Southport and Ormskirk Hospital NHS Trust

Annual Report and Accounts for the Year Ended

31 March 2019

In Accordance with the Department of Health and Social Care

Group Accounting Manual

2018-19

Annual Report 2018-2019

1 PERFORMANCE REPORT

Overview of Performance

1.1 Introduction

1.1.1 Chief Executive's Statement on the Trust's Performance

This annual reporting period marks the end of my first year as Chief Executive of Southport and Ormskirk Hospital NHS Trust.

I joined after a number of challenging years for the Trust and its staff. The commitment of everyone to move on and make up for lost time, however, has impressed me greatly.

Indeed, we have been a Trust "in a hurry" this year, keen to get things done for our patients and our community – and this report is testament to the many achievements that makes Southport and Ormskirk a very different place from a year ago.

My number one priority was to stabilise the Trust clinically, financially and organisationally with an underpinning of effective governance. It has been gratifying to have support and encouragement from colleagues at all levels in achieving this.

We successfully held our financial position despite the busiest winter ever for the NHS, together with the additional costs that generated. Our finances were supported by a Cost Improvement Programme which, although falling slightly short of target, was our best performance for many years.

Clinical improvements were supported by investment in equipment and staff, a relentless focus on mortality and dramatic improvements in patient flow despite the rise in demand.

A Rapid Review of Governance conducted by an external organisation (EY) resulted in:

- A robust integrated governance structure
- The introduction of a Hospital Management Board
- The introduction of a Hospital Improvement Board
- Performance Review Groups where Clinical Business Units (CBUs) are held to account

In addition, new systems and processes are in place, strengthening our financial governance arrangements and aiding performance.

We have worked constructively with our commissioners and partners across health and social care, to chart a way forward for hospital services.

£2.8m was invested during 2018/19 for additional clinical staff, including four more SAS doctors and eight clinical fellows. An additional £300,000 was allocated to fund a Critical Care Outreach Team to provide a 24/7 service. The team has meant an additional pair of hands to respond to raised Early Warning Scores, ensuring pathways of care are followed and provide consistency in the engagement of parent teams and critical care for our sickest patients

A capital investment of £1.25m allowed the refurbishment and improvement of Southport emergency department. It included an improved waiting room, six new ambulatory care bays, an eight bed clinical decision unit, and new reception area. In addition, £280,000 was spent on the surgical assessment unit.

The discharge and transfer lounge opened in the summer, helping with patient flow and creating a better patient experience. Finally, we opened a new day surgery unit at Ormskirk, a quiet room also at Ormskirk named the 'Chillaxation Room' for young patients needing a calming environment, a new-look café at Southport and opening this month, a new sexual health clinic in Bootle.

Silas Nicholls
Chief Executive

1.1.2 Chairman's Statement Looking Ahead to 2019/20 Year

I joined the Trust in December 2018 at the start of what has turned out to be the longest and busiest ever winter for the Trust and the NHS as a whole. I found it inspiring to see the dedication of all members of staff in successfully navigating this period especially considering the challenges they have had to face.

In the short time I have been here I have also seen encouraging signs of improvement in the quality of our patient outcomes which will continue to be our number one priority as we look ahead for this and next year to continue the delivery of Vision 2020 which was launched in autumn 2018. This is the road map that sets out how we will become a successful and sustainable provider of healthcare for local people. Since the start of the year the Trust Board has worked to refine this Vision and ensure that it fits within the context of a coherent Mission. To that end our Trust Mission Statement has been restated as *providing safe, high quality services for you and with you.*

The four core themes at the heart of Vision 2020 remain, we will:

- become a district general hospital with specialist skills in the care of older people
- be part of an integrated care system delivering seamless hospital-to-home care that works for patients
- invest in our hospitals, making them fit for the 21st Century
- create a hub for routine planned care run from a dedicated hospital

We have now added a fifth theme – we will become an employer of choice that attracts the best staff.

Our strategic objectives have been refined to reflect our Mission and Vision, for 2019/20 they are:

1. Improve clinical outcomes and patient safety to ensure we deliver high quality services
2. Deliver services that meet NHS constitutional and regulatory standards
3. Efficiently and productively provide care within agreed financial limits
4. Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
5. Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
6. Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

The Chief Executive's report describes us as having been a Trust "in a hurry" this year, keen to get things done for our patients and our community – and we want this pace to continue so we can continue to add to the achievements of this year. We have therefore set ourselves an ambitious timeframe for the delivery of these strategic objectives. One of our most important strategic objectives for the 2019/20 period for example is to engage with our partners to develop opportunities for joint working across all the health providers across the region. This is fundamental to our being able to develop an affordable, sustainable acute services model and provide a sustainable model for acute care across Sefton and West Lancashire to transform the way future health, care and wellbeing services are delivered.

By the autumn we have therefore set ourselves the target to have developed:

- A comprehensive Programme Definition Document which describes the blueprint, project portfolio, timescales and benefits realisation plan

- A strategic partnership framework, financial framework and enabling strategies and plans
- An aligned and agreed commissioner approach

Another key strategic objective for the year is to deliver safe quality care within our financial limits. Although prudence is needed, we are determined that staff will be developed and supported to equip them with the skills they need to deliver safe care to our patients.

As far as service delivery is concerned, we will concentrate on:

- Enhancing same-day emergency care pathways across medical and surgical specialities, to be delivered 12 hours a day, seven days a week.
- Give continued focus on reduction the reduction of Length of Stay
- A zero tolerance of >60 minutes delays for ambulance handover and treatment in corridors
- Improving upon Referral To Treatment (RTT) performance which includes having no more than 1% of patients waiting longer than six weeks for a diagnostic test
- Ensuring key cancer deliverables are met

For Nursing, midwifery, therapies and governance some of our priorities will be to focus on:

- Workforce-Implementation of the business case regarding recruitment, retention, new roles, new ways of working
- Clinical education**-**Development programmes across all roles including implementing new NMC Educational standards
- Quality improvement**-**Focus on fundamentals including observations of care
- Care Quality Commission (CQC)**:** Ensure Trust is prepared for forthcoming inspection
- Patient experience**:** Enhance feedback, develop volunteers, and improve care within frail older people's care.

For Medicine our focus will be on:

- Mortality improvement - external mortality review and Reducing Avoidable Mortality Group actions to be delivered across clinical workforce
- Workforce planning**-** determining shortfalls in service provision and safer staffing. Plan for a sustainable robust workforce with no single points of failure
- Medical Engagement**-** continue to drive medical engagement across the Trust

2018/19 saw stability being established after a number of challenging years for the Trust and I look forward to us building on this stability during the coming year. I am confident that by working together we can deliver the exciting opportunity offered by Vision 2020, a place we can all be proud of. We are well along the road to recovery and every day I meet incredible, enthusiastic, hard-working people, and see the green shoots of recovery. I am excited to see what the next twelve months hold for us all.

Neil Masom

Trust Chairman

1.1.3 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

1.1.4 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.

1.1.5 Key Risks and Issues That Could Have Affected Delivery of the Trust's objectives

Strategic objectives for 2018/19 and the associated principal risks are set out below:

Key Priority Area	Strategic Objective	Principal Risk
Lack of Strategic Direction	***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	***Improve clinical outcomes and patient safety***	Poor clinical outcomes and safety records
Financial Performance	***Provide care within agreed financial limit***	Failure to live within resources leading to increasingly difficult choices for commissioners
Performance on statutory targets	***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 levels	***Ensure staff feel valued in a culture of open and honest communication***	Failure to attract and retain staff
Managerial capacity and capability	***Establish a stable, compassionate leadership team***	Inability to provide direction and leadership

Table 2

1.1.6 Going Concern Disclosure

In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern. This is based on the fact that 2019/20 plans have been submitted and agreed with the Regulator, NHS Improvement (NHSI), together with a requirement from NHSI for the local system (ourselves, commissioners and other providers) to submit 5 year financial plans by Autumn 2019.

The 2019/20 plan is for a deficit of £26.567m (2017/18 £28.961m deficit). As the Trust has agreed to the NHSI control total this allows access to the Provider Sustainability Fund (£3.464m) and the Financial Recovery Fund (£14.807m) which reduces the planned deficit to £8.296m.

These are the following uncertainties: the availability of cash support from the Department of Health & Social Care (DHSC); securing additional income from commissioners in the contracting process, and delivery of the Cost Improvement Programme (CIP).

