lessons learnt. Within our open and honest culture we inform and involve the families in these reviews and bereavement services are offered for support.

We consider rigorous infection prevention and control and clean facilities to be fundamental to our care standards. We continue to work hard to minimise the chances of patients acquiring hospital acquired infections, such as Norovirus and MRSA. During 2017-18 we had only one case of MRSA bacteraemia and the number of cases of C.Difficile remained low and below trajectory.

During the winter months, flu can pose a real health risk for patients and so during 2017-18 we vaccinated the highest ever number of our staff (80%) against flu so that we limited the risk of spreading the virus.

We have focused on our patient experience and in May 2017 launched the Developing the Experience of Care Strategy 2017-19.

The strategy aims to create a culture in which staff deliver care which is evidence based, but patient, carer and family focused. Getting patient care and experience right first time, ensures positive, cost effective clinical outcomes. It sets out eight pledges to ensure patients, carers and families experience is at the heart of everything we do. Our progress is outlined in section 1.4.2 and remains a key priority for the organisation and links to our Quality Improvement plan.

Of course none of these improvements are possible without the support of all 3,000 individuals who work for the Trust and our amazing volunteers and charities whose dedication and commitment is a source of great strength for our organisation.

In the summer of 2017 the Trust was informed it was to be the subject of one of the first National Guardian Office (NGO) case reviews. As a Trust we welcomed the case review and worked very closely with the NGO during their time with us. Following the case review the NGO made 22 recommendations for the trust, and one for the CQC. In response to the

recommendations a significant and robust action has been agreed between the trust, the NGO and NHSI. It is very much hoped that the commitment the trust has shown to Freedom to Speak up will bring lasting change to the organisation.

The following pages give further detail about our progress against previous objectives and outline our key priorities for the coming year and our commitment towards safer, calmer Trust.

To the best of my knowledge the information contained in this quality report is accurate.

Silas Nicholls
Chief Executive

1.2 Introduction to 2017 /2018 Account

The Trust is pleased to present the Quality Account for the period 1st April 2017 to 31st March 2018. This document provides an overview of the progress made during the reporting period. The priorities for the coming year 1st April 2018 to 31st March 2019, and includes the regulated information prescribed under the National Health Service Quality Accounts Regulations.

1.3 Our Quality Achievements during 2017 / 2018

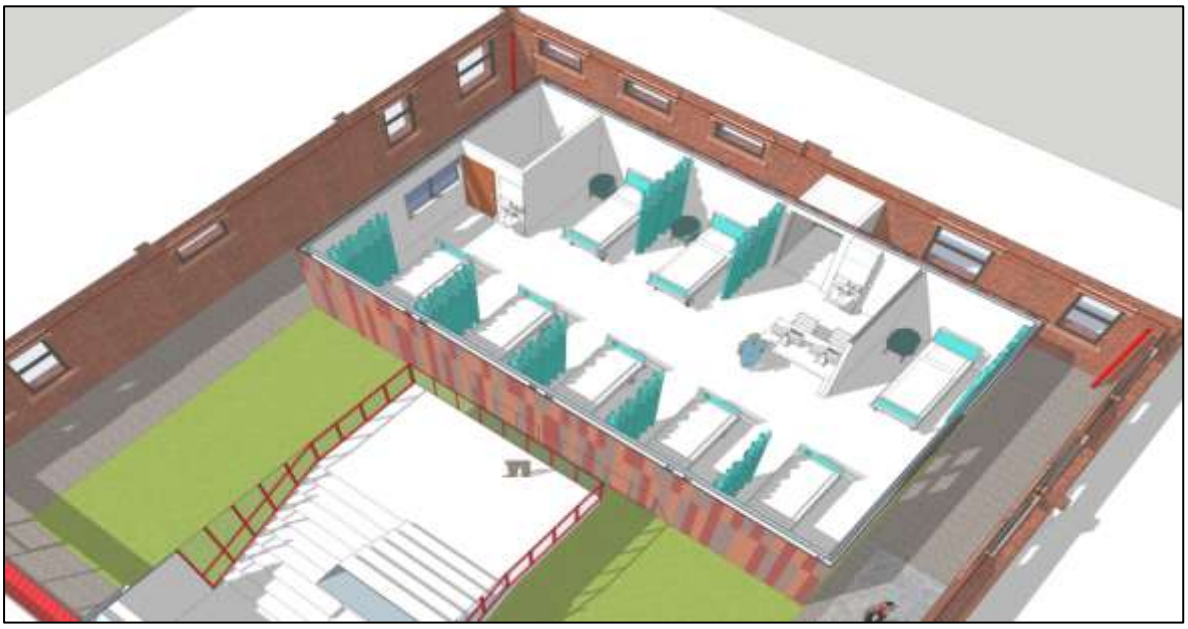
Major international award for sports injury surgeon

One of our surgeons has received a major international award for his work on a common knee injury that left untreated can end the sports careers of professional and recreational athletes.

Mr Adnan Saithna, a specialist sports knee and shoulder injury consultant surgeon at the Trust was presented with the Richard J O'Connor Award by the Arthroscopy Association of North America.
The award was given for research that was conducted through his collaboration with the FIFA Centre for Medical Excellence at the Santy Clinic in Lyon.

The research shows that their surgical reconstruction technique for dealing with the injury results in a three-fold reduction in failure rates after surgery and significantly improves rates of return to pre-injury levels of sport when compared to standard reconstruction techniques.

Quality improvements transforming patient care



£1.25m investment in Southport A&E. The centrepiece of the £1.25m improvements is an 80 square-metre, nine-bay extension constructed from four ready-built modules.
Two further bays will be created in the existing minors treatment area. There will also be upgrades to the main waiting area, toilets for the disabled and the x-ray waiting area.

The work will reduce overcrowding at the busiest times, improve the experience of care for patients and provide a better environment for our staff.

Top 10 rating for maternity staff detecting babies 'at risk' of still birth

Ormskirk hospital's maternity unit has been nationally recognised for detecting a condition which can lead to babies being stillborn. It was ranked in the top 10 for detecting unborn babies who are Small for Gestational Age (SGA). The team achieved their rating by implementing the Growth Assessment Protocol designed by the Perinatal Institute. The aim is to reduce the number of stillbirths associated with growth restriction during pregnancy and involves producing a growth chart for each patient. It is tailored specifically to their height, weight and ethnicity. The growth of the baby is then closely monitored so any concerns can be immediately acted upon.

Improvements in cancer waiting

Secretary of State for Health Jeremy Hunt praised staff for improvements to cancer waiting times. Between June and November 2017 the proportion of cancer patients starting their cancer treatment within 62 days rose from 76.1% to 88%. The national target is 85%.

Mr Hunt said: "The Trust is a real example to others, demonstrating how to improve performance in a short space of time and ensure that your patients get the care that they deserve. From visiting organisations throughout the country, I know that the immense amount of work that will have been behind this outcome cannot be underestimated. Improvements like this are impressive and testament to the hard work and dedication of the Trust's staff".

Developments in information technology

The Trust has moved forward considerably in IT. In maternity we are now only one of two trusts to use an electronic health record during labour and in the delivery suite additional screens are being fitted so that we can monitor babies heart rates digitally and remotely. As well as digitising parts of the patient journey, for example in ordering blood tests, we are also utilising our data sources intelligently, both for individual patients in how we monitor their vital signs and at an organisational level by aggregating multiple data sources in one place to create a Safety Hub. It brings together clinical data, bed availability data, staffing level data all in one place. We have also made huge strides in improving our digital security and were one of the first trusts to achieve Cyber Essentials accreditation.

Further achievements include …

- Clostridium Difficile cases below the target set for 2017-18
- Hospital trust awarded £50,000 to improve maternity services patient feedback
- National maternity survey indicating improvement in patient satisfaction
- Improvement in Advancing Quality (AQ) Pneumonia performance
- Establishment of a Reducing Avoidable Mortality programme
- Re-launch of seven-day services programme (see section 1.9 for progress)
- Introduction of Cancer Services "Walk the Wait" (see section 1.10)
- Improved results for national clinical audit projects – national cardiac arrest audit, national emergency laparotomy audit, national intensive care audit

1.4 Priorities for Improvement 2017-18

Progress against the four priorities for improvement during 2017-18 is outlined below.

1.4.1 Priority One - Embedding Good Governance

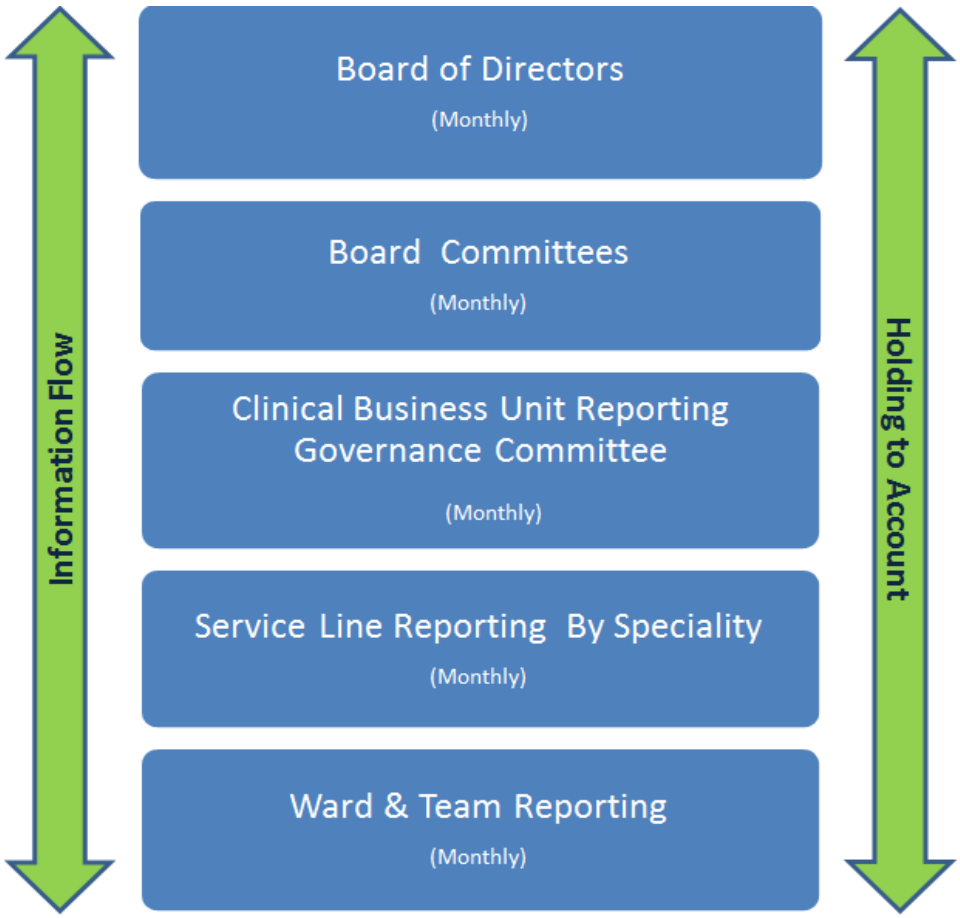
Governance is a word used to describe the ways that organisations ensure they run themselves efficiently and effectively. It also describes the ways organisations are open and accountable to the people they serve for the work they do.

All effective public and private sector organisations want to have good governance. For an NHS organisation like Southport and Ormskirk Hospital NHS Trust, good governance is about creating a framework within which we:

- Provide our patients with safe, high quality services
- Are transparent in the ways we are responsible and accountable for our work.
- Ensure we continually improve the ways we work.

To embed these principles, during 2017-18, through staff engagement, the Board approved Our Vision and relaunched our SCOPE values.

Good governance is maintained by the structures, systems and processes we put in place to ensure the proper management of our work, and by the ways we expect our staff to work. To support this we have developed clear lines of reporting through the development of a clinical, quality, safety and governance structure from 'floor to board' supported by a reporting and escalation framework for quality and risk. The chart below describes the operational process implemented to support governance process for 'floor to board' reporting.



The Trust Risk Management Strategy is in place and supports the staff to work within this framework and together with the Quality Improvement Strategy is providing our staff systems and processes which are being embedded across our trust and throughout the report we have demonstrated where we have embedded good governance (3.1, 3.4, 3.5, 3.6, 3.7, 3.10, 3.11)

We acknowledge there is still work to be done but we have made progress throughout the year. The newly-appointed Chief Executive has commissioned a governance review to ensure we continue to embed good governance through patient quality and safety, staff engagement and communication and financial and performance frameworks.

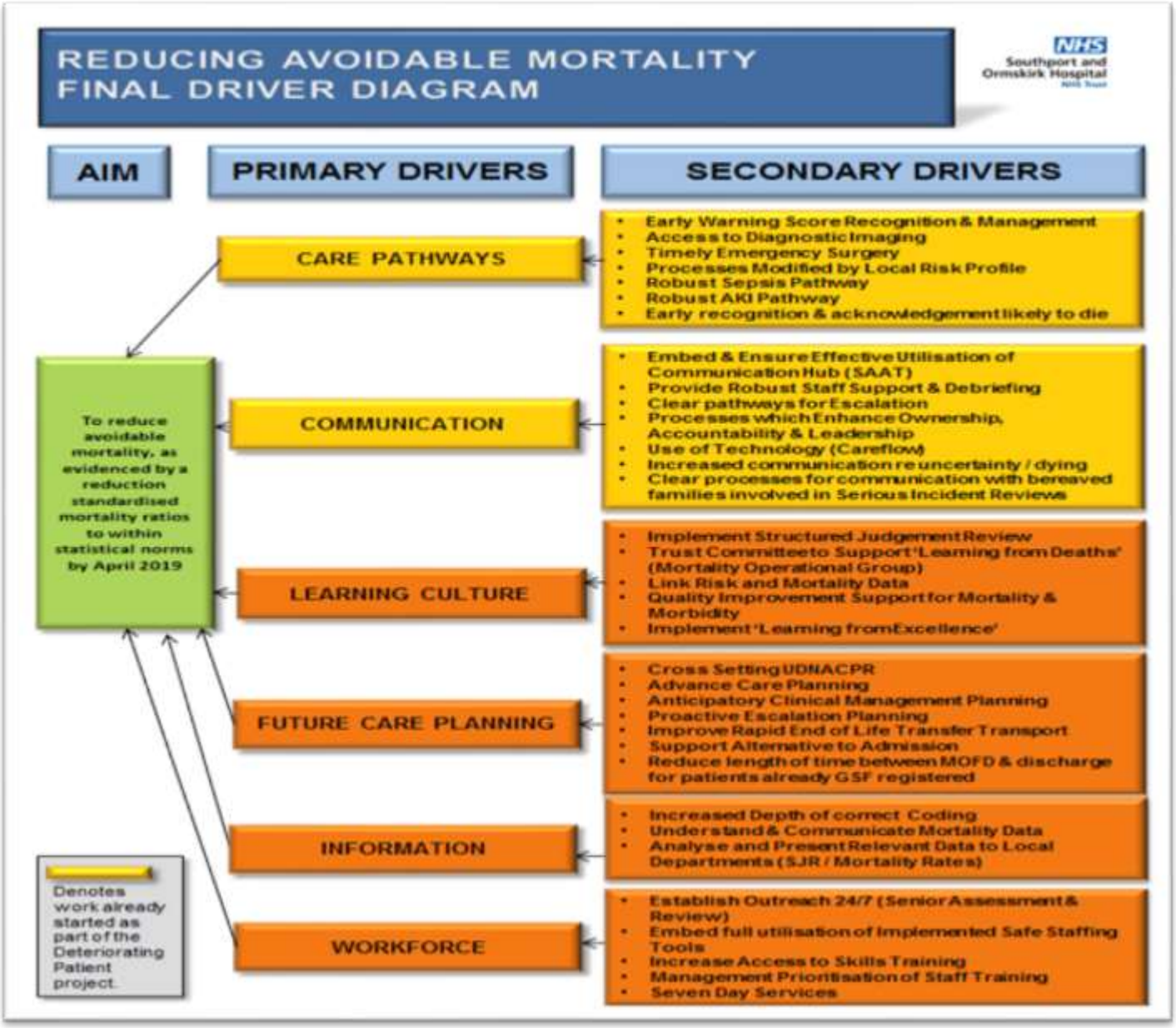
1.4.2 Priority Two - Developing the Experience of Care Strategy

During 2017-18 our aim was to implement the Developing the Experience of Care Strategy 2017-2019. Progress against the eight pledges is described below.

Pledge 1 – Develop and implement systems and processes to involve Carers and Families in decision making. ***Progress*** - Development of a ward specific information booklet for carers – to be piloted on ward 14a.	***Pledge 2*** – Ensure that access to information is easy and relevant for patients, carers, families and professionals. ***Progress*** - Ongoing review of patient information, accessibility and standardisation of ward/department information stands. Always event registered with NHS England to increase utilisation of hospital passports.
Pledge 3 – Get the basics right in caring for all. ***Progress*** - Training of therapists in the use of VitalPac and pain assessment scores. Audit of the red tray system completed to start PDSA work on more effective use. Volunteer event held on 16.3.18 with the aim of increasing dining companions.	***Pledge 4*** – Improve staff involvement and awareness of their impact on Patient, Carer & Family experience. ***Progress*** - Practice Educators are joining the group to support 'buddy system' for newly qualified staff. Re-launch the 'Hello my name is campaign' during the experience of care week in April 2017.
Pledge 5 – Improve & enhance discharge processes and facilitate better links to community support networks. ***Progress*** - Development of a combating loneliness leaflet has been led by the patient representative for this group along with support from local organisations. Leaflet to be launched in May 2018– success will be monitored via source of referrals.	***Pledge 6*** – Respond to complaints & concerns in a timely manner and follow up on lessons learned ***Progress*** - Financial support for further complaints training has been agreed. Group looking at using a 'strap-line' across the Trust to encourage staff that dealing with complaints/concerns is 'everybody's business'
Pledge 7 – Increase the profile of patient, carer & family experience, collecting and acting upon feedback and opinion in a more robust manner. ***Progress*** - Consideration of purchasing ' I want great care' to support the collection and analysis of patient feedback. Review of the FFT processes with staff to increase response rates.	***Pledge 8*** – Develop systems and processes to capture patient's and family's memories to share and cherish for the future. ***Progress*** - West Lancashire Freemasons, with the support of local businesses are supporting the redesign of quad areas to develop quite spaces for remembrance aiming to open in July in line with the 70 years of the NHS celebrations.