Cash support continues from DHSC and they are deferring all principal repayments except on capital loans. Contract negotiations are progressing. In terms of the 2019/20 CIP target of £6.3m, £5.9m of schemes have been identified.

Considering the significant challenges described above which may cast significant doubt on 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.

1.2 Performance Analysis

1.2.1 Performance Indicator Set by Our Commissioners against Key Contractual Targets

1.2.2 Financial Performance

Key Financial Targets

The Trust achieved its financial target in 2018/19.

At the beginning of the year, the Trust Board was unable to agree the Regulator's (NHS Improvement) control target of a deficit of £13.681m. Based on extensive work the Trust submitted a final plan to the Regulator for a deficit of £28.818m.

There were no major changes to the Trust's business model in year. Below is a list of factors that affected the financial performance in 2018/19:

- Increased emergency activity which has been paid for at a marginal rate.
- To support the increase in emergency demand the Trust developed new clinical pathways utilising a clinical decision unit and the ambulatory care unit.
- Elective (planned) admissions were slightly below target due to the increase in emergency demand.
- Outpatient activity was above plan.
- As the Trust had not signed up to NHS Improvement's control total it was not entitled to receive £6.9m from the Provider Sustainability Fund.
- The increase in emergency activity resulted in increased pay costs mainly with agency costs paid at premium rates.
- Reliance on temporary staff to fill gaps in medical and nursing rotas due to vacancies and sickness.

- An under-achievement of £0.75m against the Trust's Cost Improvement Programme target to save £7.54m.
- Higher sickness absence rates than planned.
- Imposition of financial sanctions by our local Commissioners particularly around A&E targets as the Trust had not agreed to the control total.

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

Performance indicator	Target 18/19	Actual 18/19	Variance	Achieved
Adjusted financial performance	-£28,818,000	-£28,961,000	-£143,000	Yes
External Financing Limit	£31,002,000	£30,883,000	£119,000	Yes
Capital Resource Limit	£6,330,000	£6,330,000	£0	Yes
Better Payment Practice Code (non NHS) by no. of invoices	95%	85%	-10%	No
Better Payment Practice Code (NHS) by no. of invoices	95%	59%	-36%	No

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 £28.961m. Although this is marginally away from target (less than 0.5%) the Regulator considers that the Trust has achieved its Board approved financial plans.

The External Financing Limit (EFL) is a cash-based control for NHS Trusts; it is shown in note 36 of the accounts. Although no longer a statutory duty the Trust has achieved this target with an undershoot of £119k.

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 full spent against its CRL in 2018/19. This is shown in note 37 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. Performance was considerably stronger than the previous year but due to cash flow timing issues particularly around being paid for the additional emergency activity, the Trust was not able to achieve this target.

NHS Improvement measures the Trust's financial performance using 5 metrics which are consolidated into a use of resources risk rating from1 (best rating) to 4.

Metric	Value		Risk rating	
	Plan	Actual	Plan	Actual
Capital service cover rating	-2.52	-2.80	4	4
Liquidity rating	-41.16	-65.27	4	4
I&E margin rating	-17.80%	-17.20%	4	4

I&E margin: distance from financial plan		0.60%		1
Agency rating	4,928	8,912		4
Overall				3

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	2018/19	2017/18	Variance	Variance %
	£'000s	£'000s	£'000s	%
Turnover	168,112	158,277	9,835	6.2%
Operating expenses	192,666	185,545	7,121	3.8%
Non-current asset base	123,067	126,790	(3,723)	-2.9%
Total assets employed	(4,902)	26,997	(31,899)	-118.2%

Turnover

Income has increased by £9.8m from 2017/18 levels. This is due to the following:

- New clinical pathways; £1.9m.
- Inflation uplifts; £1.3m.
- Activity over-performance; £3.9m
- Sanctions; -£1.6m.
- Department of Health & Social Care contribution to pay award; £2m
- Prior-year figure included a reduction in income from the Expert Determination work; £2.8m.
- Prior-year figure included additional income for A&E intensive support; -£0.5m.

Operating Expenses

This shows an increase of £7.1m from 2017/18. Of this increase, £4m relates to pay and £3.1m on non-pay. This is due to the following:

- Pay inflation: £2.5m
- Pay award shortfall: £2.1m (note, majority of this funded by Department of Health & Social Care).
- Prior-year pay figure included community staff for the month of April 17 (services transferred on 1st May 2017); -£1.6m.
- Prior-year pay figure included HR and payroll staff (services transferred July 17); -£0.5m.
- Increases in bank/agency spend and other staff relating to activity; £1.5m.
- Insurance premium for clinical negligence increase of £1.8m.
- Prior-year figure included an accounting adjustment on the premises line connected with one of our managed service contracts; £2.6m.
- Reduction in consultancy; £1.4m (note prior-year was substantially funded from external resources).

Non-Current Asset Base

The overall value of capital assets has decreased in 2018/19 by £3.7m. The majority of this decrease is solely related to the revaluation on 31st March 2019 of the Trust's land and building assets.

Total Assets Employed

The total value of the Statement of Financial Position has reduced by £32.5m and the Trust is now operating with a negative balance sheet.

The reduction is a combination of the in-year deficit position (£28.9m), reduction in the revaluation reserve (£3.9m) offset by an increase in public dividend capital (£1m). Note the increase in public dividend capital is the Department of Health & Social Care investing capital monies to support patient and visitor wifi, clinical signposting support project, further IT support and finally pharmacy software investment.

1.2.3 Clinical Performance

The Trust's clinical performance is described in detail in the annual Quality Account to be published in June 2019.

The Trust last had a CQC inspection in November 2017. During that inspection the CQC rated six of the Trust's seven services inspected as *'requires improvement'* and one as *'good'*. In rating the Trust, the CQC took into account the current ratings of the five core services not inspected at that time. Overall, the Trust was rated as *'requiring improvement'*.

In March 2018 the Trust's Urgent and Emergency Services were inspected as an unannounced responsive inspection due to concerns regarding patient safety and how responsive the department was to people's needs; at that time the CQC did not rate the Trust.

The CQC had previously inspected the urgent and emergency care service in 2017, which was given a rating overall as *'requires improvement'* and *'inadequate'* in terms of patient safety. At that inspection the CQC looked at specific areas of concern including: patient safety, medicines, staffing levels, the environment, infection prevention and control, record

keeping, mandatory training of staff, how services were planned, whether services met patients' individual needs and how the flow of patient through the department was managed

The 2017 rating was:

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Mar 2018	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Inadequate ↓ Mar 2018	Requires improvement → ← Mar 2018

The core service and overall ratings for Southport and Formby and Ormskirk hospitals are shown below reflecting the impact of service configuration and non-elective service pressures across all domains included in the inspection.

Ratings for Southport and Formby District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement → ← Mar 2018
Medical care (including older people's care)	Requires improvement → ←	Requires improvement → ←	Good → ←	Requires improvement → ←	Inadequate ↓	Requires improvement → ←
Surgery	Requires improvement ↑ Mar 2018	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Inadequate → ← Mar 2018	Requires improvement → ← Mar 2018
Critical care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Outpatients	Requires improvement Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Spinal Injuries	Requires improvement ↓ Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement → ← Mar 2018
Overall*	Requires improvement ↑ Mar 2018	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Inadequate ↓ Mar 2018	Requires improvement → ← Mar 2018

Ratings for Ormskirk District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018
Surgery	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018
Maternity	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Services for children and young people	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016
Outpatients	Good Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018

In December 2018 a peer review of quality core services was undertaken focusing on the answers to five core questions:

- Is the service safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

The following core services were grouped together for the review:

- Medicine (including Older People's Care)
- Emergency Department (including Ambulatory Care Unit, (ACU) Clinical Decisions Unit, (CDU), Surgical Assessment Unit,(SAU) and Emergency Assessment Unit,(EAU)
- Outpatients and Radiology
- Children and Maternity (including Emergency Department)
- Surgery (Theatres and Wards)
- Spinal Injuries and Critical Care

As a response to the CQC report (2017 & 2018) the Trust developed a Quality Improvement Action Plan which has been the focus for improvements since the last inspection. The review teams provided their findings and highlighted areas of good practice, potential actions as well as identified as 'quick wins' that could be implemented where identified. In terms of governance, the improvement plan is monitored through the Quality & Safety Improvement Group which reports into the Hospital Improvement Board, and then through to the Hospital Management Board, which in turn reports via an 'Alert, Advise, Assure' Highlight Report to the Board. Updates on actions being implemented are presented to both the Quality & Safety Committee and the Board on a monthly basis. (See: Integrated Governance Structure in the Annual Governance Statement).