1.4.3 Priority Three – Mortality: implement national guidance and focus on the deteriorating patient

Reducing mortality is a core priority for the Trust which is now focused through the Reducing Avoidable Mortality Project (RAM). The project incorporates a number of work streams and has a comprehensive plan and resourced project group in place which will support improvements in safety and quality with the overriding aim of reducing avoidable mortality over the next 24 months. The diagram below describes the project's aim, work streams and planned actions for delivery.



In March 2017, The National Quality Board issued "National Guidance on Learning from Deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care". This guidance included the requirements that trusts must publish a Learning from Deaths policy, and that from December 2018

onwards trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting. This data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.
The Learning from Deaths policy was approved by the Board in September 2017 and in February 2018 the first quarterly paper was presented to the Board, outlining data from July, August and September 2018.

During 2017/2018 the Trust aimed to review every death with an initial screening tool (illustrated below). Any deaths graded as "not preventable death BUT medical error or system issue was present", "possibly preventable death resulting from medical error or system issue" or "likely preventable death resulting from medical error or system issue" were reported on the Trust incident reporting system for further investigation. The Trust is currently training clinicians in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes, to be completed by end June 2018.

The Trust has invested in the DATIX ICloud (electronic risk management system) with additional functionality to log Structured Judgement Reviews electronically. 'The go-live date for Trust-wide implementation of this method is 31st August 2018.

Prescribed information

During the period 1st April 2017 – 31st March 2018, 958 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

	Number of deaths	**Number of deaths where a case review / investigation was carried out**
Quarter 1	239	232*
Quarter 2	201	201
Quarter 3	202	197*
Quarter 4	316	276*
Total	958	906 *

(* discrepancy as deaths from the end of each quarter will roll over into the next quarterly review period)

The table below shows the breakdown of non-preventable deaths and preventable deaths during 1st April 2017 – 31st March 2018:

1st April 2017 – 31st March 2018	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Not preventable death due to terminal illness or condition upon arrival at hospital	83	56	60	92
Not preventable death and occurred despite the health team taking preventative measures	144	140	130	181
Not preventable death BUT medical error or system issue was present	5	3	2	1
Possibly preventable death resulting from medical error or system issue	0	0	2	0
Likely preventable death resulting from medical error or system issue	0	0	0	0

The table below illustrates the number of deaths from 1st April 2016 – 31st March 2017 where the review was undertaken during 1st April 17 – 31st March 18:

Month of death 16/17	Number of patients reviewed in 17/18
April 2016	0
May 2016	1
June 2016	1
July 2016	1
August 2016	0
September 2016	0
October 2016	1
November 2016	1
December 2016	13
January 2017	8
February 2017	6
March 2017	55
Total	**87**

The table below shows the breakdown of non-preventable deaths and preventable deaths during 1st April 2016 – 31st March 2017:

1st April 2016 – 31st March 2017	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Not preventable death due to terminal illness or condition upon arrival at hospital	0	0	5	22
Not preventable death and occurred despite the health team taking preventative measures	2	1	10	43
Not preventable death BUT medical error or system issue was present	0	0	0	1
Possibly preventable death resulting from medical error or system issue	0	0	0	0
Likely preventable death resulting from medical error or system issue	0	0	0	0

Communicating with patients, families and carers is a key action within the RAM. The Trust website now provides information on mortality and bereavement to the general public, in line with guidance from the 2017 National Quality Board's National Guidance on Learning from Deaths.

The mortality web page gives an overview of Trust's current mortality position with links to the latest public Board reports containing mortality data along with an explanation of the way that mortality rates are measured. The page also provides a link to the Trust's Learning from Deaths policy and a dedicated bereavement webpage.

Further work is underway to ensure that there are robust processes in place to keep families and carers informed (in line with Duty of Candour requirements) throughout: the screening of a death, the SJR process and / or a serious incident review. Advice will be given to families and carers by means of a letter and a booklet, that they can raise concerns and that these will be considered when deciding whether or not to further investigate a death.

1.4.4 Priority Four – Maternity: focus on Caesarean section and Forceps Delivery

During 2017 / 2018 we aimed to reduce our number of caesarean sections. Which we have successful achieved. We chose to examine our rates of Caesarean section and instrumental deliveries so that we could encourage normal deliveries and because they are both risk factors for increased blood loss at delivery. We have successfully reduced the number of Caesarean sections. Only women who really need Caesareans are having them. The number of instrumental deliveries has not fallen, but we believe this is because women are supported by our most senior doctors when they are in labour to have instrumental deliveries rather than Caesarean sections. Instrumental deliveries are safer and have less long term problems associated with them than Caesarean sections.

Our overall Caesarean Section rate has decreased from 32.18% to 23.56% in March 2018.

The national average rate for elective caesarean sections is 16% and in March 2018 our rate was 10.23%.

The national rate for instrumental births is 11% and the Trust is currently at 11.49%.

1.5 Safeguarding

The Safeguarding Team has continued its journey of improving safeguarding arrangements within the Trust throughout 2017 / 18. This has culminated in positive recognition by CQC of the culture of safeguarding being embedded within the organisation. It has also resulted in the lifting of the CCG Safeguarding Contract Query generated in March 2015, in October 2017 following evidence of 6 months continuous and sustained improvement, in particular in relation to the safeguarding policies in place and training compliance, with the Trust being determined as giving significant assurance (RAG rated Green) in the robustness of its safeguarding arrangements.

Partnership work and the quality of the Trust Safeguarding Team engagement and input have been highlighted by the CCG Safeguarding Service and the Local Authorities. The input of the Named Midwife has addressed the previously unrecognised unborn child as a key safeguarding consideration, not previously addressed in local multi agency policies.

Changes in Trust processes and training for the Mental Capacity Act (MCA) commenced in September 2017 following a benchmark audit undertaken to assess staff understanding and confidence in applying the Act in clinical practice. Further changes are ongoing to ensure the lack of consistency in application of the Mental Capacity Act in practice is eradicated and the Trust consistently acts within a legal framework.

Local training is offered by the Safeguarding Team for undertaking 2 stage capacity assessments and Deprivation of Liberties (DoLS) Safeguard referrals to enhance training, however staff documentation remains a challenge in providing supporting evidence of rationale and decision making.

Safeguarding innovative practice

Since June 2017 the safeguarding team has referred all cases being sent for a MARAC (Multi Agency Risk Assessment Conference) referral to their GP. An audit after three months has indicated that a high percentage of GPs felt this information was useful to their practice and had allowed them to flag patients to generate prompts to GP's to consider domestic abuse. Patients who attend and disclose domestic abuse and are lower risk are referred to support services depending on where they live. Referral of lower risk cases to support services is not shared with GP practices by the Safeguarding Team.

The Safeguarding Adults team has been developing an MCA pathway as information was not always being stored together or consistently in the same place within patient's records. Immediate changes were made within the MCA policy regarding this and staff were advised by the safeguarding team regarding storage of any DoLS authorisations. A task and finish group was set up to progress work on the pathway and this will be rolled out on completion during 2018-19. On completion this work should be put forward for consideration of awards given no other area has a document supporting MCA in this way.

Work has been undertaken with the Local Authorities to devise a standard template of relevant information for DoLS referrals that supports staff making timely and thorough referrals. Early indications are that staff find the referrals much easier to complete, less onerous and the quality of the information has improved. Further audit will be undertaken regarding this in 2018 -19.

A Safety toolkit adapted by the safeguarding Children's team supports staff, children and young people in understanding risky behaviour regarding online safety, mental health, violence and sexual abuse, substance misuse and generic issues. This will be rolled out from April 2018.

Next steps 2018-19

- Increase staff analysis of risk regarding Cannabis use demonstrated. Training and Professional curiosity of staff to be recorded.
- Increase confidence and improve staff documentation in MCA/DoLS
- Concealed pregnancy – amend policy
- Maintain training compliance / localise as now e-learning
- Improvement in documentation for safeguarding, including routine enquiry, professional curiosity and mapping of injuries
- Commence Safeguarding Champions role in Southport A&E with key individuals trained to support others in the department
- Improve Trust attendance at the internal Safeguarding Assurance Group Meeting
- Embed children's risky behaviour toolkit
- Safeguarding team support for SONAS (Southport and Ormskirk Nursing Accreditation Scheme) as required

1.6 End of Life Care

Specialist Level Services

Since August 2017, the multi-professional Specialist Palliative Care Service (SPCS), provides symptom control advice, psychological and spiritual support for those with far advanced and progressive illness with complex specialist palliative care needs who are inpatients in hospital. They also provide advice and support for families and staff who care for them, arranging for follow up by the Community Specialist Palliative Care Services on discharge.

Transform Team

The Supportive Care element, the Transform Team consists of facilitators who have a helicopter view of the hospital (and community), trying to identify those patients recognised as possibly approaching the end of their lives, either as they are admitted or during an admission, to ensure that their status is recognised, care is well co-ordinated, they are supported and that their time is well used and not wasted. They educate, support and empower patients, families and the staff caring for them at any stage during their admission, but particularly at times of deterioration, especially if thought likely to be dying, to try to ensure the best possible patient and family experience at a difficult time.

Building on the Best Project

Although the vast majority of people with an advanced and progressive disease who are symptomatic or approaching the end of their lives and who want to be cared for to die at home, many will spend time in hospital for various reasons and some will die there whether from choice or otherwise.

The Trust is one of ten UK Trusts selected in 2016 to take part in the two year programme run by Hospice UK and Macmillan – Building on the Best (BotB) – which finished in March 2018. This program is designed to support improvements in the quality and experience of palliative and end of life care for patients and their families, building on previous projects undertaken by the Trust – the Gold Standards Framework Acute Hospitals Pilot and the National Transforming End of Life Care project.

Over the two year period of the project there has been a 30% increase in patients known to the SPCS which includes 36% increase in the number of hospital patients known to be approaching the last months/years of life (Gold Standards Framework (GSF) registered) and an increase of 153% of people whose GSF registration was prompted by the hospital rather than their GP; 29% increase in the number of patients known to S&SPCS who come from care homes and a 50% increase in the number known to the Transform Team.

There has been an 11% increase in the number of deaths occurring in hospital over the two years, in keeping with the increasing number of deaths across the whole community, but also an increase of 43% people who achieved a Rapid End of Life Transfer when they were recognised to be dying, but wanted to be in their own homes.

Improvements

- **Shared Decision Making –** helping frail elderly patients and their families to plan for their future care and avoid hospital readmission and die in their preferred place of care.

- **Symptom management –** improving pain management
    - A new Pain Management Education package has been developed, together with a new Pain in Palliative Care - Care Plan, and Pain Monitoring Chart.
    - Wards have developed 'Pain Pledges' signed by the Ward Manager and displayed on the ward.
    - Individual care plans developed with patients and family. Analysis of these showed that symptom control in the last days of life improved for three of the four common symptoms which occur in the dying

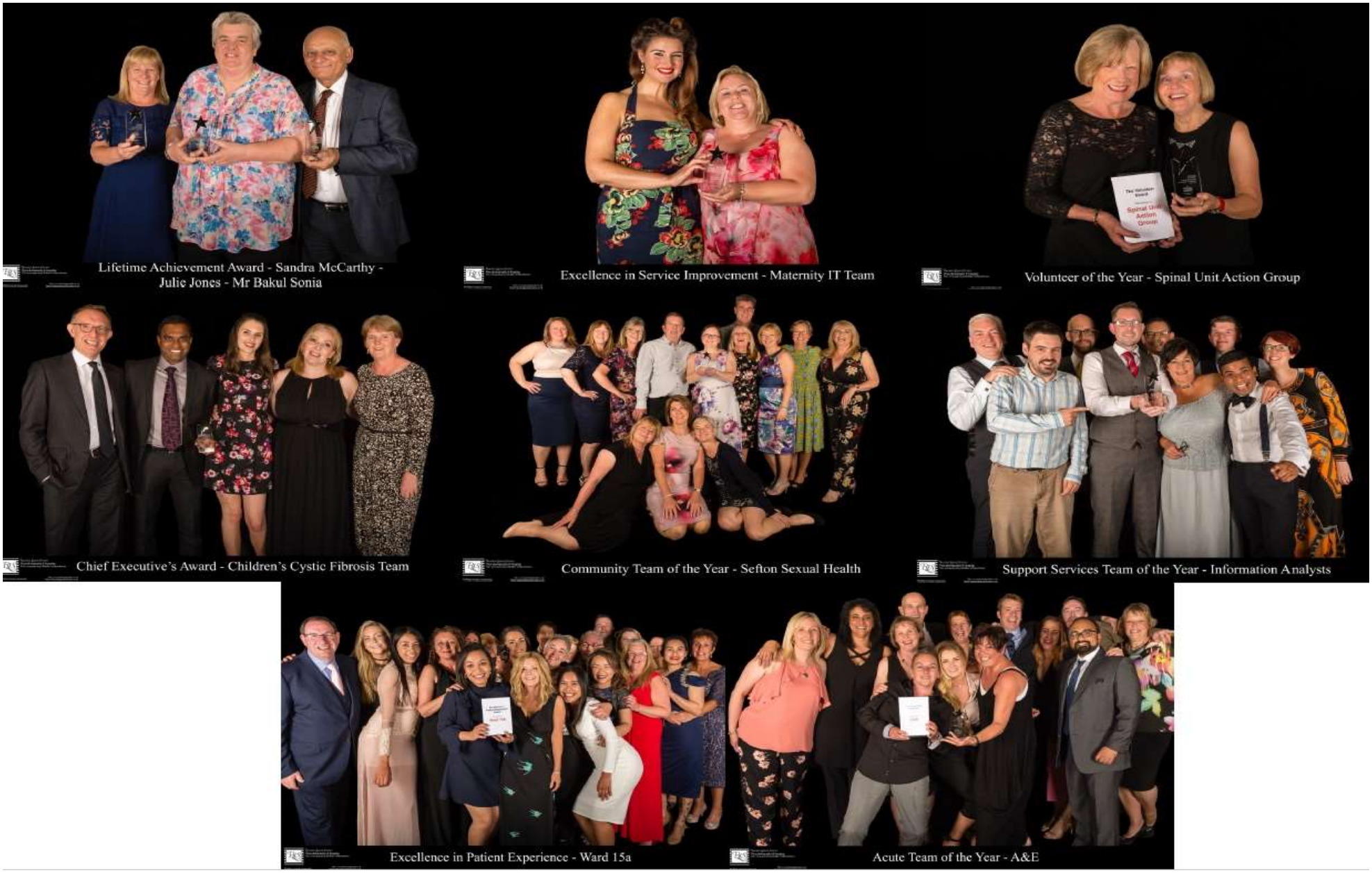
- **Carer and family support.** Families and carers of patients recognised as likely to be dying have 24 hour access to the 'Oasis Room' where they may wish to catch some sleep overnight or use for daytime breaks from the bedside. The Transform Team provide support and a listening ear, alongside the chaplaincy team. Local schools and Girl Guide groups, as well as making syringe driver bags for patients, have been hand making comfort packs to give to relatives who stay over in hospital unprepared.
  Queenscourt Hospice volunteers have also been trained to help provide support for patients who may have no family or carers. Bereavement calls are made to next of kin or carers following the death of any GSF registered patient, to offer condolences, listen to concerns and give family members a chance to feedback regarding patient and family care experience.

Future developments
Future Care Planning is an important contribution to the Trust's Patient Safety Hub development SPCS are involved in the transformational and development work currently taking place. Close working relationships between the Critical Care Outreach and Supportive and Specialist Palliative Care Services will hopefully improve managing uncertainty of patients acutely ill with an already significant disease burden.

1.7 Pride Awards

The Trust held its annual Pride Awards for staff in June 2017 at the Floral Hall in Southport. Three hundred staff and guests attended the awards dinner and ceremony at which awards recognising the skill and dedication of staff were presented.

Community Team of the Year:	Sefton Sexual Health
Excellence in Service Improvement	Maternity IT Team
People's Choice Award	Claire Albo, community midwife
Support Service Team of the Year	Information Analysts
Volunteer of the Year	Spinal Unit Act Group
Excellence in Patient Experience	Ward 15A (Southport)
Chief Executive's Award	Children's Cystic Fibrosis Team
Lifetime Achievement Awards	Bakul Soni, Sandra McCarthy and Julie Jones
Acute Team of the Year	Accident and Emergency


Lifetime Achievement Award - Sandra McCarthy - Julie Jones - Mr Bakul Sonia
Excellence in Service Improvement - Maternity IT Team
Volunteer of the Year - Spinal Unit Action Group
Chief Executive's Award - Children's Cystic Fibrosis Team
Community Team of the Year - Sefton Sexual Health
Support Services Team of the Year - Information Analysts
Excellence in Patient Experience - Ward 15a
Acute Team of the Year - A&E

1.8 Our workforce

Apprenticeships

The Trust became the first organisation in the country to sign up to UNISON's apprenticeship charter.

The charter ensures that apprenticeships deliver a positive outcome for both apprentices and employers. The charter commits the Trust to provide apprenticeships that are well-funded, high quality and that lead to a meaningful job. Apprentices will receive the correct rate for the job they are doing, high quality training, and a safe and healthy working environment.

Simon Bunting (pictured) is currently undertaking an apprenticeship. He is employed by the Trust and works in the Pharmacy as a Computer services manager.

He said: "I have really valued the opportunity to develop my career through undertaking an apprenticeship at the Trust. It is hard work, but I have learned a great deal which is already helping me to have a better understanding of leadership and management, enabling me to use this knowledge to become better at my job.

Safer Staffing – Nursing

The Trust has made a pledge as part of the new quality improvement strategy to provide safer staffing at all times. Every month a safe staffing report is taken and discussed at the Trust Board.

The report reflects the guidance within the following documents:

- National Quality Board (NQB) guidance November 2013 / updated July 2016 Care Quality Commission
- NHS Improvement Safe Staffing for adult inpatients in acute care December 2016
- NICE 2014 – Safe Staffing for Nursing in adult inpatient wards in acute hospitals
- Monthly safe staffing reports are submitted to the NHS Choices website and evidence that the average fill rate of registered and care staff on our inpatient wards is on average above the national target of 90% throughout the year. The fill rate is the number of actual staff working each shift against the planned number for the shift. The Matron teams meet three times daily to review staffing to ensure safety and patient care is prioritised on each ward

The Trust complies with the requirements to upload and publish the aggregated monthly average registered nursing and non-registered nursing staff data for inpatient ward areas. These are available on the Trust website.

The recruitment and retention of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge nationally and locally. Nurse staffing reports as a high on the Trust Risk Register and is reviewed monthly. Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus.

As of March 2018 our Trust whole time (WTE) funded establishment versus contracted is detailed below:

	Funded WTE	**Contracted WTE**
Registered	859.16	761.94
Non-Registered	377.04	340.33
Total	1236.20	1102.27

The Trust is committed to ensuring that the right staff, with the right skills are caring for our patients and welcomed NHS Improvement into the organisation to support and engage with these challenges. This has supported opportunities for the Trust to join national recruitment and retention programmes.

Ongoing recruitment methods have continued for nurse staffing vacancies across the year with the introduction of new roles and initiatives during 2017 aligned to Health Education England (HEE) strategy for widening participation and recognising talent within the workforce ensuring the organisation aligns to Health Education England's "Get in, Get on, Go further" vision .

Nursing Associate pilot site – a regulated health care role. Southport and Ormskirk was successful in becoming a 'Fast Follower Test Site'. A clinical facilitator has been employed as part of the pilot within the partnership which has been key in providing support in clinical practice for this new emerging role.

Apprenticeship Levy. The Trust activated the digital Apprenticeship Levy recruiting to a lead role in November 2017.

ACORN nurses. Health and Social Care locally delivered and placed at Southport and Ormskirk Hospital. This is a 2 year programme delivered at our local Further Education

facility with placements provided in the organization. Our ACORN programme has been developing with pleasing and increased success.

A community engagement manager has been appointed to manage the widening participation agendas and commences in post in January 2018.

The Trust showcased its NHS career opportunities at the Southport Flower Show in August 2017 proving to be a positive engagement opportunity with the local and surrounding population for both clinical and volunteer roles across the organisation.

Key actions to be taken in 2018 to support safe staffing include:

- The embedding of recognised evidence-based nursing assessment tools (Shelford tool) to establish safe staffing levels and review nurse staffing levels
- The introduction and embedding of SafeCare (system to compare staffing levels and skill mix) to inpatient units
- Ongoing monthly reports to the Trust Board as an exception report relating to safe staffing levels.
- Continued publication of nurse staffing hours monthly on NHS Choices and the Trust website
- Daily staffing levels remain publicly available on boards outside each ward area
- Continued collaborative working with NHS Improvement national workforce team providing further support to the recruitment and retention methods and tool kits.
- The Trust plans to showcase NHS career opportunities at the Southport Flower Show in August 2018

Freedom to Speak Up – National Guardian's Office case review

In 2013 the first Francis Report was published, following the serious failures in care at the Mid-Staffordshire NHS foundation trust. It is believed over 1,200 patients died needlessly because of substandard care between January 2005 and March 2009. In his first report Sir Robert Francis recognised that as early as 2005 whistleblowers tried to raise concerns. However, it appeared there was a bullying culture which discouraged people from coming forward with threats made to those who did.

In 2015 the second Francis report was published. As a result of this the National Guardians Office (NGO) was established. The NGO is an independent, non-statutory body. It is sponsored by CQC, NHS England and NHS Improvement. One of the main remits of the NGO is to lead cultural change, which makes speaking up "business as usual". As well as the creation of the NGO, and the appointing of a national guardian for the NHS, Francis 2 made the key recommendation that every NHS trust appoint a Freedom to Speak up Guardian (FTSUG).

Among other things the FTSUG is there to protect patient safety and the quality of care by ensuring staff are supported in speaking up and that a positive culture of speaking up is fostered and barriers to speaking up are addressed. The FTSUG is to work with, and where necessary challenge, the board to enable an open culture where speaking up is considered normal practice.

In the summer of 2017 the Trust was informed it was to be the subject of one of the first NGO case reviews. The NGO had received information that within the trust a bullying and discriminatory culture existed, there was evidence of poor responses to staff who had spoken up, policies and procedures do not always support staff in speaking up, BME staff have previously highlighted issues of discrimination with CQC inspectors and some board members had been suspended, and subsequently dismissed, as a result of whistleblowing.

As a Trust we welcomed the case review and worked very closely with the NGO during their time with us. On their arrival they noted the interim chief executive was taking steps to improve the culture, the new trust leadership was improving engagement in addressing issues raised by staff, a temporary FTSUG was in post with plans to improve the speaking at process and the trust had already commissioned an external cultural review.

Following the case review the NGO made 22 recommendations for the trust, and one for the CQC.

In response to the recommendations a significant and robust action has been agreed between the trust, the NGO and NHSI. A timescale of three, six and 12 months was placed on these recommendations.

The Trust has placed a significant amount of resources into not only ensuring the completion of the action plan, but in cultural change enabling speaking up to become the norm. The appointment of a half time FTSUG is a significant example of this.

The fulfilling of the action plan is on schedule, with many actions completed. This is monitored by monthly meetings with the FTSUG, DoN, ADHR and the responsible NED.
Things achieved so far include:

- A substantive FTSUG has been appointed
- An Equalities Lead has been appointed
- Training is being developed for all staff and the managers on how to deal with concerns raised
- All new staff have a presentation on Freedom To Speak Up
- A new raising concerns policy has been published
- There is a dedicated intranet page
- There is improved visibility of leaders
- All existing staff have received information on FTSU with payslips and posters are visible across the organisation
- Further communications are planned
- Increase in concerns raised
- Standardised approach in dealing with concerns
- Mediation training commissioned

It is very much hoped that the commitment the trust has shown to Freedom to Speak up will bring lasting change to the organisation.

1.9 Implementing priority clinical standards for seven-day hospital services

During 2017 / 18 we have participated in the NHS England mandated self assessments and our results are displayed below.

Measures and Achievements	March 2017 Audit Results	Sept 2017 Audit Results	National
Standard 2 - *Clinical assessment by a suitable consultant within 14 hours of arrival at hospital .*	63%	71%	72.3%
Standard 5 *-7 day access to diagnostic services, consultant-directed diagnostic tests and completed reporting will be within 1 hour for critical patients and within 12 hours for urgent patients and within 24 hours for non-urgent inpatients*	100%	Not collected nationally in Sept 2017	95.9%
Standard 6 *- 24 hour 7 day a week access to consultant-directed interventions; on-site or through formally agreed networked arrangements*	100%	Not collected nationally in Sept 2017	93.5%
Standard 8 - *All patients in high dependency areas must be seen and reviewed by a consultant twice daily. Patients on a general ward should be reviewed by a consultant at least once every 24 hours, 7 days a week*	86%	Not collected nationally in Sept 2017	85.2%

We have a two-year plan to achieve the four priority standards by 2020. The diagram below highlights the area's we plan to target:

All emergency admissions seen by suitable consultant within 14 hrs

- Capacity and Demand Assessment
- Resources and funding for required cover
- Protocols to assign consultant delegates
- Change time of ward rounds / Increase to the no. of ward rounds
- Compliance in Completing Case Notes in Adherence with Audit Requirements (Review, Time & ID)

Hospital inpatients have 7 day access to diagnostics

- Address Differing Levels of Provision Across Services
- Capacity & Demand Planning Required
- Protocols for Services which are Not Covered Locally (e.g. Renal)
- GI Bleed Cover – Shared Endoscopy Provision to be investigated
- Radiology & Endoscopy staffing issues
- Risk Assessment for split site provision of CT & MRI

24/7 Access to consultant directed interventions for: Critical Care, Interventional Radiology, Interventional Endoscopy & Emergency General Surgery

- Address Differing Levels of Provision Across Services
- Networked Arrangements with Other Providers
- Treat and Transfer Arrangements

All patients on high dependency areas must be seen and reviewed by a consultant twice a day. Once transferred to an acute area, to be reviewed by a consultant once a day

- Surgical Assessment Unit (SAU) Currently Under Construction
- Consultant Workforce

1.10 Cancer Services

Cancer Services reported the following achievements and successes:

- Successful implementation of a Risk Stratified Follow-Up pathway for prostate patients with current recruitment standing at 110 patients

- Continued sustained recruitment to Risk Stratified Follow-Up pathway for colorectal patients, current caseload is 119 patients

- 62-day national standard dropped through the middle of the year, this prompted work to review our processes within Cancer Services, leading to an initial surge in the 62-day National Standard. Improvement work continues including Training Strategy, Local Cancer Strategy and a Training Needs Matrix

- As a direct result of last year's National Cancer Patient Experience survey we ran a successful "In Your Shoes" event, working directly with cancer patients, listening to concerns raised and addresses the issues in a fashion that resolved problems and created a better experience for all patients within the Trust

- Introduction of patient pagers (pictured) which will allow patients to more around the hospital freely, while waiting for an out-patient appointment, without the fear of missing the scheduled appointment. The pagers were funded by League of Friends at Ormskirk Hospital. They are available in the Medical Day Unit and Outpatients department.

- Recruitment to both Early Diagnosis Lung and Colorectal Support Workers, with monies allocated from the Cancer Alliance as a two-year funded project

- We secured funding via the Cancer Alliance to upgrade the video-conferencing equipment across both hospital sites to allow enhanced cross-Trust MDT and cancer meeting

- Participation in revamped Regional Optimal Care Pathways in Lung, Colorectal and Prostate

- Continued supportive working with both Southport and Formby and West Lancashire Macmillan support and information centres

- West Lancashire Macmillan Support and information centre manager (hosted via the Trust) has been recognised for her dedicated work, and has been invited to a garden party at Buckingham Palace to celebrate HRH the Prince of Wales' 70th birthday

- Recruitment to vacant Head and Neck Cancer Nurse Specialist (CNS) roles and additional Haematology and Acute Oncology CNS roles

1.11 Statement of Responsibilities from Board of Directors

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

NHS
Southport and Ormskirk Hospital
NHS Trust

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) regulations to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health and Social Care guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chairman June 2018

Chief Executive June 2018

PART 2

2.1 Priorities for Improvement 2018- 2019

This section sets out our firm commitment to improving the quality of care for our patients and how we will make this a reality in terms of equipping our staff with the skills and tools to provide safe, high quality services.

We are committed to ensuring that quality drives everything we do. It underpins our vision, values, corporate objectives and our improvement priorities.

Our five quality priorities for improvement are:

- Developing the Experience of Care
- Delivering Care for You
- Safer Staffing at All Times
- Reducing Mortality
- Preventing Harm

All five quality improvement priorities have an Executive sponsor who will work with the Clinical Lead to ensure delivery of the improvements.

Southport & Ormskirk Quality Priorities Plan on a Page 2018-2019

Enablers

- Communication & Engagement
- Improvement Methodology
- CQC Improvement Plan
- Leadership Capacity & Culture
- Good Governance
- Evaluation Measurements

Our Vision

Providing safe, high quality services.

For you.

With You.

Goal	Aim	How we measure
Developing the Experience of Care	Identify lesson learn Improve quality, safety and efficiency Reduce harm	➢ Complaints and Compliments ➢ National patients survey ➢ Friends and family test (FFT) ➢ Ward/departmental specific patient surveys ➢ Patient and carer stories
Delivering Care for You	Increase clinical engagement in improvement Improve quality, safety and efficiency Improve use of existing capacity	➢ Service Reviews ➢ AQuA Advancing Quality Pathway ➢ NICE guidelines ➢ Get It Right First Time (GIRFT) ➢ Model Hospital ➢ Staffing levels
Safer Staffing	Safe Sustainable and Productive Staff Improved Patient Outcomes Increase Staff Satisfaction Financial Sustainability Reduce Variation	➢ Workforce / Staffing KPIs ➢ Evidence Base Workforce Planning ➢ Health Education England (NW) ➢ Health Roster/SafeCare (Allocate) ➢ Continued Professional Development
Reducing Mortality	Reduce harm Rapid senior assessment Improve length of stay / flow Implement rapid improvements Identify lessons learnt	➢ Learning from Deaths (mortality reviews) ➢ Mortality Dashboard ➢ Standardised Hospital Mortality Index (SHMI) ➢ Serious Incidents (Sis)that result in patient death
Preventing Harm	Reduce harm Identify lessons learnt Improve length of stay / flow Increase clinical engagement in improvement	➢ Safety Thermometer ➢ Healthcare associated infections ➢ Never Events ➢ Serious untoward incidents that results in patient harm ➢ Ward Accreditation

2.2 Review of Services

Statements of Assurance from the Board (in regulations)

Between April 2017 and March 2018 the Trust provided acute hospital, paediatric and sexual health community based NHS services made up of the following regulated activities for which the Trust became registered with the Care Quality Commission (CQC) without conditions from April 2010:

- Treatment of diseases, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Maternity and Midwifery services
- Termination of pregnancies
- Assessment or medical treatment for persons detained under 1983 Mental Health Act
- Family planning

The Trust has reviewed all the data available on the quality of care in all of these NHS services

The income generated by all the services reviewed in the period April 2017-March 2018 represents ***92%*** of the total income generated from the provision of all services by the Trust for April 2017 -March 2018.

2.3 Participation in Clinical Audit - April 2017-March 2018

Thirty-seven National Clinical Audits and five National Confidential Enquires covered services that the Trust provides

The Trust participated in 100% of the National Clinical Audits and 100% of the National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in can be found in **Appendix 1**

The reports of 37 national clinical audits were reviewed by the Trust and the actions the Trust intends to take to improve the quality of healthcare provided are described throughout this report.

The reports of 215 local clinical audits were reviewed and the Trust intends to take the actions outlined throughout this document to improve the quality of healthcare provided:

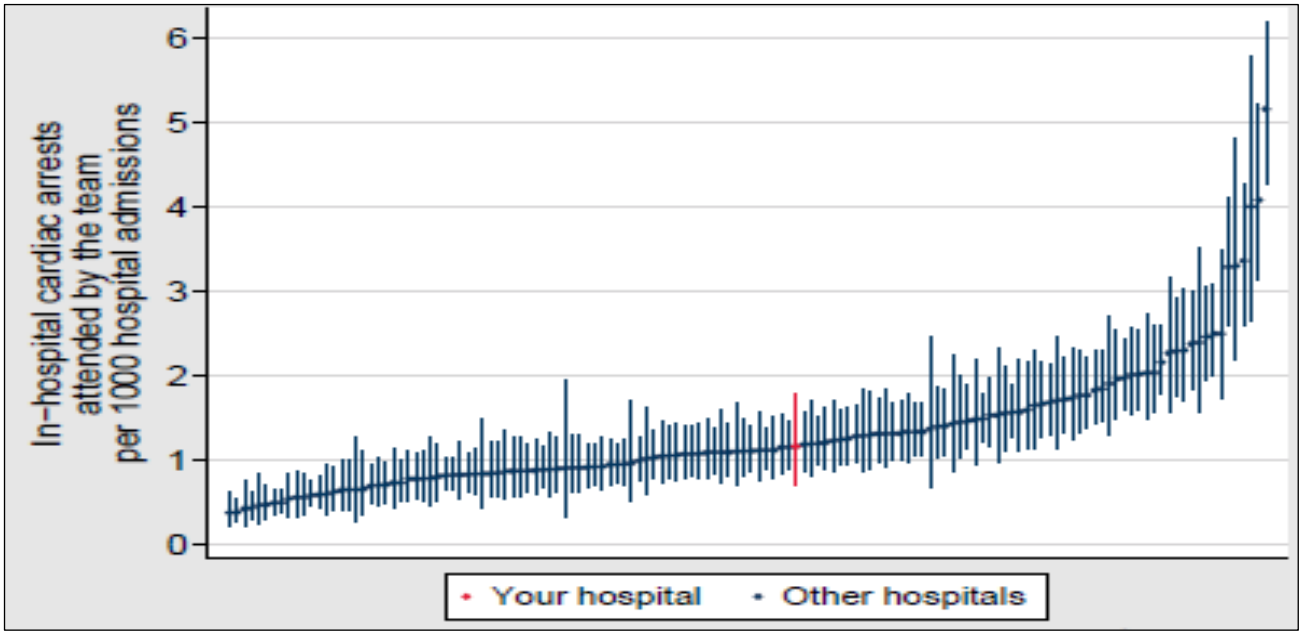
Improvement and changes made following National Clinical Audit Projects

National Paediatric Diabetes Audit. The Paediatric team looking after children with diabetes at Ormskirk hospital has been recognised as one of the best in the country. The national audit organised by the Royal College of Paediatrics and Child Health found we were among the top performers for supporting children with type 1 diabetes in terms of quality improvements.

The National Paediatric Diabetes Audit showed the Ormskirk team had continued to make significant quality improvements.

62.3% of our patients received 4 or more HbA1c measurements in a year, compared to the North West average of 41.1%	85.5% of our patients received structured education about their diabetes compared to the North West average of 83.8%
56.5% of our patients were referred and seen by psychology services compared to the North West average of 24.6%	

National Cardiac Arrest Audit. We review every cardiac arrest that occurs within the Trust and learning from this process has led to a decrease in the number of in hospital cardiac arrest throughout 2017 / 18.



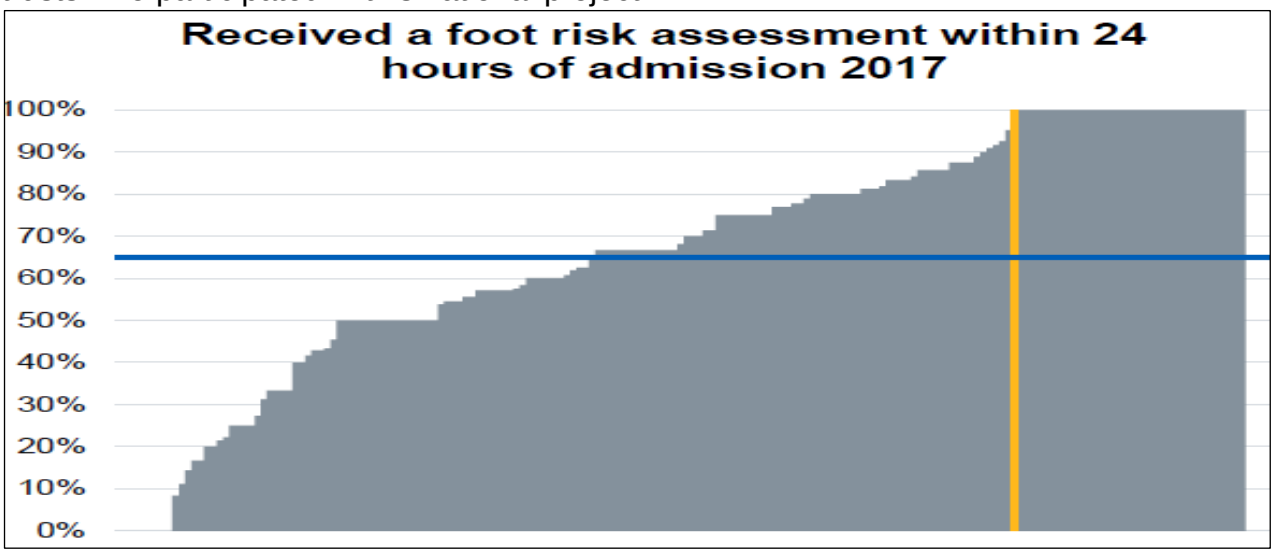
National Chronic Obstructive Pulmonary Disease Audit. The project has resulted in the introduction of new paperwork which aims to standardise the care patients with chronic obstructive pulmonary disease (COPD) receive and follows best practice guidance.
We have introduced the DECAF score (**D**yspnea, **E**osinopenia, **C**onsolidation, **A**cidemia, and atrial **F**ibrillation) onto our medical clerking in sheet which is a robust predictor of

mortality, using indices routinely available on admission. Its generalisability is supported by consistent strong performance; it can identify low-risk patients (DECAF 0–1) potentially suitable for early supported discharge services, and high-risk patients (DECAF 3–6) for escalation planning or appropriate early palliation.