Areas of good practice since 2017 are listed below:

- Ward Processes – good examples where highlighted and the increasing use of checklists to ensure standards are met along with some innovative approaches to improving quality.
- Caring Staff – staff were described as welcoming, empathetic, caring, kind and friendly.
- Leadership – comments from frontline teams in relation to the CEO visibility, support from Matron's and practice facilitator, visibility of senior nursing team as well as enhanced team work.
- Culture – positive changes in culture were seen including raising concerns and alternative approaches to enhancing safety, especially within critical care.
- Patient involvement – examples were evidenced within the spinal unit regarding involvement and partnership working with third sector organisations.
- These are excellent examples (many more were identified) and demonstrate change in focus following new leadership and staff commitment to driving quality improvement forward.

The recommendations from the review have been incorporated into the Quality Improvement Plan.

This is evident in the steady improvements made in several areas.

Mortality

There has been a marked improvement in the Trust's mortality performance. The Trust has gone from 123.4 for 12 month rolling HSMR (Hospital Standardised Mortality Ratio) in March 2018 down to 109.9 in December 2018 which is the most recent data we have. These improvements have been made due many pieces of improvement work including a review of Best Practice Care Pathways and improvements to Communication and Escalation of the Deteriorating Patient. There has also been work on Future Care Planning and encouraging a Learning Culture within the organisation. This work will continue to ensure we reach our goal of reaching a HSMR below 100 which will mean we are performing better than the majority of Trust's nationally.

Referral to Treatment (RTT)

The Trust continuously achieves target, and whilst we were achieving the standard in 2017/18, 2018/19 saw higher performance in each month compared to the same month in the previous year. There is ongoing focus on maintaining the high performance in all areas and also improving in areas where performance is slightly below the target in the areas of Oral Surgery, Respiratory and Vascular

A&E Performance

Despite increased demand, the Trust has made significant improvements in A&E performance. Emergency care flow remains a challenge with significant blockages in timely bed release and unprecedented peaks in times of attendance. Specialty Reviews routinely

take place down in A&E to consider alternative pathways. CDU and ACU continue to support ED in streaming appropriate patients, and there is work continues to maximise opportunities to replicate this in SAU. The department has successfully recruited 4 new Physicians Associates who commenced at the end of March to support a longer term staffing model, and looks forward to welcoming 2 new substantive consultants in summer 2019

Pneumonia

Our monthly figures for community acquired pneumonia indicate we provide patients with quick screening and prescribing of antibiotics on presentation to A&E. We have developed a pathway for hospital acquired pneumonia and are currently implementing this on all our inpatient wards and A&E.

Sepsis

We have had a poster detailing our quality improvement journey accepted at the national Patient Safety Congress. We have improved our screening and identification of sepsis which means our patients are receiving the correct treatment more timely.

Hip and Knee

We have presented regionally to highlight the improvements we have made ensuring all our patients undergoing elective hip and knee replacement receive the highest quality care. We are particularly proud of or therapy team who met and advice patients before their surgery and after surgery to encourage early mobilisation for the best outcomes.

1.2.4 Key Performance Measures

Key clinical targets	Target	2018/19
% of urgent care patients seen within 4 hours	95	87.8%
% of patients first seen within two weeks when referred from their GP with suspected cancer	93	94.6%
% of patients receiving cancer treatment within 62 days of GP referral (*Year to Date end Feb*)	85	78.75%
% admitted patients treated in 18 weeks of referral	92	94.5%
% of patients treated within 28 days following a cancelled operation	100	
% waiting more than 6 weeks for diagnostic test	1%	3.37%
Hospital-acquired MRSA bacteraemia	0	0
C Difficile cases attributed following appeal	<36	12

Table 7

Key clinical activity data	2017/18	2018/19
Outpatient 1st attendances	65,390	67,172
Outpatient follow-up attendances	179,769	182,603
Elective inpatients	2,805	2,438
Day cases	22,298	22,518
Non-elective inpatients *(excluding maternity)*	21,918	30,254*
Adult A&E attendances	50,498	55,567
Adult A&E admissions	16,315	24,334*
Child A&E attendances	27,802	29,184
Child A&E admissions	4,335	4,809
All births	2,437	2,250

* New assessment wards introduced.

Table 8

1.2.5 External Audit

The annual financial statements were reviewed by our independent external auditors, Mazars, 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.

The total external audit fee for 2018/19 was £60k comprising statutory audit work. Non-audit work relating to the Quality Account was £13k.

1.2.6 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's *Standards of Business Conduct and Managing Conflict of Interests Policy* has been at the forefront in ensuring that senior staff are aware of their responsibilities in relation to declaration of interests and outside work. The Policy is accessible from the Company Secretary.

1.2.7 Related Parties

During the year there were two (2) related party declarations (recorded on the Declaration of Interests Register) between Trust Board members and current suppliers - Ernst & Young LLP and Ramsay Healthcare. The value of invoices in 2018/19 for Ernst & Young LLP was £468,845 (£235,260 in 2017/18) and for Ramsay Healthcare £3,644 (not a related party in 2017/18).

1.2.8 Charitable Funds

As an NHS Trust we make no political or charitable donations. We do, however, 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 2018/19 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.

1.2.9 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.

1.3 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 completed a Workforce Race Equality Standard (WRES) action plan for 2018/19 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

In January and February, the Board at two workshops discussed and approved the key priorities of the Trust for 2019/20, which themselves informed the strategic objectives and principal risks for 2019/20 all of which were finally approved by the Board in April 2019.

Based on the above a new Board Assurance Framework (BAF) Model was designed and discussed at the Board in May 2019. A Risk Appetite Statement was also discussed and agreed.

In April 2019, Professor Michael West of Lancaster University and the King's Fund held a Workshop for the entire senior leadership team on Cultural Change through Compassionate Leadership.

Finally, the Human Resources and recruitment function which was contracted out to St Helens and Knowsley Hospital NHS Trust was brought back into this Trust on 1 April 2019.

External Reviews

During the period a number of external reviews were conducted geared at improvement. These are summarised below along with outcomes and lessons learned:

- A Rapid Review of Governance resulted in a new integrated governance structure which included new reporting mechanisms and escalation from the Clinical Business Units (CBUs).

  Three new forums were created; they are:

  - Hospital Management Board
  - Hospital Improvement Board
  - Performance Review Boards

- A Medical Engagement Review resulted in the following key outcomes:
  - Highlighted poor engagement amongst medical staff.
  - Should increase medical staff in medicine and orthopaedics
  - Should have regular meetings with senior management team
  - Should address issues raised by junior doctors for example mess facilities, double bleep carrying etc.

- Following the Emergency Care Review and receipt of a number of recommendations, the Team has delivered the following:
  - Improvement in Triage Process,
  - Improvement of Emergency Department (ED) co-ordination to accelerate decision making,
  - Agree and implement Internal Professional Standards (IPS).
  - Maximising ambulatory pathways by improving streaming and assessment Flow Management
  - Implementing key elements of the National SAFER patient flow and adopted best patient flow practice bundle in bed management.

- The Mortality Review listed a number of recommendations including:
  - Improve patient flow,
  - improve awareness of Sepsis 6 standards and monitor adherence,
  - review and/or establish a pneumonia pathway to ensure that it meets national guidance,
  - review antibiotic recommendations to meet recent national guidance,
  - review doctors' rotas, review standards of documentation,
  - review nursing and AHP documentation,
  - ensure prescribing is legible, clearly signed and in line with national legal requirements,
  - review escalation and ceilings of care policies,
  - review end-of-life care policy,
  - individual end of life care plans should commence promptly,
  - ensure development of a more robust mortality review process with central reporting.
- Key outcomes for the Nurse Staffing/e-Rostering included: Roll out of e-rostering to every ward, embedding of the e-roster and rostering of all Clinical Nurse Specialists.
- The actions relating to the Acute Sustainability Case for change are taken up within the work of the Acute Sustainability Programme.