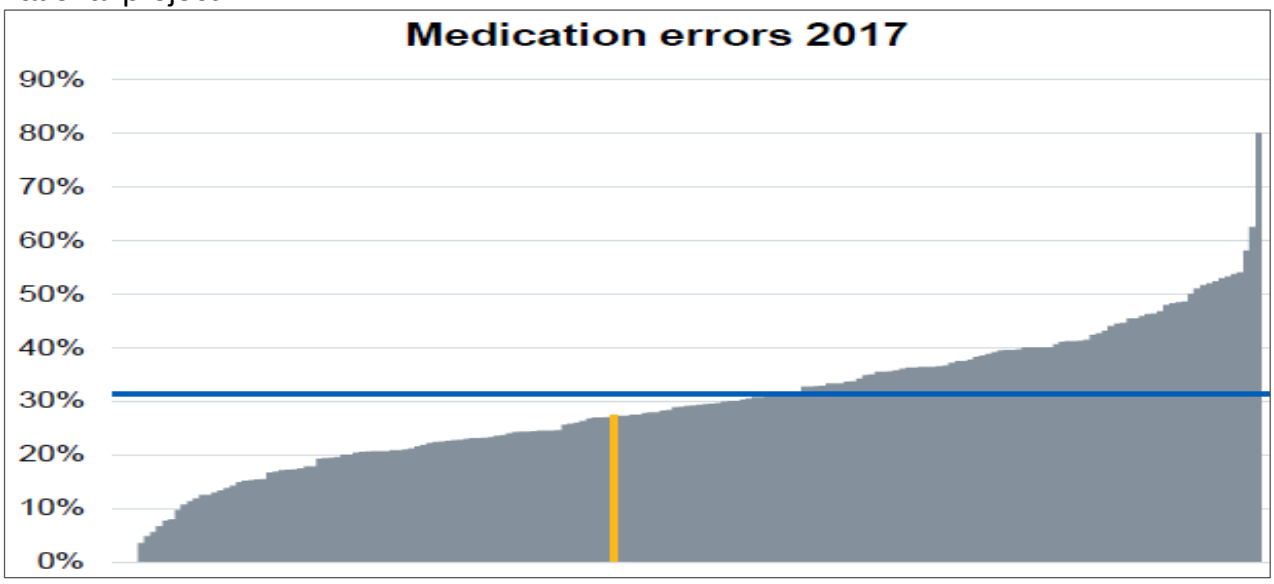
The national audit has also led to the introduction of a discharge bundle for all COPD patients.

National Inpatient Diabetes Audit. This project audited patients who were inpatients within the hospital during census day in 2017. Our results indicate that patients receive a good level of care:

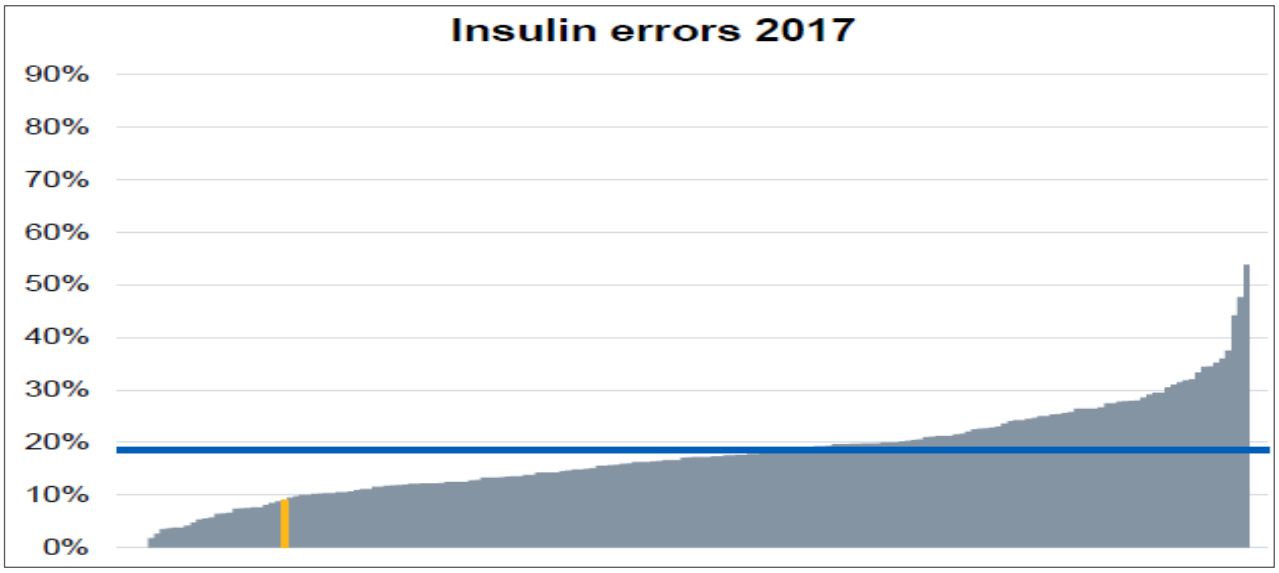
a) High percentage of patient receiving a foot inspection within 24 hours of admission. The yellow line on the graph indicates the Trust position compared to other trusts who participated in this national project.



b) Lower number of medication errors compared to national average. The yellow line on the graph indicates the Trust position compared to other trusts who participated in this national project.



c) Low number of insulin errors compared to national average. The yellow line on the graph indicates the Trust position compared to other Trusts who participated in this national project.



National Rheumatoid and Early Inflammatory Arthritis Audit. In January 2106 the 1st national report for this audit indicated the Trust had a low response rate. As a result of this the Rheumatology department developed a new pathway for patients referred with suspected early inflammatory arthritis and a suspected early inflammatory arthritis clinic referral proforma was developed. Following the introduction of the pathway a local audit was undertaken which indicated the referral rate had increased.

Improvement and changes made following Local Clinical Audit Projects

Audit Project	Improvement / Change
Improving access to medication for palliative care patients	This project aimed to make it easier and quicker for palliative care patients to get the medication they needed. Following the first round of the audit it was agreed to change practice and it was decided that the Palliative Care Nurse Specialists could inform the hospital team of changes to the patient's prescription.
Rapid End of Life transfers re-audit	Introduction of a booklet which cuts down on the amount of paperwork & photocopying required which is important as it enables a quicker process to be followed for these critically ill patients.
Audit of Triage waiting times on Maternity Assessment Unit	This audit provides full assurance that women are provided with timely assessment on arrival and care in line with Maternity Unit guidelines.

Audit of documentation in Sexual Health Clinic records, documentation and completion of consent forms.	Through periodic ongoing auditing of documentation in sexual health throughout 2017 / 2018. Documentation has improved and the most recent audit undertaken in January 2018 provided significant assurance
Audit of proton-pump inhibitors for upper GI Bleeding	Development of prescription chart which will improve compliance with prescribing medication timely for patients.
Audit of nursing documentation	Following this audit there was a review of all nursing documentation within the organisation in consultation with nursing staff to ensure the new documentation is fit for purpose and reduces duplication.
Audit of Do Not Attempt Cardiopulmonary Resuscitation" (**DNACPR**)	During 2017 / 2018 there has been improvement in DNACPR documentation including a clear summary of reasons for the DNACPR being documented, evidence of discussion with relatives / carers and clear documentation stating if DNACPR is indefinite of for review. There is also a change in policy which means the DNACPR travels with the patient from the community to hospital and back again, improving communication and continuity of patient care.
Pharmacy Contributions audit	This project indicates has 6% severe contributions which is within the nationally expected range.

2.4 Participation in Clinical Research

The aim of Clinical Research is to offer patients access to new and emerging treatments. The Trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research.

Our focus is on improving care, developing better treatments and increasing our understanding of disease by providing an environment that is conducive to the undertaking of quality research and development activities.

The UK Policy Framework for Health and Social Care in Research was introduced in 2017. It includes principles to protect and promote the interests of patients, service users and the public in health and social care research, by describing ethical conduct and proportionate, assurance-based management of health and social care research, so as to support and facilitate high-quality research in the UK that has the confidence of patients, service users and the public. SOHT is fully committed to ensuring that the Trust adheres to these principles.

The Trust is a partner organisation in the North West Coast Clinical Research Network (NWC CRN) and works closely with them to ensure a culture of Research and Innovation is embedded within the Trust.

This partnership working helps the Trust to support the National Institute for Health Research (NIHR) commitments, including improving the quality, speed and co-ordination of clinical research by removing the barriers within the NHS, unifying systems, improving collaboration with industry and streamlining administrative processes.

The Trust employs a team of dedicated research staff to support clinical research across the organisation to increase recruitment to high quality clinical trials and other robust research studies. Our reputation for research is yet another area of growth, with the Trust having exceeded its target for recruiting patients to studies by some distance.

During 2017-18 the Trust actively recruited to 19 studies and the NIHR supported 18 of these.

The number of participants, including patients and staff, receiving NHS services provided or sub-contracted by STHK between April 2017 and March 2018 was 341 The total recruitment was made up of:

- 336 recruited to NIHR adopted studies
- 5 recruited to non-NIHR adopted studies, that is local and student

We were pleased that NIHR recruitment figures have exceeded those forecasted during 2017-18, and that the Trust successfully recruited 336 participants against the proposed target of 150.
The Trust has research activity across a wide range of clinical specialities. Since 1st April 2017 we have produced RDI Permission (Confirmation of Capacity & Capability) for 16 NIHR studies in the following areas:

Speciality	Number of Studies
Anaesthetics /Surgery	1
Genetics	1
Infectious Diseases	1
Musculoskeletal	2
Neurological	1
Paediatrics	6
Reproductive Health	3
Surgical	1

Performance in initiation and delivery of research (PID data)

We report quarterly to the Department of Health on the initiation and delivery of research (for clinical trials only).

The Trust has a 70-day benchmark to recruit the first patient into a clinical trial. This is a very challenging target, and at present the Trust is running at approximately 54% for all activity. (7 of the 13 clinical trials met the benchmark). There was a nil return on the delivery data as no clinical trials closed within 2017/18.

Commercially sponsored studies

During April 2017 to March 2018 we have participated in (n 4) commercially sponsored studies in both Paediatrics and Reproductive Health.

Key achievements

- We are extremely pleased that Dr Sharryn Gardner (Consultant in Emergency Medicine) was successfully appointed as local Specialty Research Group (SRG) lead for Injuries and Emergencies by the NWC CRN. This is excellent news for the Trust

- We have encouraged our staff to work generically across specialties, and this has proven to be a really successful initiative, not only has this increased our recruitment figures but has offered the nurses an insight into a range of research specialities and provided an opportunity to further develop their skills

- SOHT have been recognised as a top recruiting site in January 2017 for the FUTURE initiative study. The success of this is due to team work including setting a recruitment strategy/ goals and clarifying responsibilities for each member of the team

- All of our other research specialties, including Anaesthetics/Surgery, Dermatology, Neurology, Paediatrics, Reproductive Health and Rheumatology have worked extremely hard, and with their input we are pleased that the annual NIHR recruitment target for 2017/18 was met in December 2017

- There was a 75% increase in the number of NIHR studies where capacity and capability was assessed between the 1st April 2017 and the 31st March 2018. A total of 16 new studies were assessed in 2017/18 compared to 4 in 2016/17

- Regular Research Team meetings play an important role in the delivery of good quality research. NIHR recruitment is a standing item on the agenda and updates on performance are discussed and plans are put in place to achieve compliance

- We are committed to making sure that our patients have the chance to participate in clinical trials and encourage our patients to discuss research opportunities with their doctors and nurses. We have promoted research via a new research Twitter account and also have a research section on the Trusts library website

These achievements have only been made possible by the continued support from the committed Consultants, who take the role of Chief and Principal Investigators, the research teams, support services and, most importantly, the patients, who give up their time to take part in clinical trials.

Research aims for 2018-19

Our aims for 2018-19 are to continue to:

- To engage with industry, this is a key priority for the Department of Health, NHS Trusts and the Research Networks. In 2018/2019 we aim to generate increased research funding by increasing the number of commercially sponsored studies on our portfolio

- Develop a comprehensive performance management system to improve NIHR National targets for RDI approval times and recruiting patients to time and target. Regular performance updates will be disseminated at the Research Team meetings

- Ensure that we build on existing strengths and key areas of current research as well as supporting developments in other health priority areas

- Maintain high levels of research conduct, providing assurance to the Board through audit and monitoring.

- Improve engagement at all levels within the Trust and the public this will be achieved by increasing the number of promotional events, providing speakers at local groups, conducting satisfaction surveys and providing activity reports to the Clinical Effectiveness Committee.

- Engage with the Research Design Service, who provide support to health and social care researchers across England, on all aspects of developing a grant application.

2.5 Goals agreed with commissioner's use of CQUIN payment framework

A proportion of Trust income in the period April 2017- March 2018 was conditional in achieving quality improvement and innovation goals agreed between the Trust and its commissioners, through Commissioning for Quality and Innovation payment framework (CQUIN). At the time of writing the report the CQUIN has not been finalised but the table indicates our current position. – Link to further CQUIN information.

CQUIN Scheme	Status	CQUIN Detail
NHS Staff Health & Wellbeing		Improvement of health and wellbeing of NHS staff
		Healthy food for NHS staff, visitors and patients
		Improving the uptake of flu vaccinations for front line staff within Providers
Reducing the impact of serious infections		Timely identification of sepsis in emergency departments and acute inpatient settings
		Timely treatment for sepsis in emergency departments and acute inpatient settings
		Antibiotic review
		Reduction in antibiotic consumption per 1,000 admissions
Improving services for people with mental health needs who present to A&E		Improving services for people with mental health needs who present to A&E.
Offering advice and guidance		Offering advice and Guidance (A&G)
NHS e-Referrals (1718 only)		NHS e-Referrals
Supporting proactive and safe discharge		Supporting Proactive and Safe Discharge – Acute Trusts

2.6 What others say about us: statements from the CQC

The Trust is required to register with the CQC under section 10 of the Health and Social Care Act 2008(c).

On the 27th and 28th November 2017, the Trust underwent a two-day inspection by the Care Quality Commission Chief Inspector of Hospitals using the new inspection model.

The Trust has not participated in any special reviews or investigations.

Overall Trust ratings

Safe	**Requires Improvement**
Effective	**Requires Improvement**
Caring	**Good**
Responsive	**Requires Improvement**
Well-led	**Inadequate**

Southport and Formby hospital

Overall rating for this hospital	**Requires Improvement**
Urgent and emergency services	**Requires Improvement**
Regional spinal injuries unit	**Requires Improvement**
Medical care (including older people's care)	**Requires Improvement**
Surgery	**Required Improvement**
Critical care	**Good**
Outpatients and diagnostic imaging	**Good**

Ormskirk hospital

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	**Good**
Surgery	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
Services for children and young people	**Requires improvement**
Outpatients and diagnostic imaging	**Good**

2.7 Data quality: relevance of data quality and action to improve data quality

The Trust has a programme of work aimed at improving data quality and for the financial year 2018/19 is focussed at reviewing and improving data captured within the Trust's Electronic Patient Records (EPR) including A&E, Maternity and Joint Health.

Data quality is routinely monitored throughout the Trust, this is done through a number of areas including internal data quality reports from the Trust's data warehouse and external sources such as NHS Digital and Dr Foster.

These monitor improvement for a number of key fields over the different Commissioning Data Sets, they assess our organisation's data being sent externally to ensure completeness and compliance with data standards and also allow us to compare against other organisations regionally and nationally.

The latest Data Quality Dashboard (April 17 – Jan 18) shows the Trust ranked greater than the national average for 11 out of 13 indicators for Admitted patients, 16 out of 17 for Outpatients and 12 out of 14 for Accident & Emergency.

2.8 NHS number and general medical practice code validity

The following information is taken from the latest data quality dashboard published by NHS Digital. This information shows the percentage of valid NHS numbers and general medical practice codes submitted by the Trust to the Secondary Uses Services (SUS) at the December reconciliation point covering Admitted Patient Care, Outpatients and A&E attendance activity during April to January 2018. Below is for the period April to January 2018 (latest release):

Which included the patient's valid NHS number was:

- 99.5% for admitted patient care
- 99.5% for outpatient care
- 97.9% for accident and emergency care

Which included the patient's valid general medical practice code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

Please note that there are no specific PbR Coding Audits now being undertaken. The process is now a Reference Costs Assurance Programme which incorporates clinical coding.

2.9 Information governance toolkit attainment level

The Trust Information Governance Toolkit Assessment Report overall score for 2017/ 2018 was fully compliant at 66% Satisfactory; meaning the Trust evidenced attainment Level 2 or above on all requirements.

2.10 Clinical coding error rate

Clinical data must be accurately and consistently recorded to well defined national standards to enable it to be used for statistical analysis. Information drawn from accurate clinical coding better reflects the pattern of practice of clinicians and provides a sound basis for the decision-making process.

The audit was based on the methodology detailed in the current version 9.0 of the Clinical Coding Audit Methodology as set out by the Health and Social Care Information Centre using Clinical Classifications Service approved clinical coding auditors.

The aim of the audit was to evaluate the quality of the coded clinical data by making comparisons between the source document and the information held on the Trust's Patient Administration System (PAS) and to establish a baseline for continuous improvement and allow assessment of the quality of the source document.

The audit would identify good practice, any areas of weakness and provide recommendations as necessary to ensure that the quality of data is maintained and improved. The areas for the audit were identified by the CCGs (pneumonia, acute cerebrovascular disease and gastroenterology).

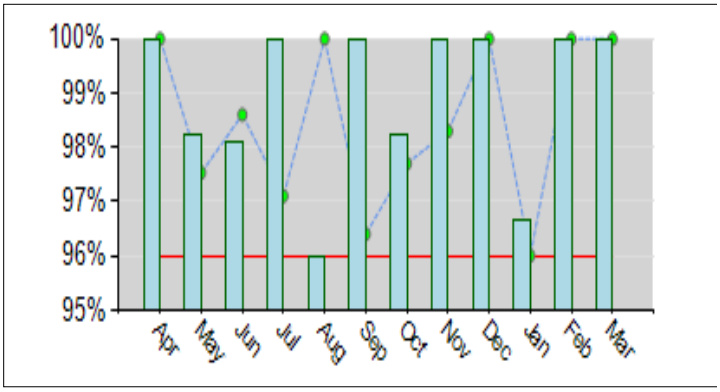
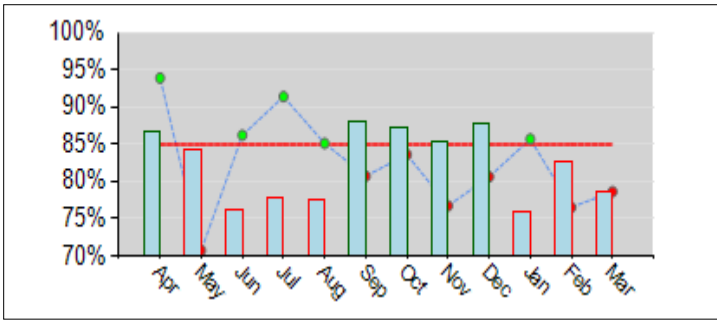
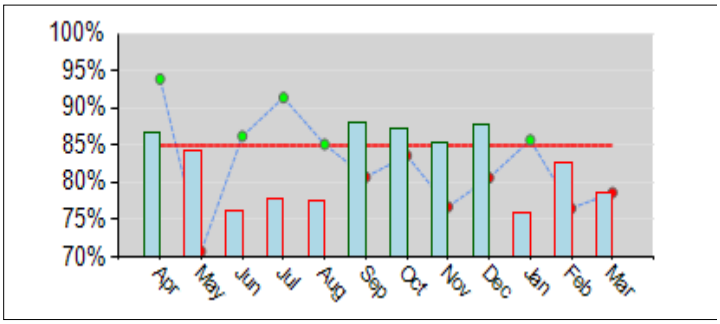
The audit was carried out by two Clinical Classifications Service approved experienced auditors from Blackpool Teaching Hospitals NHS Foundation Trust. The results of the audit were:

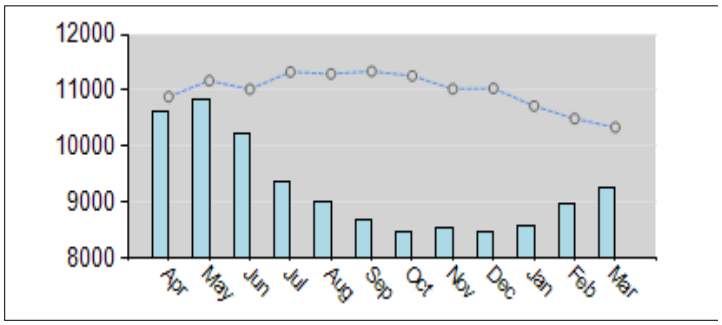
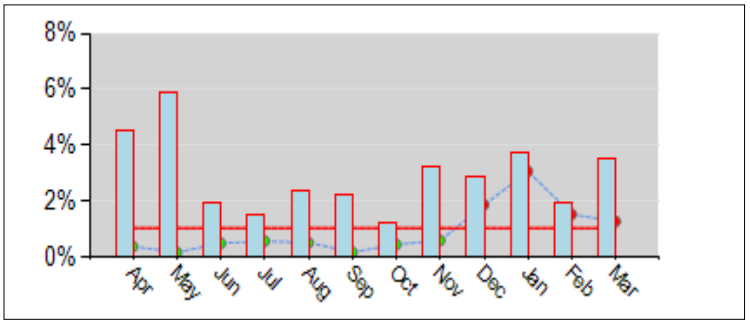
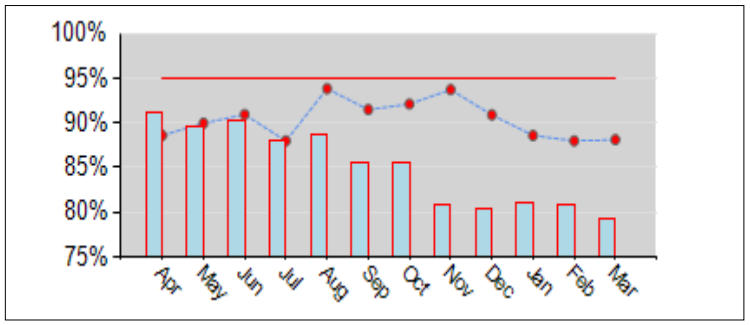
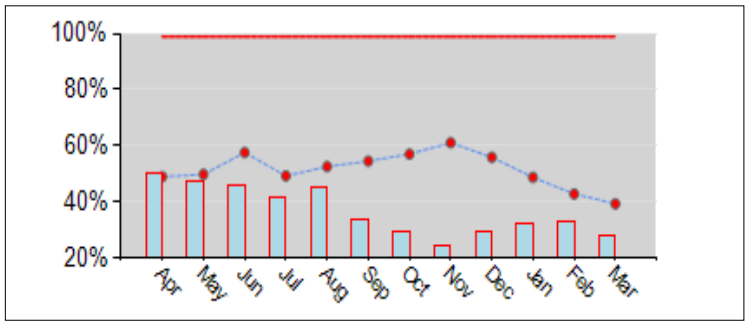
	Percentage correct		
Coding field	**2015 / 16**	**2016 / 2017**	**2017 / 2018**
Primary diagnosis	90%	95%	96%
Secondary diagnosis	94.79%	94.7%	90.76%
Primary procedure	94.93$	95.78%	95.89%
Secondary procedure	95.05%	96.55%	90.32%

PART 3

REVIEW OF QUALITY PERFORMANCE

3.1 Performance During 2017 / 2018 on National Metrics

Indicator Name	Description	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. Line = Last Financial Year Bar = This Financial Year	
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. Line = Last Financial Year Bar = This Financial Year	
62 day pathway view	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment. Target 85%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	

Waiting list size	The number of RTT patients currently waiting. Line = Last Financial Year Bar = This Financial Year	
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. Line = Last Financial Year Bar = This Financial Year	
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher. Line = Last Financial Year, Bar = This Financial Year	
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. Line = Last Financial Year Bar = This Financial Year	

3.2 Summary Hospital Level Mortality (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) is a measure used to compare the actual number of patients that have died either in hospital or within 30 days of discharge against the expected number of deaths based on average England figures, given the characteristics of the patients treated. it includes all diagnostic groups and deaths after discharge from hospital. The Trust is currently ranked 108th out of 136 English NHS trusts. Mortality has been on our key quality improvement priorities during 2017 / 2018.

The data below is provided by Dr Foster on a quarterly basis using data submitted to Secondary Uses Service (SUS) so that information from all NHS Trusts in England can be taken into account. This means the data can be up to 9 months behind.

Prescribed information: *The Trust considers that this data is as described for the following reasons**:** All activity data is submitted by the Trust to Secondary Uses Service (SUS) in line with national mandated requirements complying with data definitions as per the Data Dictionary*.

	Oct 16 - Sep 17
Trust	117.73
Banding	1
England	100
Highest performing trust	112.78
Lowest performing trust	124.73

Data from NHS Digital

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

The information provided in the Quality Account is comparing the Trust to other Trusts within the same banding only.

Mortality is a core priority for the Trust which is now focused through the Reducing Avoidable Mortality Project (RAM). The project incorporates a number of work streams and subsumes the work previously undertaken by the Deteriorating Patient Project. There is now a comprehensive plan and resourced project group in place which will support improvements in safety and quality with the overriding aim of reducing avoidable mortality over the next 24 months by:

- Providing timely access to diagnostic imagine

- Introducing a robust Sepsis and Acute Kidney Injury Pathway
- Early recognition and acknowledgement a person is likely to die
- Establishing a communication Hub for quick identification and treatment of the deteriorating patient
- Clear processes for communication with bereaved families involved in Serious Incident Reviews
- Implement the Structured Judgement Review
- Improve Rapid End of Life Transfer Transport
- Support alternatives to admission
- Establish and outreach team providing 24 hour support
- Link to seven day services project

3.3 Percentage of patient deaths with palliative care coded

The Summary Hospital Level Mortality Indicator (SHMI) makes no adjustments for palliative care. The percentage of patient deaths with palliative care coding presents percentage rate of deaths that are coded with palliative care either in diagnosis or treatment specialty fields.

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level	**Oct 16 - Sep 17**
Trust	20.10%
England	31.20%
Highest performing trust	59.50%
Lowest performing trust	11.50%

During 2018 the Trust plans to undertake a review of palliative care coding to improve our rates.

Prescribed information (Data from NHS Digital)

3.4 Patient Reported Outcome Measures (PROMS)

Patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves.

Using source data available through NHS Digital the following reports show performance based on the four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations.

EQ-5D-3L: Comprises of five qualitative dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has three levels: no problems, some problems, extreme problems. The respondent is asked to indicate his/her health state by ticking (or placing a cross) in the box against the most appropriate statement in each of the five dimensions.

April 2017-September 2017 data provided by NHS Digital

	Trust Score % Reporting Improvement	England % Reporting Improvement	Trust Score %Reporting Same	England %Reporting Same	Trust % Reporting Worse	England % Reporting Worse
Groin Hernia	41.7%	52.9%	45.8%	28.7%	12.5%	18.4%
Varicose Vein	100%	54.7%	-	30.5%	-	14.8%

The table above indicates using the EQ-5D-3L scoring tool our patients are reporting an improvement in quality life following surgery for groin hernia and varicose veins.

April 2016-March 2017 data provided by NHS Digital

	Trust Score % Reporting Improvement	England % Reporting Improvement	Trust Score %Reporting Same	England %Reporting Same	Trust Score % Reporting Worse	England % Reporting Worse
Hip Replacement	82.5%	89.1%	9.3%	5.5%	8.2%	5.4%
Knee Replacement	77%	81.1%	10.7%	9.8%	12.3%	9.1%

The table above indicates using the EQ-5D-3L scoring tool our patients are reporting an improvement in quality life following surgery for hip replacement and knee replacement which is below the national average. More patients are reporting a worse score than the national average.

EQ VAS: The EQ VAS records the respondent's self-rated health on a vertical, visual analogue scale which can be used as a quantitative measure of health outcome as judged by the individual patient: "Best imaginable health state" and "worst imaginable health state".

April 2017-September 2017 data provided by NHS Digital

	Trust % Reporting Improvement	England % Reporting Improvement	Trust % Reporting Same	England %Reporting Same	Trust % Reporting Worse	England % Reporting Worse
Groin Hernia	44%	40.3%	24%	17.8%	32%	41.9%
Varicose Vein	50%	38.7%	25%	20%	25%	41.3%

The table above indicates using the EQ-VAS scoring tool our patients are reporting an improvement in quality life following surgery for groin hernia and varicose veins above the national average.

April 2016-March 2017 data provided by NHS Digital

	Trust % Reporting Improvement	England % Reporting Improvement	Trust %Reporting Same	England %Reporting Same	Trust % Reporting Worse	England % Reporting Worse
Hip Replacement	60.6%	67.2%	9.6%	10.4%	29.8%	22.4%
Knee Replacement	49.2%	57.4%	11.9%	12.9%	39%	29.7%

The table above indicates using the EQ-VAS scoring tool our patients are reporting an improvement in quality life following surgery for hip replacement and knee replacement which is below the national average. More patients are reporting a worse score than the national average.

The Trust considers that this data is as described for the following reasons: external company contracted to undertake PROMs data collection and analysis of returned questionnaires.

The Trust has taken the following actions to improve this indicator and so the quality of its services, by introducing monthly reporting via the business units integrated governance reports of monthly questionnaire returns. There has been a concerted effort during 2017 / 2018 to increase the number of patients who opt in to receiving the PROMs questionnaires.

3.5 Readmissions

Readmissions are often undesirable for patients, and they can be a burden for resource-stretched NHS hospitals. Importantly, readmissions have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway including during initial hospital stays, transitional care services and post-discharge support.

Readmission rates are, however, an imperfect measure with substantial limitations. Not all reasons for readmission are under the control of the health care service or hospital, and they also are not a measure of patient preference or experience.

30 Day Readmissions following an Elective Admission

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
ReAdms	44	37	36	47	31	36	28	42	29	31	30	27	418
Spells	3669	3860	4208	3973	3883	3786	4047	4095	3826	4001	3677	3961	46,986
	1.20%	**0.96%**	**0.86%**	**1.18%**	**0.80%**	**0.95%**	**0.69%**	**1.03%**	**0.76%**	**0.77%**	**0.82%**	**0.68%**	**0.89%**

30 Day Readmissions following a Non Elective Admission

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**YTD**
ReAdms	164	174	176	139	149	147	147	149	136	174	131	153	1839
Spells	3669	3860	4208	3973	3883	3786	4047	4095	3826	4001	3677	3961	46,986
	4.47%	**4.51%**	**4.18%**	**3.50%**	**3.84%**	**3.88%**	**3.63%**	**3.64%**	**3.55%**	**4.35%**	**3.56%**	**3.86%**	**3.9%**

30 Day Readmissions following an Admission

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
ReAdms	208	211	212	186	180	183	175	191	165	205	161	180	2257
Spells	3669	3860	4208	3973	3883	3786	4047	4095	3826	4001	3516	3961	46,986
	5.67%	**5.47%**	**5.04%**	**4.68%**	**4.64%**	**4.83%**	**4.32%**	**4.66%**	**4.31%**	**5.12%**	**4.58%**	**4.5%**	**1.82%**

Prescribed information: The Trust considers that this data is as described for the following reasons all activity data is submitted by the Trust to Secondary Users Service (SUS) in line with national mandated requirements complying with data definitions as per the Data Dictionary. Please note the latest figures from the NHS Digital are for 2011/12.

3.6 Responsiveness to the Personal Needs of the Patient

National Inpatients Survey 2017

This survey looked at the experiences of 72,778 people who were discharged from an NHS acute hospital in July 2017.

Between August 2017 and January 2018, a questionnaire was sent to 1,250 recent inpatients at each trust.

Responses were received from 394 patients at Southport and Ormskirk Hospital NHS Trust.

The CQC represent data as below to demonstrate a comparison of positive response to questions in the survey. The higher the score the better the performance.

	2012/13	2013/14	2014/15	2015/16	2016 / 17	2017/2018
Trust	62.2	74.8	74.4	76.3	74.5	76.5
England average	68.1	76.9	76.6	77.3	76.7	78.4
Highest performing trust	84.36	87.1	87.4	88.0	88.0	87

The Trust asked people to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was scored out of 10 for each question (the higher the score the better).

Each trust also received a rating of 'Better', 'About the same' or 'Worse'.

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

The Emergency / A&E department	**8.4 / 10**	About the Same
Waiting lists and planned admissions	**8.8 / 10**	About the Same
Waiting to get to a bed on a ward	**6.9 / 10**	About the Same
The hospital and ward	**8.0 / 10**	About the Same
Doctors	**8.5 / 10**	About the Same
Nurses	**7.7 / 10**	About the Same
Care and treatment	**7.8 / 10**	About the Same
Operations and procedures	**8.0 / 10**	About the Same
Leaving hospital	**6.8 / 10**	About the Same
Overall views of care and services	**4.1 / 10**	About the Same
Overall experience	**4.9 / 10**	About the Same

Prescribed information. The Trust considers that this data is as described for the following reasons: It is co-ordinated centrally for all trusts by an External source. The Trust has taken the following actions to improve this score and so the quality of its services, by the following actions:

- The Patient Experience Group monitors the results of all the patient experience questionnaires undertaken with the Trust and monitors actions taken to make improvements
- A patient's experience strategy called Developing the Experience of Care Strategy has been launched
- During 2018 / 2019 the Trust is planning to focus on improving 4 key questions from the national inpatient survey, the results are not expected to be seen until the 2019 survey results are published:
    - Nurses: did not always know which nurse was in charge of care
    - Doctors: did not always have confidence and trust
    - Nurses: did not always have confidence and trust
    - Care: did not always have confidence in the decisions made

National Children's Survey 2017

This survey looked at the experiences of 34,708 children and young people who received inpatient or day case care during October, November and December 2016.

Between February and June 2017, a questionnaire was sent to a maximum of 1,250 recent patients at each trust.

Responses were received from 142 patients at Southport and Ormskirk Hospital NHS Trust.

We developed an action plan for the area's where we scored worse than the national average and concentrated on those areas to make improvement.

The survey said	**We did**
Child felt there were not enough things for the child to do on the ward	All children now have access to age appropriate toys and activities during their stay in hospital, for example games machine now available. Adequate resources available for all age groups. Play Specialists now inform matron of additional resources required to enable access to appropriate funds
Child felt staff did not always communicate with child in a way that they could understand.	Improved age appropriate communication which is readily available All nursing staff attend Paediatric study days annually therefore all will receive updated training.
Child not fully involved in decisions about their care and treatment	Voice of child has been added to all admission documentation and care plans Evidence in ward round notes regarding communication with child.
Parent did not receive written information but would have liked it.	Patients are now discharged with completed discharge letters. All information leaflets have been updated and are accessible to parents near the nurses' station on the ward. When a patient is discharged the nurse is expected to give the appropriate leaflet to the child / parent and explain the contents. All leaflets given to parents are documented on discharge documentation

Complaints and compliments

Feedback from our patients, their families and carers give the Trust a valuable opportunity to review our services and make improvements. The Patient Experience and Complaints service is integral part of the corporate patient safety team. The Patient Experience and Complaints team act as a single point of contact for members of the public who wish to raise complaints, concerns and compliments.

The service is responsible for coordination the process and managing the responses once the investigations and updates are received from the relevant Clinical Business units. They are contactable by telephone, email, via the Trust web site, in writing or in person. The service acknowledges all formal complaints within the required 3 days achieving 94% compliance on the standard for 2017- 2018.

Patient Experience and Complaints Team information, (formal complaints, information requests and concerns by financial year- April 2017 to March 2018:

	2016/17	**2017/18**
Formal Complaints	656	321
Concerns/Information Requests	241	429
Totals	897	750
Percentage change against previous year	25% decrease	16% decrease

Complaints are a vital source of information about he views of our patients, families and carers about the quality of our services and standards of our care. Southport and Ormskirk from April 2017 to March 2018 the Trust received 321 formal complaints, and 429 information requests and concerns. There has been a 16% decrease in all complaints, concerns and information requests; the decrease is a direct result of the community services being recommissioned outside of the Trust.