- Lessons Learned and key outcomes from the Well Led Review:
    - Identified Quality Priorities,
    - Highlighted areas for continued focus and improvement, preparation for CQC
    - Testing progress against the Quality Improvement Plan

Accountable Officer's Approval

Signed as Accountable Officer of the Trust

Chief Executive: Silas Nicholls

Signed:

Date: 22 May 2019

2 The Accountability Report

2.1 Corporate Governance Report

2.1.1 Annual Governance Statement (AGS) 2018/19

2.1.2 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding 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 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.*

2.1.3 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 Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

The objectives for 2018/19 and the associated principal risks were approved by the Board at its 7 March 2018 meeting. They are shown below at **Table 1**.

Table 1

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

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

2.1.4 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:

Responsibility	**Executive Team Member**
Overall Risk Management	Executive Director of Nursing, Midwifery and Therapies
Clinical Governance	Executive Director of Nursing, Midwifery and Therapies
Clinical Risk & Medical Leadership	Executive Medical Director (Caldicott Guardian & Responsible Officer)
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, Midwifery and Therapies
Information Risk	Executive Director of Finance (*Senior Information Risk Officer* (SIRO)/ Company Secretary (Data Protection Officer)

In addition the Deputy Chief Executive/Executive Director of Strategy is responsible for risks related to Acute Sustainability and Strategic Planning; the Chief Operating Officer is responsible for the day-to-day management of risk and performance within the Clinical Business Units. There are designated roles of Assistant Director, Safer Care and Standards and Deputy Director of Nursing, Midwifery and Therapies providing leadership and support in their respective areas. The Director of Human Resources & Organisational Development is responsible for workforce and organisational development risks.

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

Figure 1: Integrated Governance Structure

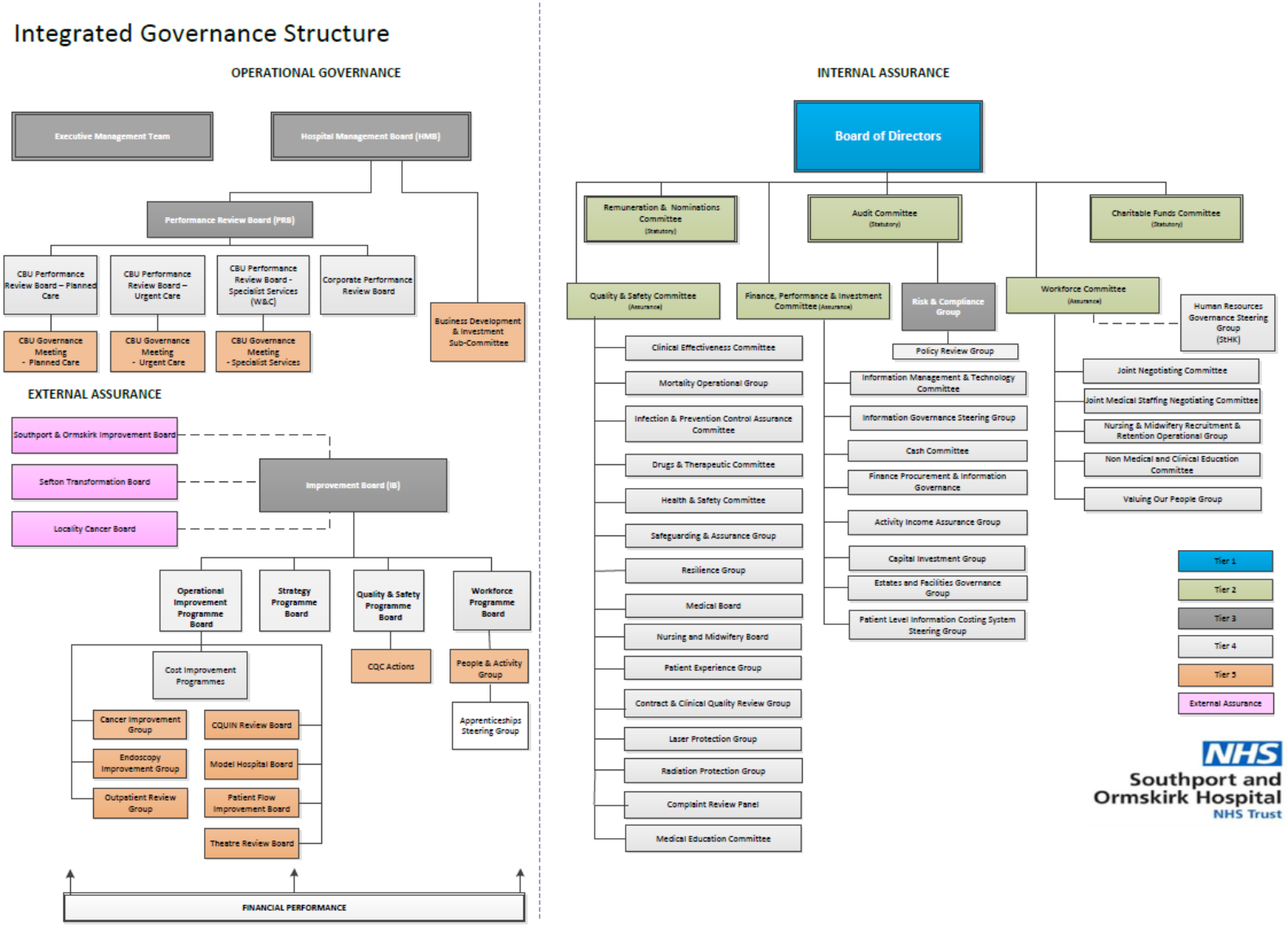
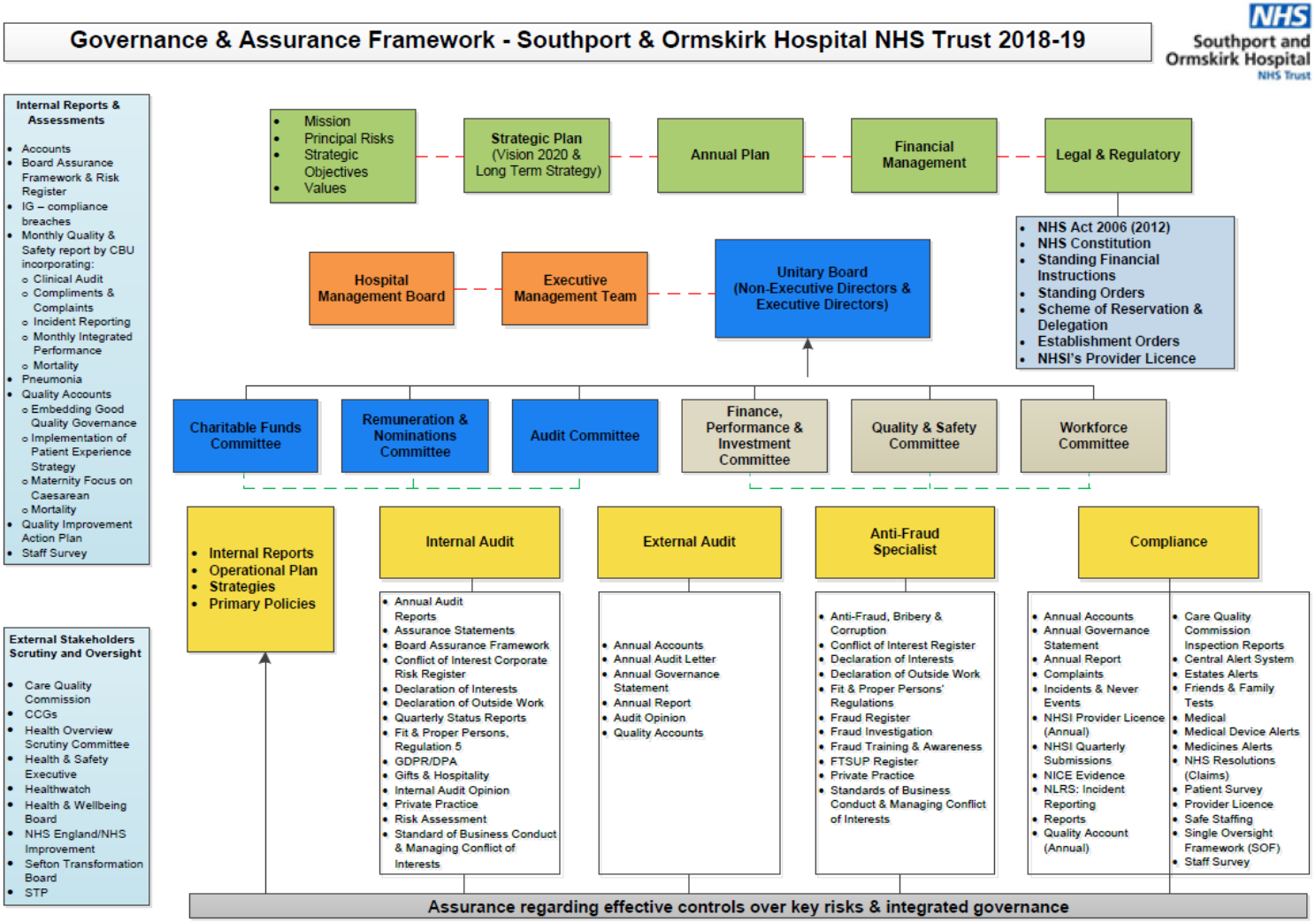