Southport and Ormskirk hospitals has achieved 46%% against the target set by the Trust of a 60 day response rate for formal complaints and 81% against the national 6 months target. There is a clear need to improve the Trust turnaround times. The Trust is in the process of developing an improvement plan to address the Trust response timescales.

Reopened Complaints

	Formal complaints received	**Formal complaints reopened**	**% resolved at first response**
2017/18 Q1	71	9	87%
2017/18 Q2	73	9	88%
2017/18 Q3	100	8	92%
2017/18 Q4	77	15	81%
Totals	**321**	**41**	**87%**

Learning from complaints

We are keen to listen, learn and improve feedback from the public, Healthwatch, feedback from our local stakeholders and also from national reports by the Parliamentary Health services Ombudsman.

Most frequent complaint themes are clinical care, attitude of staff, and verbal communication. We are continuing to address the themes within the Business units, through investigation, training and feedback to staff. Some examples of changes that have taken place in year following the investigation of complaints has included:-

- Updated policy and patient letters in order to inform patients how long they have to fast before an operation.
- Stickers for decompensated liver disease have been introduced with an alerting system being embedded in the trust patient information system
- Development of a new pathway for patient who have had a Transurethral resection of a bladder tumour
- Additional promotion of 'John's campaign' across the Trust to support patient's with dementia to enable extended visiting times on wards and to provide the public with additional information on the campaign
- Implement robust systems to ensure staff are competent in using the equipment, with ongoing training and monitoring in place
- Work is ongoing across the Trust to support deteriorating patients; this has included the reconfiguration of some of the wards, and has included the development of a safety hub to ensure ongoing monitoring
- New nursing documentation has been implemented at the end of April and this will be audited in autumn 2018
- Quality of the food is now monitored through the friends and family feedback mechanism and inpatient surveys by the facilities team.
- Updates to mandatory training across the Trust

The complaints process does enable feedback to staff to happen and this is happening in different ways across the Trust. The feedback is used in the following ways:

- Sharing patient stories across clinical Business units to share the learning between teams
- Reflective practice by staff
- Discussions in safety huddles of issues raised in complaints
- Discussions during personal development reviews

The Trust will continue to ensure that patient complaints are seen as a way to make improvements into the delivery of service and care to our patients.

Parliamentary Health Service Ombudsman (PHSO) complaints April 2016 – March 2018

	2016/17	2017/18
Investigated - not upheld	3	3
Investigated - fully upheld	0	0
Investigated - partially upheld	3	3
Complaint withdrawn by PHSO	1	1
No decision made yet - carried forward	5	4
Total Number	12	11

The Trust has a low number of complaints referred by complainants to the Ombudsman, 35 of the total number of formal complaints in 2017-2018. On review the only ongoing theme apparent is regarding discharge of patients. A review of discharge is currently underway within the Trust in line with the inpatient survey findings.

3.7 Staff recommending organisation as a place to work

There is an annual national survey which NHS staff are asked to complete. The Trust had 1,646 staff take part in this survey. Which gave us a response rate of 49%. The survey ask staff what it is like to work for the Trust and compares us nationally with other NHS Trusts.

Staff recommendation of the Trust as a place to work or receive treatment

2017 score	2016 score	2015 score	2014 score
3.52	3.48	3.56	3.5

Higher scores are better indicating our score of 3.52 is an improvement from the previous year.

	Trust 2015	Trust 2016	Trust 2017
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	***54%***	***52%***	***53%***
Percent of staff believing the organisation provides equal opportunities for career progression / promotion	***87%***	***79%***	***79%***

Lower scores are better

	Trust 2015	Trust 2016	Trust 2017
Percent of staff experiencing harassment, bullying or abuse from staff in last 12 months	***22%***	***25%***	***25%***

The five key findings for which the Trust compares most favourably with other combined acute and community trusts in England:

Percentage of staff working extra hours
Percentage of staff feeling unwell due to work related stress in the last 12 months
Percentage of staff experiencing discrimination at work in the last 12 months
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
Percentage of staff attending work in last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

The five key findings where staff experiences have deteriorated since 2015 survey:

Support from immediate managers
Effective team working
Percentage of staff able to contribute towards improvement at work
Quality of appraisals
Fairness and effectiveness of procedures for reporting errors, near misses and incidents.

Our plan for improvement

The Trust is committed recruiting and retaining the best staff and the staff survey will assist us in coming up with an action plan to address the areas where the Trust has deteriorated since the 2015 survey.

The Trust has invested in leadership development for its managers through internal workshops or supporting staff to achieve accreditation through NHS Employers Programmes (e.g. Mary Seacole). Each CBU will have an action plan to ensure line managers demonstrate support to staff.

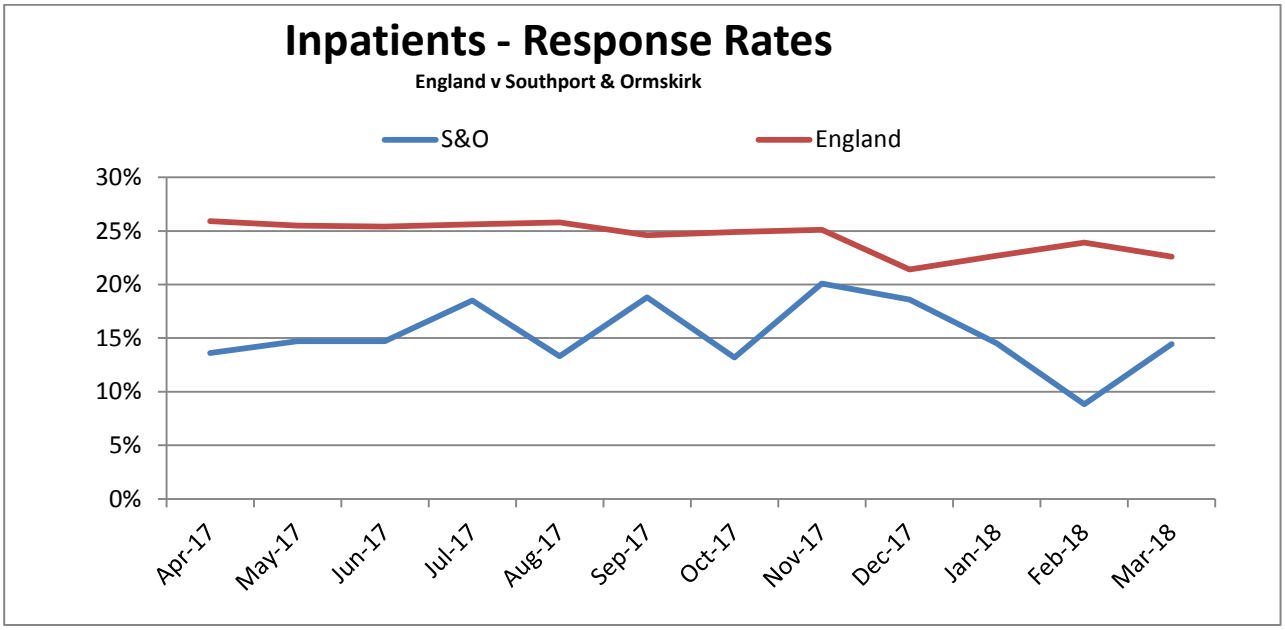
The Trust recognises the benefits of effective team working fully acknowledging the link between good team working and higher productivity which ultimately leads to better patient outcomes. The ability contribute to improvements at work is key to positive staff engagement appear. This will be achieved through improved communications, listening events and focus groups.

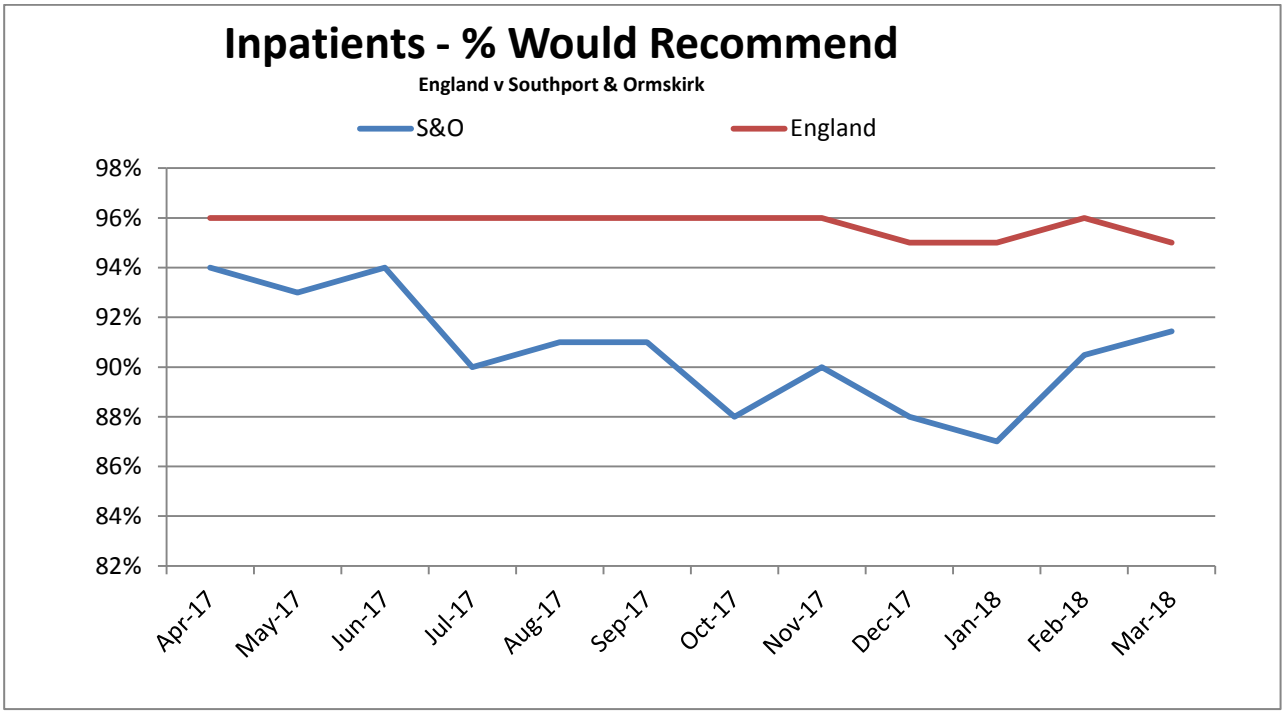
The Trust has revised its appraisal form and training line managers is available from the HR Department. The HR Department will monitor the quality of appraisals.

3.8 National Friends and Family Test

Patient feedback is now obtained through the implementation of the Hospedia system via the bedside screens. This system has been implemented for inpatient areas. The Friends and Family Test was a Department of Health initiative that was introduced in April 2013. The Trust was required to ask all patients the following question:

Would you recommend the hospital wards or accident and emergency unit to a friend or relative based on your treatment?'





The Trust considers that this data is as described for the following reasons: response cards are collected and sent immediately back to the information team for analysis.

Work is ongoing to imporove and localise patient carer and family feedback through the devloping experience of care strategy. Pledge Seven “increase the profile of patient carer andf family experiennce, collecting and acting upon feedback and opinion in a more robust manner”.

3.9 Venous Thrombo-Embolism (VTE) Risk Assessment

Prescribed information: The Trust considers that this data is as described for the following reasons: it carries out local checks to validate this data.

% of patients risk assessed	2017 / 2018			
	Q1	**Q2**	**Q3**	**Q4**
Trust	98.19%	98.33%	98.27%	96.08%
England	95.20%	95.25%	95.36%	95.18%
Highest performing trust	100.00%	100.00%	100.00%	100.00%
Lowest performing trust	51.38%	71.88%	76.08%	67.04%

Data from NHS Digital

The Trust is pleased consistently being above the average. The Trust has taken the following actions to improve this percentage and thus the quality of its services:

- Embedding of root cause analysis and learning lessons
- Review process for recording incidents on DATIX
- Introduce robust process to check data accuracy

3.10 Infection Prevention and Control

There is a zero target for MRSA bacteraemia as set by NHS England for all Trusts. In year 2017/18 the Trust had one case in September. This was investigated by the Infection Prevention & Control (IPC) team in conjunction with the clinical and nursing staff from AED and PIU. The case was presented and discussed in a Post Infection Review (PIR) which included a CCG representative.

As part of the PIR it was identified that the MRSA admission screen request form had no patient location written on the form, hence the result was delayed and was only reported on day 5 of the patient's admission.

Actions following the incident include:

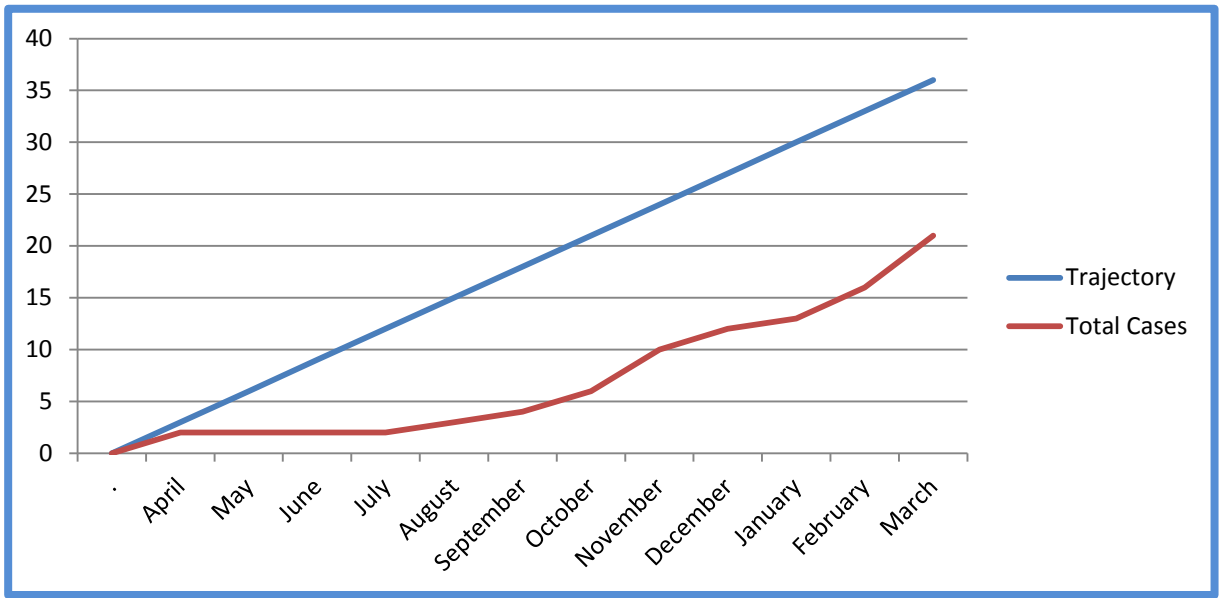
1. Review of learning points in each mandatory training
2. Clinical audit by IPC team into cannula placement, recording and monitoring
3. Reported through CBU Governance meetings
4. Cannulation packs to contain a sticker to be place in each patient record verifying date and site of cannula placement
5. Cannula placement training includes learning points from the incident
6. The Trust Sepsis pathway to include early identification of sepsis and actions required for both emergency admissions and in-patients
7. CBUs to imbed monitoring and recording of cannula on VitalPac

NB. The Trust is in the process of electronic "order coms" being introduced; this will provide assurance that essential patient information is included on all laboratory requests.

Nationally the Trust is recognised as a low incidence site for MRSA blood stream infections.

Clostridium difficile infection (CDI). The Trust target for CDI as set by NHS Improvement was to have no more than 36 cases; this target was achieved with total cases for the year reported as 21.

2017/18 CDI cases against trajectory**:**



All of these cases are reviewed by the IPC team, the patient's Consultants and Senior Nurses, the Antimicrobial Pharmacist, a Consultant Microbiologist and an Associate Medical Directors; learning points are discussed in mandatory training as well as through CBU governance processes.

It is recognised that CDIs can occur even though the patient has been appropriately treated and cared for, hence there is a process of appeals through a CCG led appeals panel. The appeals panel wasn't held until late in the year due to the low number of cases, however of the 6 cases presented 5 were upheld as being no lapses in care – there are a further 6 cases pending appeal.

In addition to the continuing work to ensure a clean safe hospital environment the Trust has a very proactive Antimicrobial Pharmacist who with the Consultant Microbiologist strives to improve antimicrobial stewardship, hence changes to the antimicrobial guidelines (some of these enforced due to antibiotic shortages) and embracing innovative disinfection technologies (Ultraviolet band C disinfection units) the Trust has been able to maintain its position as one of the lowest for CDI in the region.

Escherichia coli and other Gram Negative Blood Stream Infections. In November 2016 the Health Secretary announced the target to reduce Gram Negative Blood Stream Infections by half by 2020. The IPC team has presented Escherichia coli audit presentations to both North Mersey and Lancashire Collaborative' s which include colleagues from NHS England, NHSI, CCGs, Public Health and Acute Trusts. Plans continue to be developed within health economies to identify risk factors of infection and develop a prevention strategy.

Hospital-acquired MRSA by year

10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18
2	5	0	0	2	2	1	1

Prescribed information: The Trust considers that this data is as described due to the following reasons: all data is collected and verified by the Infection Prevention and Control Team who fully investigate each case.

The Trust has taken the actions described in the previous pages to improve this rate, and so the quality of its services.

C.diff rate per 100,000 bed days	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Trust	33	22.5	15.6	22.7	23.8	25.7
England	29.7	22.2	17.4	14.7	15	14.9
Highest trust	0	0	0	0	0	0
Lowest trust	71.8	51.6	30.8	37.1	62.6	66

Information Centre data

C. diff Infection by 100,000 bed days	
15/16	24.76
16/17	14.2

Internal data source

3.11 Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

In 2017/18 one incident was reported which met the definition of a Never Event. Thorough root cause analysis (RCA) is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence. The following table gives a description of the one Never event, its primary root cause, the key recommendations to prevent reoccurrence and the level of patient harm. The patient was informed of the subsequent investigation.

Never Event Type	Description of incident and level of harm	Primary root cause	Key recommendations to prevent reoccurrence
Surgical/invasive procedure.	During surgery bilateral stents should have been removed, only single stent removed..	Failure to follow policy and procedures within the Trust.	Review of Consent form Review of process in listing for operations to ensure procedure left, right, bilateral is clearly noted.. Revise current use of stent register. Development of clear procedure documentation in the form of a LocSSIPs for this procedure.

3.12 Reported Patient Safety Incidents

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm or more receiving NHS care.