Figure 2: Governance & Assurance Framework



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 incidents, *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 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 Effectiveness Committee and Serious Incident Review Group (SIRG). 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 the Health & Social Care 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:

- *Finance, Performance and Investment Committee*, which provides assurance on management of risks relating to resources – both financial and human; performance and accountability.
- *Quality and Safety Committee* (which receives reports from the Mortality Operational Group and Clinical Effectiveness 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.
- *Workforce Committee,* which provides assurance against safe staffing, workforce and organisational development issues.

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

2.1.5 The Risk and Control Framework

Risk management by the Board is underpinned by three interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Clinical Business Units, Departments and Teams)
- The Risk Management Process

In addition the Audit Committee monitors the risk management systems and processes and receives the BAF on a quarterly basis.

The Annual Governance Statement is a composite report on how risks are managed and how assurances were received in relation to the integrated governance and internal control.

2.1.6 Board Assurance Framework

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: and
- receiving assurance that the controls in place are effective and mapped against robust actions to close gaps in both controls and assurance

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 and assurances.

A Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the 2018/19 *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 on a quarterly basis. Updates of progress against actions are provided at two-monthly meetings of the Quality & Safety Committee, the Finance Performance & Investment Committee and the Workforce Committee. The Audit Committee and the Board receive quarterly reports.

Risks monitored by the Trust via the BAF over the year included:

Strategic Direction - *Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards.*

A number of key steps were taken during the year to address this. They include:

- The appointment of a Director of Strategy whose substantive role was to work with systems partners around an Acute Sustainability programme for the Trust
- The appointment of a Programme Director for Acute Sustainability
- The Establishment of a Programme Management Office
- Being a key and active member of the Sefton Transformation Board
- The involvement of the STP programme of which the Trust is a work-stream
- The development and rolling out of a Vision 2020 programme
- During the year planning the next strategic steps by setting key priorities, strategic objectives and principal risks
- Acute Sustainability Case for Change Review

Financial Resources - *Failure to live within resources leading to increasingly difficult choices for commissioners.*

Because the Trust is a challenged provider, the Regulator, NHS Improvement, made available additional support for the quality agenda and Cost Improvement Programme governance, one of which was the services of a Turnaround Director for a limited period.

A number of initiatives were taken to improve financial governance including:

- A review of the Scheme of Delegation and Reservation to reduce budgetary levels of control for operational managers
- The establishment of a sub-group of the Workforce Programme Board called People Activity Group (PAG) to approve all expenditure not covered by an established budget
- The establishment of a Business & Development Investment Committee (BIDSC) which received proposals on new investment and initiatives and reports to the Hospital Management Board for approval accordingly.
- Monthly report to the Board on financial performance and the control total
- Monthly reports to Hospital Management Board
- 2-weekly Efficiency Programme Group (EPG) meetings with the CBUs

In addition, a cost improvement programme was robustly pursued with one to one meetings with budget holders and monthly reports to the Executive Team and the Board of Directors. Details of the CIP programme and delivery process are set out below:

2018/19 Achievement

- The 2018/19 Cost Improvement Programme (CIP) target for the Trust was £7.5 million; the Trust achieved actual in-year CIPs of £6.8 million and full-year CIPs of £5.5 million. This equates to 92% and 77% of the target respectively.
- This represents significant improvement on previous year.
- The critical success factors in the successful delivery of CIPs include changes to the CIP governance structure, formalisation of weekly CIP check & challenge meetings, strong clinical engagement and leadership.
- There have been substantial changes made to the Trust PMO and how it operates which again had a positive impact on CIP delivery.

- The changes to the Trust CIP governance are based on the review undertaken by KPMG LLP.
- Throughout the focus has been on ensuring that schemes are subject to a rigorous quality impact assessment process to ensure that the cost savings are being delivered safely.

CIP Next Steps

- The 2019/20 CIP target will be circa £6.3 million, an increase on the initial target of £6.2million, which equates to nearly 3% target of the addressable spend and represents significant challenge for the Trust.
- Whilst the 2018/19 schemes were mainly tactical in nature; the 2019/20 schemes will focus on transformation and efficiency improvements and will be underpinned by the national programmes such as Model Hospital and Get it Right First Time (GIRFT) or by local programmes such as Right Care.
- The key flagship programmes will focus on:
    - Workforce (including significant reduction in recruitment times, reduction in dependency on agency staff and e-rostering for nursing and AHP workforce and job plans for medical staff);
    - Operational efficiencies (focus will continue to be on theatre, endoscopy, outpatients and GIRFT); and
    - Corporate areas (estates & facilities, procurement and general reduction in dependency on interim staff)

Financial Plans

The Trust submitted draft 2019/20 financial plans to NHS Improvement on 12th February 2019. The Trust has agreed the control total of £8.296 million deficit which requires the following to be achieved:

- CIP of £6.2 million
- Non recurrent Provider Sustainability Fund (PSF) of £3.464 million
- Non recurrent Financial Recovery Fund (FRF) of £14.807 million
- Both the PSF and FRF will only be paid providing the Trust achieves its financial plan each quarter.
- The Trust's final 2019/20 financial plan was submitted to NHS Improvement on 4th April 2019.

Workforce - recruitment and retention - *failure to attract and retain staff, addressed by:*

- Having in place a Workforce and Organisational Development Strategy
- Workforce & Organisational Development Action Plan 2018-2020
- Conversations commenced with AQuA to co-design a Quality Improvement Strategy and training programme for all staff
- Quality appraisal conversations training programme commenced
- Staff Survey Action Plan
- Senior Leaders' Development Programme
- A Shadow Board Programme geared at aspiring Directors
- Recruitment of a dedicated apprenticeship lead to deliver an extensive range of apprenticeship programmes to recruit and develop clinical and non-clinical staff

- Role re-design supported by new apprenticeship programmes i.e. Nursing Associates
- Launch of eLearning to deliver core mandatory training, clinical knowledge and management skills
- Conversations commenced with NHS Elect to design and deliver our staff engagement approach “Big Conversations” with a focus in year one on culture, values & behaviours
- The Trust’s Library & Knowledge Service maintained a 97% achievement following the annual review against the Library Quality Assurance Framework

Leadership and culture - *inability to provide direction and leadership* has been addressed by:

- The appointment of a substantive Board with full complement of Non-Executive and Executive Directors.
- A Board Development Programme focusing on: Culture, How increased ownership of inclusive leadership behaviours will reduce discrimination, unfairness, bullying and harassment, and how it’s everyone’s responsibility”. External Well Led Review, Cultural Change Through Compassionate Leadership and High Performing Team among others
- Compassionate Leadership with a presentation by Professor Michael West
- Development of a pool of coaches to create an in-house coaching service for staff
- All staff have access to Level 2-7 Leadership & Management Apprenticeships

Quality, patient safety and clinical outcomes - *poor clinical outcomes and safety records,* this was addressed by:

- A Quality Improvement Assurance programme being developed and led by AQuA
- The Quality Improvement Action Plan with monthly reports to the Quality & Safety Committee and the Board
- Monthly Safe Staffing Report to Board and Quality & Safety Committee
- External Reviews including:
    - Mortality,
    - A Rapid Review of Governance
    - Emergency Care Performance including Patient Flow Pathway
    - Acute Services Transformation plus CIP Reporting/CIP Governance/PMO Review
- The Serious Incident Review Group examines all serious incidents and ensures that lessons learned are rolled out across the Trust

Although mentioned at 1.2.3 above under Clinical Performance, this section is included here as the AGS itself although included in the Annual Report is also a stand-alone document.