Southport and Ormskirk Trust actively encourage a culture of open reporting and widespread sharing and learning from incidents to improve patient safety. The safety of our patients is our principal concern and we are working towards reducing avoidable harm. We are open and transparent about our incidents and our actions for improvement.

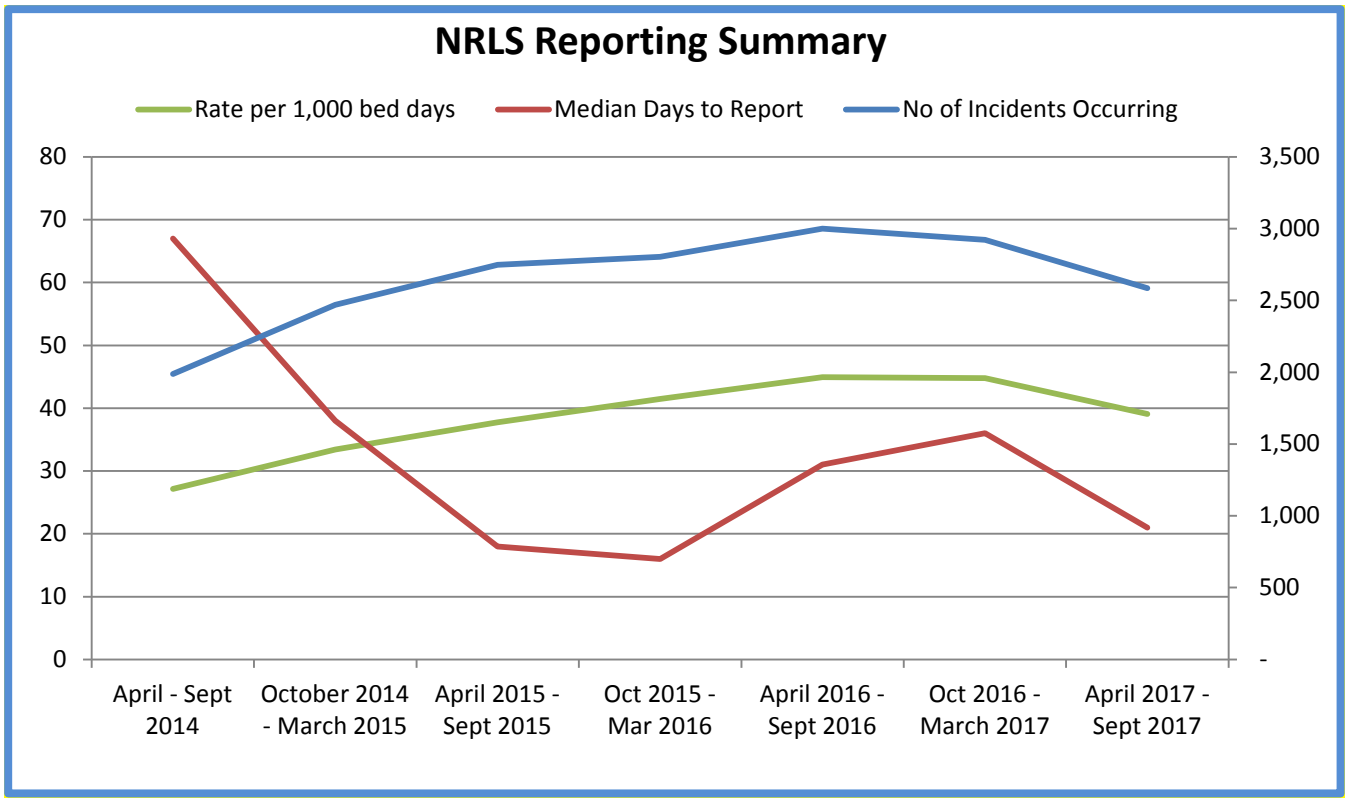
During 2017/2018, the Trust has implemented patient safety meetings within all Clinical Business units, involving senior clinicians, managers and nurses from each of the clinical Business unit and they review all incidents that have been reported through a structured process, ensuring compliance with Duty of Candour requirements when patients have been harmed. The Datix system supports incident reporting, decision making and links into providing a robust process of Serious Incident Management in the Trust.

The Clinical Business Units have a Quality and Safety Report which has been developed in year and provides performance in line with policy key performance indicators for incident reporting, and Serious Incident reports. The Clinical Business Units are responsible on a monthly basis top provide escalation and assurance to key committees within the Trust, with escalation to the Board as and when required.

The trust up loads the reporting patient safety incidents into the National Reporting and learning System (NRLS) via the Datix system. The current position of the Trust is 82nd of all reporting Trusts; the result has been disappointing as the Trust has seen a reduction from achieving 43rd out of the 135 Trusts measured using the National Reporting and Learning System reporting system. There is some reduction in the reported incidents due to the movement of community services into other organisations.

Time period	No of incidents occurring	Median Days to Report	Rate per 1,000 bed days	Position based rate per 1,000 Bed days- all Acute Trusts
April 2017- Sept 2017	2,585	21	39.07	82/135

The Trust considers that this data is as described for the following reasons: we report all relevant incidents through the national central reporting scheme. The figures supplied are provided from the National reporting and Learning System (NRLS) and are only provided currently for the first six months of the reporting year.

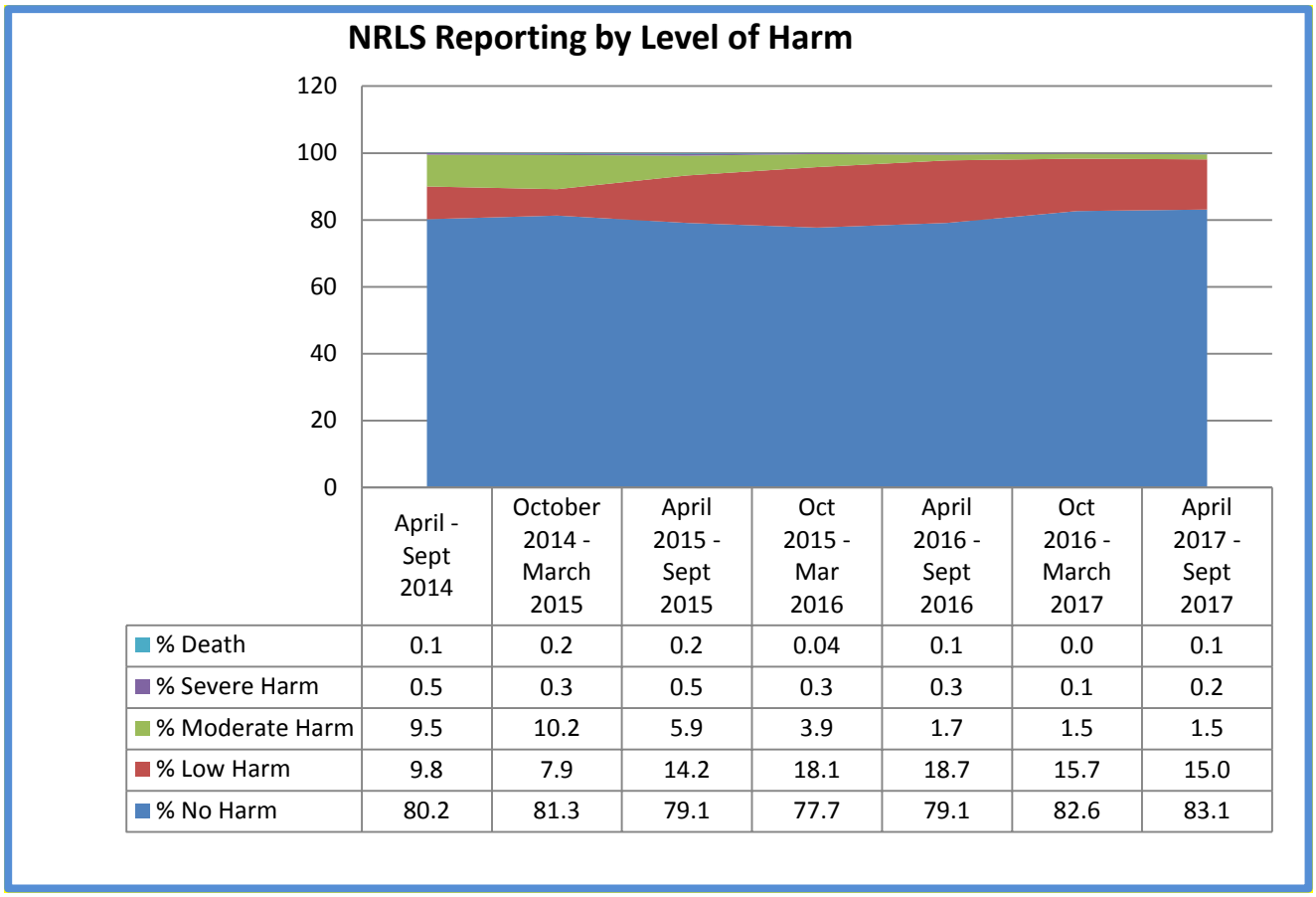


The reported levels of severe patient harm have remained at a consistently low level of reporting as can be seen in the table above. The Trust continues to encourage a culture of reporting all incidents in order to change practice and learn lessons.

The Trust top two reported incidents from this year have been accidents, which includes slips trips and falls and bed management issues. Ongoing in the Trust is a falls group who are looking at different ways to help prevent falls in patient areas, some on the new initiatives have included bay watch where patient have a member of staff within the bay at all times to ensure the patient remain safe from falls, improvements in documentation to improve the assessments process of falls, and the purchase of falls alarms. This work will continue with the multi-disciplinary falls group work.

The second area of high reporting has been in relation to bed management issues, which include patient flow throughout the hospital. This has been particularly difficult during the winter pressures through A&E and throughout the hospital. The work is ongoing to review patient flow with key pieces of work including reconfiguring ward areas and having clear escalation processes with A&E and within other areas of the hospital. Work with the local clinical commissioning groups has also enabled the Trust to purchase beds in the local nursing and residential homes in the community in order to step down patients form an acute hospital ward.

Keeping our patient safe is high on the agenda, the safety of our patients is our principal concern and we are working towards reducing avoidable harm moving forward.



	April - Sept 2014	October 2014 - March 2015	April 2015 - Sept 2015	Oct 2015 - Mar 2016	April 2016 - Sept 2016	Oct 2016 - March 2017	April 2017 - Sept 2017
% Death	0.1	0.2	0.2	0.04	0.1	0.0	0.1
% Severe Harm	0.5	0.3	0.5	0.3	0.3	0.1	0.2
% Moderate Harm	9.5	10.2	5.9	3.9	1.7	1.5	1.5
% Low Harm	9.8	7.9	14.2	18.1	18.7	15.7	15.0
% No Harm	80.2	81.3	79.1	77.7	79.1	82.6	83.1

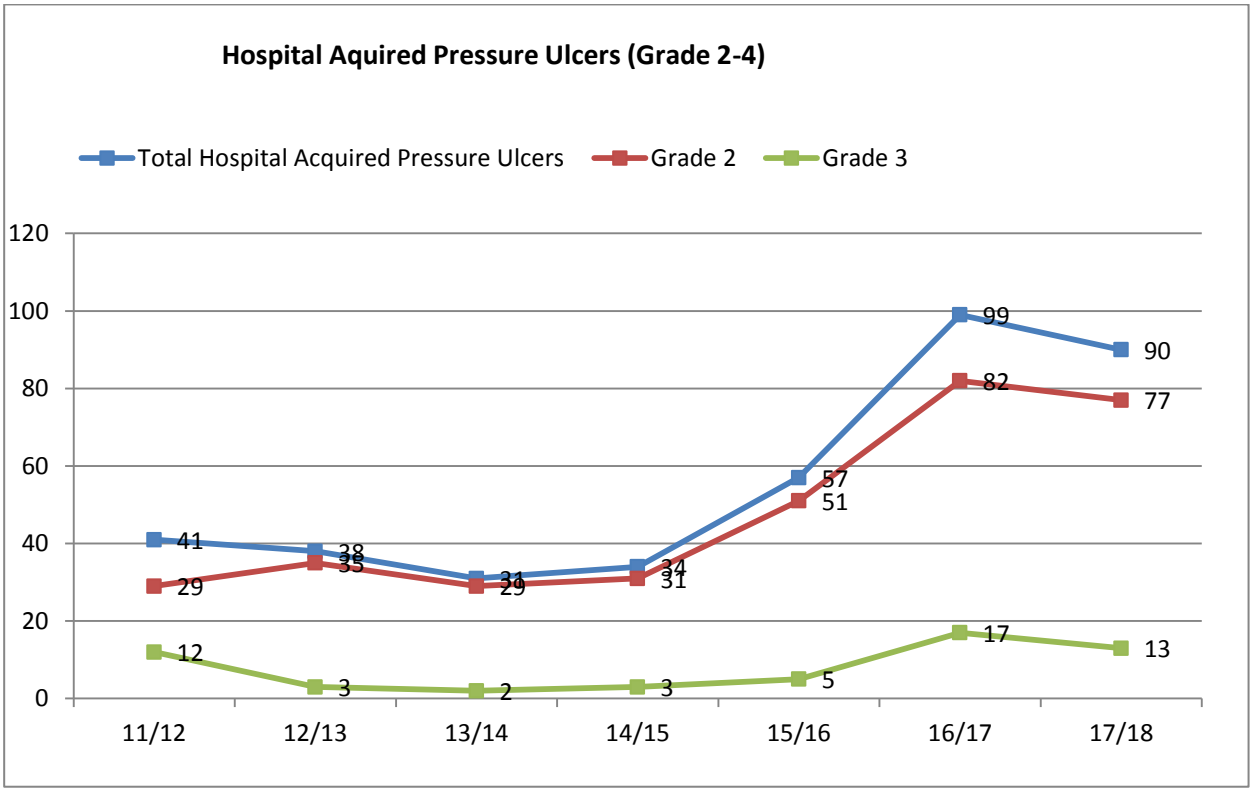
3.13 Pressure Ulcers

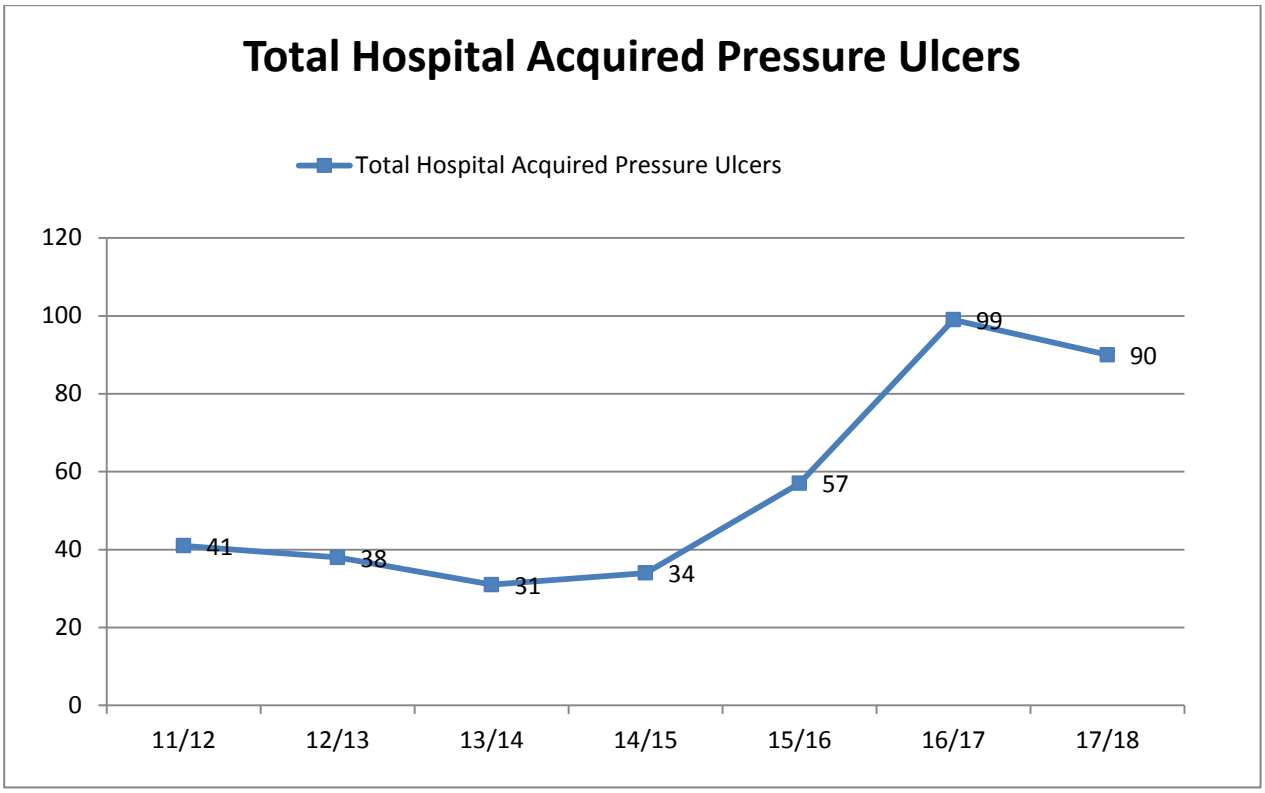
Last year we aimed to undertake the following actions to improve our pressure ulcer management:

What we said	What we did
Intensive SSKIN bundle training on a rolling basis is in place, facilitated by tissue viability team. Ongoing TV Link Nurse Sessions include pressure ulcer risk assessment, repositioning, care plans, reporting, and management of pressure ulcers.	Training was delayed due staffing which is still an issue, however we have recently restarted the skin bundle training.
Improve root cause analysis (RCA) reviews by introducing training on the process to ensure the root cause of the pressure ulcer is always identified in the final report.	There is now RCA training and approximately 50 staff have completed this. Pressure ulcer risks/incidents are now routinely discussed at safety huddles on the wards and departments. Our RCA tool is now being tested/evaluated across most of Cheshire and Merseyside as part of a research

	project by Edge Hill university. Data collection is about to close and once analysis is completed, the results and research paper will be published, and the tool amended as needed. This will then be embedded across the region as a standard RCA tool.
An Over-arching action plan has been devised by Regional Pressure Ulcer Steering group facilitated by CCG's and NHS England which addresses the most common themes elicited from the RCA process. Future incidents will be investigated, and if outcomes are covered by this action plan, an individual action plan will not be required.	The action plan (now called composite action plan) is in place and used for pressure ulcer reviews. It covers common themes, and any themes outside of the action plan are added additionally.