In December 2018 a peer review of quality core services was undertaken focusing on the answers to five core questions:

- Is the service safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well led?

The following core services were grouped together for the review:

- Medicine (including Older People’s Care)

- Emergency Department (including Ambulatory Care Unit, (ACU) Clinical Decisions Unit, (CDU), Surgical Assessment Unit,(SAU) and Emergency Assessment Unit,(EAU)
- Outpatients and Radiology
- Children and Maternity (including Emergency Department)
- Surgery (Theatres and Wards)
- Spinal Injuries and Critical Care

As a response to the CQC report (2017 & 2018) the Trust developed a Quality Improvement Action Plan which has been the focus for improvements since the last inspection. The review teams provided their findings and highlighted areas of good practice, potential actions as well as identified as 'quick wins' that could be implemented where identified. In terms of governance, the improvement plan is monitored through the Quality & Safety Improvement Group which reports into the Hospital Improvement Board, and then through to the Hospital Management Board, which in turn reports via an 'Alert, Advise, Assure' Highlight Report to the Board. Updates on actions being implemented are presented to both the Quality & Safety Committee and the Board on a monthly basis. (See: Integrated Governance Structure in the Annual Governance Statement).

Breach of performance data- *failure to meet key performance targets leading to loss of services,* this was addressed:

- By requesting a Consensual Audit of Specialist services in particular and the Trust as a whole which took place in August 2018 and at the time of writing all the recommendations have been met.
- By giving renewed focus on Information Governance Training across the Trust with compliance rate at above 85%

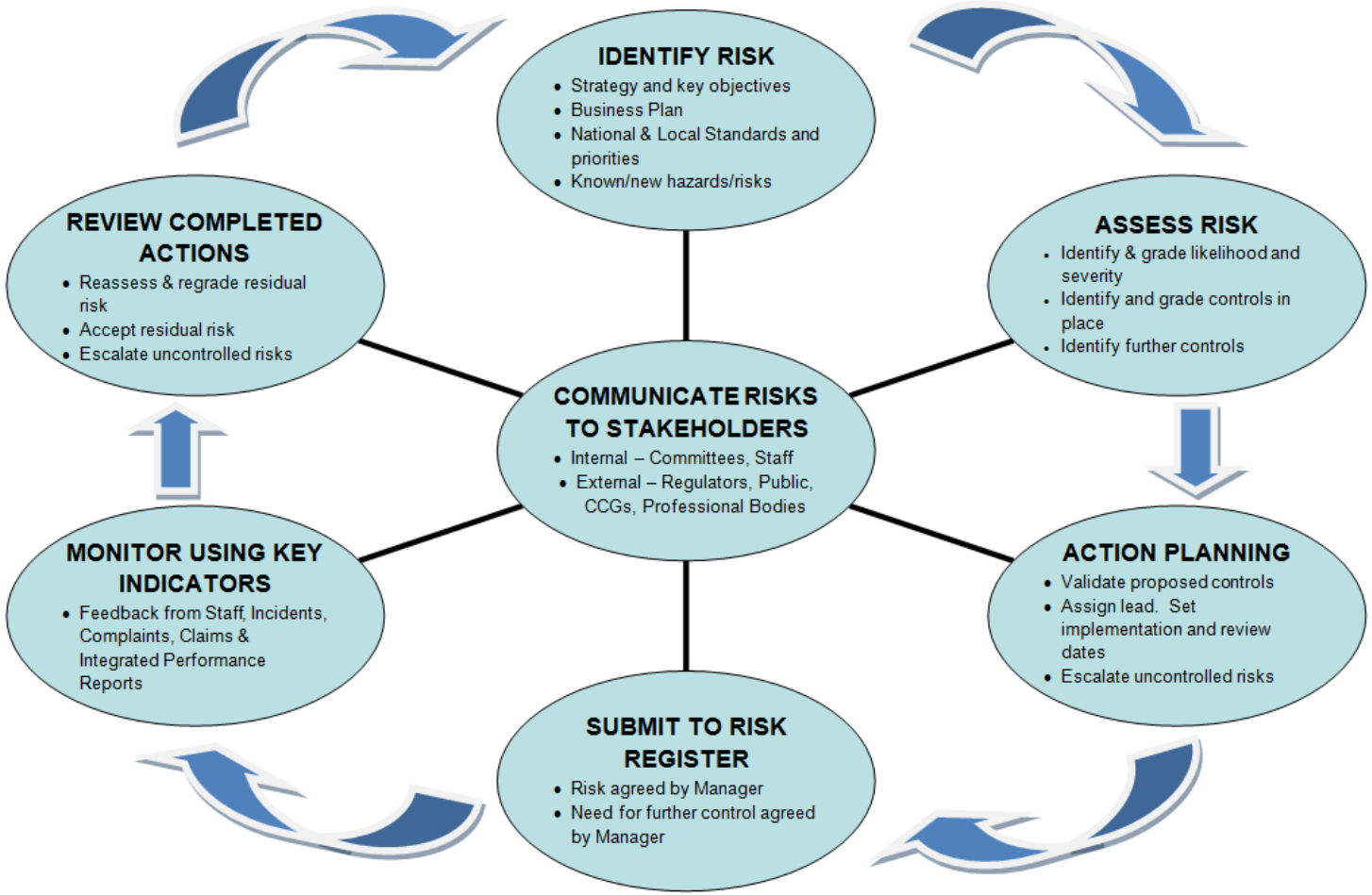
The BAF is a dynamic tool which supports the Chief Executive to complete the *Annual Governance Statement* at the end of each financial year. It is part of this wider '*Assurance and Escalation Framework'* to ensure the Trust's performance across the range of its activities is monitored and managed; 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 on the Trust's risk management system, Datix, by each Principal Risk Owner (Executive Directors). This is to ensure the controls and assurances remain valid, are effective, of the right level and any identified gaps are mitigated by timely implementation of clearly defined actions.

The *Risk Management Strategy* and *Risk Management Policy*, which are effective guides on risk management, have continued to work effectively during 2018-19. 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. Both the Corporate Risk Register and the Board Assurance Framework are monitored and updated on Datix. The risk management processes remained the same as defined within the Board Assurance and Escalation Framework. These clearly outline 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.

Figure 3 shows how 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



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 key performance indicators (KPIs) were incorporated into the BAF to show synergy between the KPIs and controls shown within the BAF.

2.1.7 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 three 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. This is illustrated at Figure 4 below.

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.

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 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, Midwifery and Therapies and Medical Director, who is also the Caldicott Guardian. The lead for corporate risks is the Company Secretary.

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 Serious Incident Review Group (SIRG) convenes every time there is a serious incident or data breach. The processes for these are embedded in the culture of the organisation and through robust processes and procedures such as raising concerns at work and the '*floor to board'* assurance and risk escalation processes.

Discussions have taken place at board meetings and workshops 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**) from Ward to Clinical Business Units and onto the Corporate

Risk Register. There is also 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.

2.1.8 Local and Directorate Risk Registers

Each ward, team, CBU 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. The appropriateness of updates, scores and escalation are discussed at the RCG.

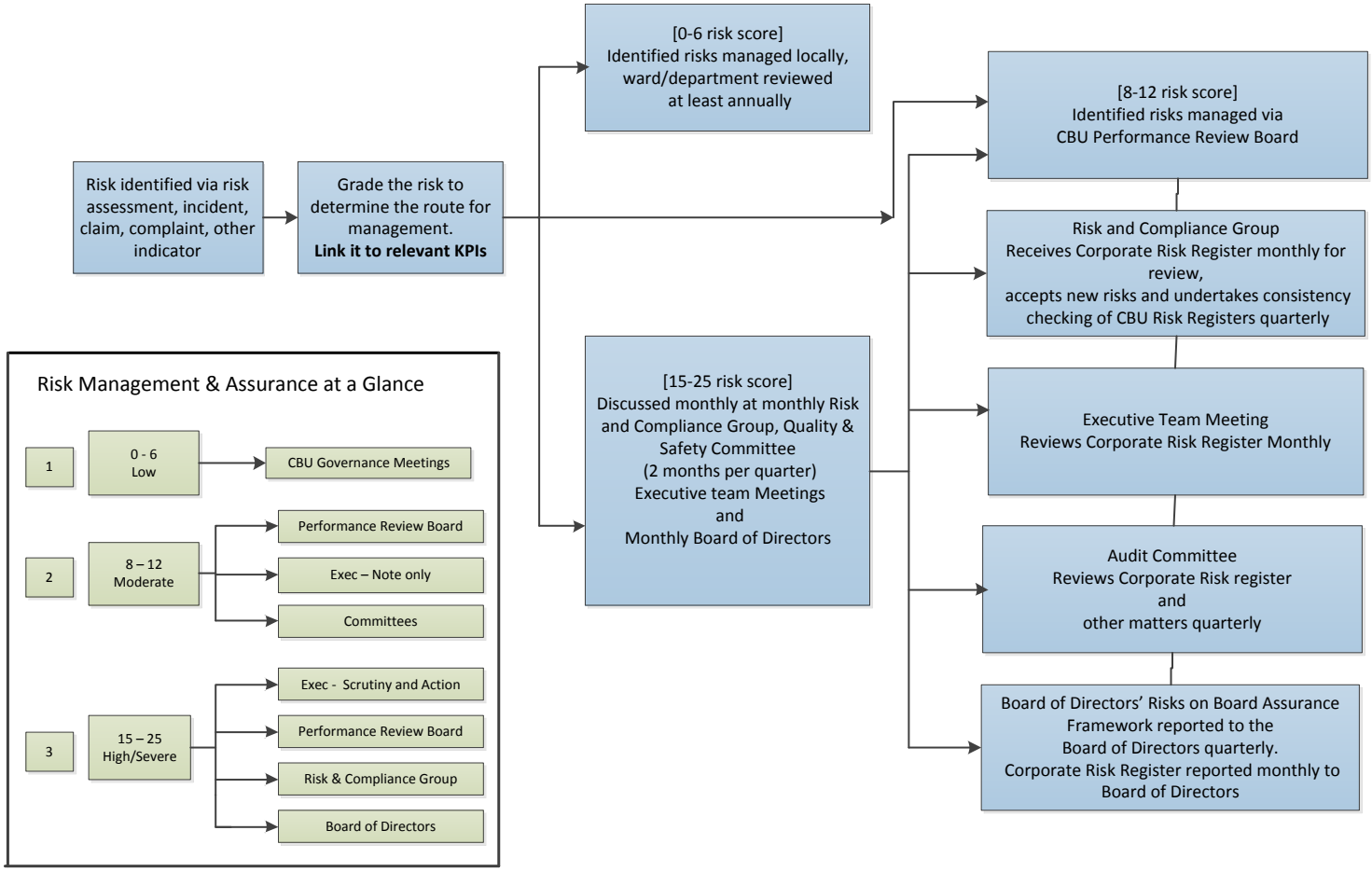
All local risks are systematically reviewed within a specified time frame by the local teams to ensure that controls in place are effective, and assess whether the risk changes over time.

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.

Figure 4:

Management and Assurance of Risks

Southport and Ormskirk Hospital NHS Trust



A description of the principal risks to compliance with the NHS provider licence[1, 2] condition 4 and actions identified to mitigate these risks, particularly in relation to items listed below are set out:

- the effectiveness of governance structures-these have recently been the subject of an external review by EY and the structures have been strengthened to include a new Hospital Management Board, Performance Review Boards for CBUs aimed at holding them to account

- the responsibilities of directors and subcommittees: each committee has robust terms of reference and annual business cycles. Assurance Committees are chaired by Non-Executive Directors. There are job roles for both non-executive and executive directors

- reporting lines and accountabilities between the board, its subcommittees and the executive team-the assurance committees on behalf of the Board holds management to account on operational issues and report monthly to the Board via three areas: Alert, Advise and Assure;

- the submission of timely and accurate information to assess risks to compliance with the conditions of the licence-this is done on an annual basis with sign off by the Board after review by the Audit Committee;

- the degree and rigour of oversight the board has over the Trust's performance-the Board receives a monthly Integrated Performance Report with each executive director giving assurance and/or action plans relating to regulatory and constitutional standards and other areas of performance.

2.1.9 Statutory and Assurance Committees

The Trust has three statutory committees as required by the *Health & Social Care Act 2012.*

They are:
- *Audit Committee*
- *Remuneration & Nominations Committee*
- *Charitable Funds Committee*

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 of its monthly meetings and annually, on its work via the *Annual Report of the Audit Committee* in support of the *Annual Governance Statement*, specifically commenting on whether the

[1] https://www.gov.uk/government/publications/the-nhs-provider-licence

[2] While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance. We aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. We therefore base our oversight, using the Single Oversight Framework, of all NHS trusts and NHS foundation trusts on the conditions of the NHS provider licence.

BAF is fit for purpose, the efficacy of the assurances within the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements.

The Trust has created a Risk & Compliance Group (RCG) which ensures that risks are appropriately managed at operational level, that is, within the Clinical Business Units and that the appropriate risks are placed on the Corporate Risk Register and are appropriately escalated. In addition, the RCG monitors risks relating to policy management, claims and the Information Governance Risk Register which is also monitored at the Information Governance Steering Group the Group reports into the Audit Committee.

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

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

***Remuneration*:**

- Determine the framework for the remuneration of the Chief Executive, Executive Directors and Company Secretary including performance related elements, pensions and cars as well as arrangements for termination of employment and other contractual terms.
- Take into consideration when determining performance related elements the performance of individual directors and senior managers
- Oversee appropriate calculation and scrutiny of termination payments.

Nomination:

- Regularly review the structure, size and composition of the Board and make recommendations to it with regards to any changes.
- Give full consideration to succession planning for Directors and other senior managers, taking into account current challenges and future opportunities.
- Ensure appropriate job specifications are prepared for Board vacancies
- Be responsible for identifying and nominating for approval of the Board, candidates to fill Board vacancies as and when they arise.
- Review the results of Board performance evaluation as they relate to the composition of the Board.

The Charitable Funds Committee

The Committee is established to manage the charitable funds on behalf of the Trustees in line with appropriate legislation, Charity Commission requirements and the Trust's Charitable Funds Governance Procedures.

In order to achieve its purpose the Committee will:

- Ensure that the charity is managed and administered in accordance with the requirements of the *Charities Act 1993* and *Charities Act 2006* (or any modification of that Act).
- To agree appropriate limits, policies and procedures to ensure the effective distribution and management of the charitable funds.
- To make decisions involving the sound investment of charitable funds in a way which both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
    - *Trustee Act 2000*
    - *The Charities Act 1993 & 2006*
    - *Charitable Fund Governance Procedures*
- To receive reports for the ratification of investment decisions and action taken through delegated powers.
- To recommend a *Scheme of Delegation* and authorisation limits to the Board of Directors as Corporate Trustee.
- To monitor expenditure in line with the delegated authority.
- To approve all individual charitable fund expenditure within appropriate limits defined by the *Scheme of Delegation*.
- To ensure funding decisions are appropriate and consistent with the purpose of the fund, the donors' wishes and the Trust's objectives and values.
- To receive the Annual Report and Annual Accounts of the Charity and recommend them for approval by the Board of Directors as Corporate Trustee

The Committees below are the Trust's assurance committees:

The Quality and Safety Committee scrutinises and gives overview on clinical risks and holds the Executives to account by 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 & Safety 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.

- Receiving reports on recommendations made by internal or external forums or bodies and monitoring the achievement of associated action plans
- 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.

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

- Financial performance – includes monthly performance, working capital and Cost Improvement Plans (CIPs)
- Patient flow, includes activity levels, Accident & Emergency Department 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

The Workforce Committee has delegated authority to:

- Review evidence relating to external standards, including NHS Resolution (formerly (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
    - Disclosure Baring Service (DBS)
    - Staff Survey
    - Flu Vaccination
    - Recruitment & Staffing levels
    - Commissioning for Quality & Innovation (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

2.1.10 Equality, Diversity and Human Rights

As a public sector organisation, the Trust is statutorily required to ensure that equality, diversity and human rights are embedded into its functions and activities in line with the Equality Act 2010 and Human Rights Act 1998.

The Trust will have due regard to achieving the General Duties set out in the *Equality Act 2010 to:*

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share protected characteristics and those who do not.
- Foster good relations between people who share protected characteristics and those who do not.