We have reduced the overall number of hospital acquired pressure ulcers from 99 in 2016 / 2017 to 90 in 2017 / 108. That equates to a 9% reduction.





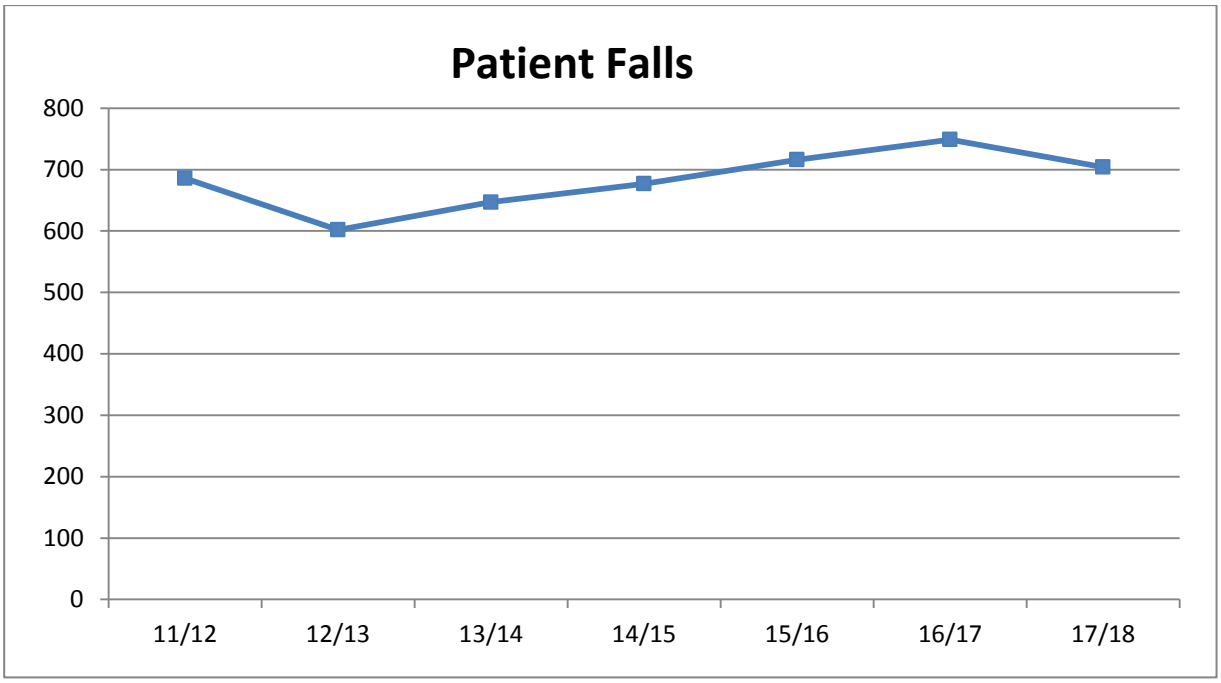
This is a multi-disciplinary team approach to managing pressure ulcers. All teams identify small changes that they can make that will make a difference in pressure ulcer management. The CCGs discuss Trust performance in pressure ulcer management on a monthly basis.

3.14 Falls

There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial.

However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay in hospital.

The total number of patient falls has decreased by 45 (6%) from 749 in 2016 / 2017 to 704 in 2017 / 108



During 2017/2018 there has been a review of the Trust falls risk assessment in conjunction with a review of all nursing documentation.

We also have a falls steering group which reviews all falls over the previous month to identify areas of good practice and areas of concern which are then noted in the minutes and then feedback to clinical business units.

Appendix 1 - The national clinical audits that the Trust participated in during April 2017 – March 2018 are as follows:

Eligible – 37

Participated/participating – 37

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Eligible / Participating
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Behind in cases submitted due to staff illness
BAUS Urology Audits: Cystectomy	British Association of Urological Surgeons	Not eligible
BAUS Urology Audits : Nephrectomy	British Association of Urological Surgeons	All eligible cases submitted
BAUS Urology Audits: Percutaneous Nephrolithotomy	British Association of Urological Surgeons	All eligible cases submitted
BAUS Urology Audits:Urethroplasty	British Association of Urological Surgeons	All eligible cases submitted
BAUS Urology Audits:Female Stress Urinary Incontinence	British Association of Urological Surgeons	All eligible cases submitted
Bowel Cancer (NBOCAP)	Royal College of Surgeons of England	All eligible cases submitted
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Not eligible
Case Mix Programme (CMP)	Intensive Care National Audit Research Centre	All eligible cases submitted
Child Health Clinical Outcome Review Programme	The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	All eligible cases submitted
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	Not eligible
Coronary Angioplasty/National audit of percutaneous coronary interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Not eligible
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	All eligible cases submitted
Elective Surgery (National PROM's Programme)	NHS Digital	All eligible cases submitted
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	Not eligible
Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians	All eligible cases submitted
Fractured Neck of Femur	Royal College of Emergency Medicine	All eligible cases submitted
Head and Neck Cancer Audit (HANA) (TBC)	Saving Faces – The Facial Surgery Research Foundation	Not eligible
Inflammatory Bowel Disease (IBD) programme	Inflammatory Bowel Disease Registry	All eligible cases submitted
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	All eligible cases submitted
Major Trauma Audit	The Trauma Audit & Research Network (TARN)	All eligible cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	All eligible cases submitted

Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	All eligible cases submitted
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide (NCISH)	Not eligible
National Audit of Breast Cancer in Older People (NABCOP)	Clinical Effectiveness Unit, The Royal College of Surgeons of England	Not eligible
National Audit of Dementia	Royal College of Psychiatrists	All eligible cases submitted
National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	Not eligible
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	Not eligible
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	All eligible cases submitted
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)	Royal College of Physicians	All eligible cases submitted
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury	London North West Healthcare NHS Trust	Not eligible
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	All eligible cases submitted
National Diabetes Audit – Adult	NHS Digital	All eligible cases submitted
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	All eligible cases submitted
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Behind in cases submitted due to staff illness
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	All eligible cases submitted
National Lung Cancer Audit (NLCA)	Royal College of Physicians	All eligible cases submitted
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	Initial problems with providing patient sample
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	All eligible cases submitted
National Ophthalmology Audit	The Royal College of Ophthalmologists	Initial problems with software leading to delay in providing patient sample
National Vascular Registry	Royal College of Surgeons of England	Not eligible
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Not eligible
Oesophago-gastric Cancer (NAOGC)	Royal College of Surgeons of England	All eligible cases submitted
Paediatric Intensive Care (PICANet)	University of Leeds	Not eligible
Pain in Children	Royal College of Emergency Medicine	All eligible cases submitted
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	Not eligible
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	All eligible cases submitted

Prostate Cancer	Royal College of Surgeons of England	All eligible cases submitted
Sentinel Stroke National Audit Programme (SSNAP)	Royal College of Physicians	All eligible cases submitted
Serious Hazards of Transfusion (SHOT) UK National haemovigilance scheme	Serious Hazards of Transfusion	All eligible cases submitted
UK Parkinson's Audit	Parkinson's UK	All eligible cases submitted

The national confidential enquiries that Southport & Ormskirk Hospital NHS Trust participated in during April 2017 – March 2018 are as follows:

	Number of clinical questionnaires returned	**Number of case notes returned**
Chronic Neurodisability	1	1
Young People's Mental Health	4	4
Cancer in Children, Teens & Young Adults	Not eligible	Not eligible
Acute Heart Failure	1	6
Perioperative Diabetes	1	1

PART 4

ANNEX

STATEMENTS OF ASSURANCE

The Draft Quality Account was circulated for comments to both CCGs, both Healthwatches and to the Overview and Scrutiny Committee. On the following pages are the responses received.

4.1 Sefton Healthwatch

healthwatch Sefton

Southport & Ormskirk Hospital NHS Trust.
Quality Account 2017-18 Commentary.

Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the draft Quality Account 2017-18.

Healthwatch Sefton members who reviewed the draft account found the format of the document easier to read than those previously reviewed and it is great to see that following our request, a summary version will be made available from 12th July.

It was good to see that within the account, the post of Chief Executive not described as 'interim' and its great to see that the trust will have a substantive executive in place. As a member of the Trusts Patient Experience Group, we were introduced to Silas Nicholls and we hope to set a formal meeting with him in the future.

In reviewing how the trust has performed over the past 12 months, we were concerned about the increase in the number of pressure ulcers recorded but note the reduction plan in place. We would be keen to receive updates on this work moving forward.

In reviewing the information within the account relating to mortality, we found it difficult to compare figures from last year but it is good to read about the plans in place to reduce avoidable mortality.

In examining information relating to clinical standards for seven day hospital services, we were concerned that standards five, six and seven had not been measured in September 2017. Is there a particular reason for this?

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info@healthwatchsefton.co.uk, www.healthwatchsefton.co.uk
Healthwatch Sefton *Company Ltd by Guarantee Reg. No: 8453782*

healthwatch Sefton

After reading the overview of key highlights for 2017-18, we note the expansion of the Southport A&E department as this supported a number of the recommendations from our Listening Event, which we held in July 2017. We were also interested in the work of Cancer services who introduced a 'walk the wait' system and we would welcome this being rolled out across all departments across the Trust, particularly as this helps patients who may be anxious and also supports patients who may be Deaf/Hard of hearing.

In reviewing the quality aims for 2018-19, it is good to see that the trust continues its focus on the implementation of the 'Patient, Family and Carer' Patient Experience Strategy'. Within the account it is good to see that there is a focus on improving experience and there are a number of positive examples of how patients are being supported (for example, Lancelots Diabetic Support Group) and evidence of good communication with Cancer patients. As a member of the Patient Experience Group, there is clear evidence that work has been undertaken on the pledge areas, including support for Carers and also in tackling the issue of loneliness. It would have been good to see the name of the lead for each of the pledge groups included within the account.

It is good to know that there has been a 7% increase in the number of compliments received by the Trust. There does seem to be some confusion regarding support for patients and carers in that the PALS department has now been combined with the complaints department and how this has been communicated to the public.

During December 2017 – February 2018 we undertook engagement work at The May Logan Health Centre to review family planning services provided by the Trust. The service scored an average Healthwatch Sefton rating of 4.5 stars out of 5 stars. Staff attitude scored 100% positive feedback as did quality of treatment & care'. We are currently working with the trust to gain updates on a number of the recommendations but were disheartened that in the Trusts response,

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there was no mention of the positive outcomes and how this feedback would be or has been fed back to the front line staff working within the family planning service.

Healthwatch Sefton members have been involved in PLACE audits and again, this area of work continues to not be included within the account, despite this being one of recommendations in previous commentaries. This information would be useful for the public when reading the account.

Healthwatch Sefton continues to be welcomed by the Trust and over the past 12 months, we have held monthly stands to gather independent feedback from patients, carers, visitors and staff.

Healthwatch Sefton

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4.2 Sefton Overview and Scrutiny Committee

Declined to comment on the 2017 / 2018 quality account.

4.3 West Lancashire CCG and Southport & Formby CCG

NHS West Lancashire Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

Quality Account Statement – Southport & Ormskirk Hospital NHS Foundation Trust.

NHS Southport & Formby, NHS South Sefton and NHS West Lancashire CCGs, welcome the opportunity to jointly comment on Southport and Ormskirk Hospital NHS Trust's Quality Account for 2017/18. The CCGs have worked closely with the Trust throughout 2017/18 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and support their strategy to deliver high quality, harm free care.

It is noted the Quality Account that is being reviewed is a draft version and the CCGs look forward to receiving the finalised account. The CCGs actively collaborate with partners to commission services for the local population and to ensure that the providers meet the required quality standards. The work the Trust has undertaken and described within this Quality Account has helped to improve patient safety and the quality of patient experience and endorses the Trust's commitment to the delivery of world class care for all.

The account gives a number of quality achievements gained throughout 2017/18 and these are well received by commissioners. Examples of successful areas of achievement have been; the 62 day cancer waits, which was recognised by the Secretary of State; Top 10 rating for maternity staff detecting babies 'at risk' of still birth and the re-launch of the seven day services programme. The focus on maternity, specifically caesarean section and forceps delivery rates have been recognised for the improvements made in outcomes for this priority.

Pledges to patient care have been put in place, with each pledge focussing on a different aspect however some of the strategy is yet to be put in place and actions fully launched. Various changes have been made in relation to the reviewing of mortality, and the Trust has welcomed external scrutiny as the year has progressed. Implementation of national guidance and a focus on the deteriorating patient has also been evident. There is recognition of the training of staff and changes in governance processes for board oversight on mortality, but there is still further work needed to improve mortality outcomes. Embedding Good Governance made some progress during 2017/18, but work is still to be done to embed it within the Trust.

The review of SOCAS (Southport and Ormskirk Clinical Accreditation Scheme) during 2017/18 has identified the need to re-introduce ward accreditations and a matron's checklist for 2018/19.

The CCGs recognise the Quality challenges faced at the Trust with the recent Care Quality Commission inspection rating of "requires improvement" and will look to support and work with the Trust on the Action Plan to improve standards. The outstanding CQC actions from the previous year's inspections and the actions from the 2017/18 inspections, will be a large part of the 2018/19 quality strategy.

Commissioners welcome the areas that the 2018/19 quality strategy will focus on, these being:

- Developing the experience of care
- Delivering care for you

- Safer staffing at all times
- Reducing mortality
- Preventing harm

The CCGs are looking forward to seeing and supporting continuing development of quality improvements throughout the Trust and expect the new and substantive leadership at the Trust to bring the necessary improvements to all five of the quality strategy areas.

The draft Quality Account is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and describes the ambitions moving forward. The report lacks information however on what actions are needed to achieve these goals but it is noted detail is contained in the Trust's Quality Strategy.

Commissioners are aspiring through strategic objectives and 5 year plans to develop an NHS that delivers positive outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving positive outcomes for our patients is the central focus of the work of the local system and is paramount to local system success.

It is felt that the priorities for quality improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Southport & Formby CCG/ South Sefton CCG

Signed Fiona Taylor. Date: 21 May 2018

Fiona Taylor, Chief Officer

West Lancashire CCG

Signed M. Maguire Date: 29 May 2018

Mike Maguire , Chief Officer

4.4 Independent Auditors Limited Assurance Report to the Directors of Southport and Ormskirk Hospitals NHS Trust on the Quality Account

Independent auditor's limited assurance report to the directors of Southport and Ormskirk Hospital NHS Trust on the Quality Account

We have been engaged by Southport and Ormskirk Hospital NHS Trust to perform an independent assurance engagement in respect of Southport and Ormskirk Hospital NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein.

NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care (DHSC) has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and Social Care guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DHSC on 29 January 2015 ("the Guidance") and applicable to 2017-18; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and consider whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to April 2018;
- papers relating to quality reported to the Board over the period April 2017 to April 2018;
- joint feedback from NHS West Lancashire, South Sefton and Southport and Formby Clinical Commissioning Groups dated 21 May 2018;
- feedback from Healthwatch Sefton dated 18 June 2018;
- the Trust's latest complaints report (Annual Patient Experience Report) published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- Care Quality Commission inspection report dated 13 March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment for the year ended 31 March 2018;
- the annual governance statement dated 24 May 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

This report, including the conclusion, has been prepared solely for the Board of Directors of Southport and Ormskirk Hospital NHS Trust.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Southport and Ormskirk Hospital NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and Social Care. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Southport and Ormskirk Hospital NHS Trust.

Basis for qualified conclusion

We identified four errors from a sample population of twenty items in our detailed testing of the percentage of patients risk-assessed for venous thromboembolism (VTE) indicator. The indicator included in the Quality Report for the year ended 31 March 2018 has not been reasonably stated in all material respects in accordance with the Regulations and six dimensions of data quality set out in the Guidance.

Qualified Conclusion

Based on the results of our procedures, except for the effect of the matter described in the Basis for Qualified Conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and supporting Guidance.

Cameron Waddell, Partner for and on behalf of Mazars LLP
Salvus House, Aykley Heads, Durham, DH1 5TS

22 June 2018

GLOSSARY	
A&E	Accident and Emergency Department
ACS	Appropriate Care Score - All measures passed for an individual patient
AQ	Advancing Quality
CBU	Clinical Business Unit
CCU	Coronary Care Unit
C.diff	Clostridium difficile
CQC	Care Quality Commission
CQS / CPS	Composite quality Score - Aggregated delivery of several clinical processes
CQUIN	Commissioning for Quality and Innovation
DAHNO	Data for Head and Neck Oncology
DON	Director of Nursing
DDON	Deputy Director of Nursing
DIPC	Director of Infection Prevention and Control
DNACPR	Do Not Attempt to Resuscitate
DSSA	Delivering Same Sex Accommodation
EoL	End of Life
EPaCCS	Electronic Palliative Co-ordination System
GSFAH	Gold Standard Framework Acute Hospitals
HAPS	Hospital Acquired Pressure Sores
HCAI	Health Care Acquired Infections
HCC	Health Care Commission
HES	Hospital Episode Statistics
HONS	Heads of Nursing
HRG	Healthcare Related Groups
HSMR	Hospital Standardised Mortality Ratio
HQIP	Healthcare Quality Improvement Partnership
IBD	Irritable Bowel Disease
ICT	Integrated Care Teams
IV	Intravenous
LD	Learning Difficulties
MDT	Multi-Disciplinary Team
MINAP	Myocardial Infarction National Audit Project
MRSA	Methicillin Resistant StaphlococcusAureus
MSA	Mixed Sex Accommodation
NCEPOD	National Confidential Enquiry into Patient Outcome and Death

NCISH	National Confidential Enquiry into Suicide and Homicide
NICE	National Institute of Clinical Excellence
NICOR	National Institute for Clinical Outcome Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
OSA	Obstructive Sleep Apnoea
OSC	Overview and Scrutiny Committee
PDR	Personal Development Review
PLACE	Patient Lead Assessments of the Care Environment
PREMIER	American Advancing Quality lead company
PPC	Preferred Place of Care
PROMS	Patient Reported Outcome Measures
RAG	Red, Amber, Green
RAM	Risk Adjusted Mortality
RCOG	Royal College of Obstetricians and Gynaecologists
RCPH	Royal College of Paediatric and Child Health
REoLT	Rapid End of Life Transfer
SHMI	Standardised Hospital Mortality Indicator
SIRRS	Serious Illness Recognition and Response Committee
STEIS	Strategic Executive Information System
SUI	Serious Untoward Incident
SUS	Secondary Users Services
TARN	Trauma Audit and Research Network
UTI	Urinary Tract Infection
VAP	Ventilator Acquired Pneumonia
VTE	Venous Thrombo-Embolism
WRVS	Women's Royal Voluntary Service