To achieve the Specific Duties the Trust publishes on its public website a range of equality diversity and inclusion information:

- Annual Equality Diversity and Inclusion Report
- The Workforce Race Equality Standard Report (WRES)
- Gender Pay Gap Report

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

- Trust Board Sign Off
- Workforce Committee
- Valuing our Peoples Group
- Patient Experience Group
- Learning Disability Group
- Updates to the Clinical Commission Groups (CCGs)
- Updates to NHS England

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. This statement is on our website.

Our policies, governance and legal arrangements are robust, ensuring that proper checks including pre-employment, fit and proper persons' in relation to *Schedule 5 of the Fit & Proper Persons' Regulation 2014* 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.*

2.1.11 Workforce Strategies and Compliance

The key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place and which assure the Board that staffing processes are safe, sustainable and effective are described below and also shows how the Trust complies with the '*Developing Workforce Safeguards*[3]

Short-term Workforce

The key issues are:

Daily safe staffing huddles with terms of reference have been established.

Currently Nurse staffing shortfalls are escalated, discussed and resolved on a day by day basis at the Safe Staffing Huddle. Safe Staffing Huddle is chaired by Head of Nursing/Midwifery, Associate Director of Nursing, Midwifery and Therapies or Deputy Director of Nursing, Midwifery and Therapies. Due consideration is given to the following:

- Any immediate adverse implications from staffing shortfalls
- Unexpected changes in acuity and dependency within a clinical area
- 1:1 supervision, Enhanced Levels of Care or cohorting of patients with specific nursing dependency needs is reviewed
- The mitigation of risk using professional nursing judgement for wards where nurse staffing numbers fall below planned levels

Out of hours this process is undertaken by the Site Manager, who is 'clinical'. In addition, any adverse incidents relating to nurse staffing are reported through the existing Datix system and discussed at the Daily Incident Review Meeting including the 'Red Flag Events'

Medium-term Workforce

Bi-annual staffing establishment review – The bi-annual nurse staffing establishment review is currently due to complete in March including the first data collection using Safer Nursing Care Tool. From the review there is a Business Case being prepared to increase the current funded nursing establishment. This was considered and approved at the Board at its 3 April 2019 meeting.

In October and November 2018 a gap analysis of Safe Staffing for nursing in adult inpatient wards in acute hospitals (National Institute for Clinical Excellence (NICE), July 2014), Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals (National Quality Board, January 2018) and 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – safe sustainable and productive staffing (NQB 2016) has been undertaken. The compliance with each set of guidance and summary of our 'gap analysis' has been shared with Workforce

[3] https://improvement.nhs.uk/resources/developing-workforce-safeguards/

Committee & Trust Board over the same period of time. Updates on the Improvement plan are provided on a monthly basis.

A gap analysis of the Developing Workforce Safeguards' was undertaken during March 2019 and outstanding actions were added to the Nursing & Midwifery Improvement Plan. The Trust is partially complaint with this guidance.

Long-term Workforce

These are:

- Workforce implementation plan post establishment reviews and outcome approvals via business case
- NHSI Improvement Plan- continued progression
- A Gap analysis of the deployment of nursing associates in secondary care

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.

The Trust is in Quadrant 3 of a Challenged Provider Trust and is current and future risks are being addressed via a Quality Improvement Programme.

2.1.12 Register of Interests

The Trust has published an up-to-date register of interests for decision-making staff-the Board of Directors on the Trust Website and internally for other decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. Our policy, *Standards of Business Conduct and Managing Conflict of Interests,* has clearly set out these obligations which are monitored by the Audit Committee on behalf of the Board.

2.1.13 Pension Scheme

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

2.1.14 Climate Change and Carbon Emission

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.

During the period the van travelled 5,000 miles and has cost the Trust approximately £92 to run (Trust rate of electric due to CHP - £220 at average National Grid rate). This is a cost of £1.84 per 100 miles – the approximate cost for use of an equivalent diesel vehicle is £15.83 per 100 miles, therefore, a saving of £699 for the year has been achieved.

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.

Next year the Trust will consider:

- The viability of reopening a borehole at Ormskirk Hospital to supply water for the laundry
- Modifying all large motors and pumps at Southport to make them run more efficiently
- Evaluate the costs/benefits of utilising solar heat for heating the swimming pool

With regards to Waste Management**,** the switch across the NHS from reusable items to single-use disposable items continues to increase the quantity of waste produced and the

cost of waste disposal. The new confidential waste disposal method has also caused logistical issue in working and this has led to a significant cost pressure on the waste budget**.**

Regarding Waste Segregation**,** in 2019/20, the Trust will review waste segregation from both a compliance and cost view point. It is widely accepted that improved segregation will provide costs savings.

2.1.15 Review of Economy, Efficiency and Effectiveness of the Use of Resources

The following sets out a number of initiatives, systems and achievements demonstrating how effectively we have used our resources to deliver safe care for our patients.

Workforce Developments

During the period we continued to recognise the contribution of our workforce and to develop staff as future leaders illustrated by the initiatives below:

- Having in place a Workforce and Organisational Development Strategy
- Workforce & Organisational Development Action Plan 2018-2020
- Conversations commenced with Advancing Quality Alliance (AQuA) to co-design a Quality Improvement Strategy and training programme for all staff
- Commenced a quality appraisal conversations training programme
- Staff Survey Action Plan
- Senior Leaders' Development Programme
- Started Shadow Board Programme geared at Aspiring Directors
- Recruitment of a dedicated apprenticeship lead to deliver an extensive range of apprenticeship programmes to recruit and develop clinical and non-clinical staff
- Designing new job roles such as Nursing Associates
- Launched eLearning to deliver core mandatory training, clinical knowledge and management skills
- Conversations commenced with NHS Elect to design and deliver our staff engagement approach "Big Conversations" with a focus in year one on culture, values & behaviour

Quality, Patient Safety and Clinical Outcomes

Quality continued to be a key focus for the Trust and during the period we have given particular focus to the following:

- A Quality Improvement Assurance programme being developed and led by AQuA
- The Quality Improvement Action Plan with monthly reports to the Quality & Safety Committee and the Board
- Monthly Safe Staffing Report to Board and Quality & Safety Committee
- Commissioned External Reviews including:
    - Mortality,
    - Emergency Care Performance including Patient Flow Pathway
    - Acute Services Transformation plus CIP Reporting/Continuous Improvement Plans (CIP) Governance/Project Management Office (PMO) Review

Research Governance

Background

Southport and Ormskirk NHS Trust is committed to providing the best possible care to patients, and acknowledges that research has been widely recognised as being an important factor in providing high quality care for healthcare organisations. Not only does organisational involvement in research improve clinical outcomes and service user satisfaction but it is also suggested in the evidence that organisations are able to attract higher quality employees, organisational culture benefits so that employees are more interested in basing care and treatment decisions on the best available evidence and on measurable improvements in outcomes.

Research Governance

The Trust is committed to the promotion of good research practice, ensuring that research is conducted according to appropriate ethical, legal and professional frameworks, obligations and standards. Research should be undertaken in accordance with commonly agreed standards of good practice. Good Clinical Practice (GCP) is a set of internationally recognised ethical and scientific quality requirements which must be observed for designing, conducting, recording and reporting clinical trials that involve the participation of humans. An understanding of GCP is a prerequisite for anyone carrying out, or involved in, clinical research and clinical trials. The RDI department ensures that information and support is available to researchers, and that GCP training is made available to all staff involved in research. The RDI department has a set of instructions which act as a guide to researchers and assists them in accessing and setting up NIHR online GCP training.

The 19 principals in the UK Policy Framework for Health and Social Care Research (2017) serve as a benchmark for the conduct of research. Adhering to these standards is a must and ensures the health and safety of research staff and participants.

The RDI Department have a suite of Standard Operating Procedures (SOPs). The SOPs cover all aspects of the set up and conduct of a research project. These SOPs are reviewed and amended to reflect changes in the regulations.

In order to maintain the highest standards of rigour and integrity at all times, Principal Investigators are expected to sign an Investigator Declaration form prior to commencing any new research study. The declaration form very clearly outlines the Investigators responsibilities when undertaking research at SOHT.

Key Achievements

The following are examples of how SOHT continuously drive to improve the quality of service provided through research:

The Research Team was inspirational in the delivery and set up of the FUTURE initiative study and recruited 225 participants. This resulted in the team winning the 2018 Time to Shine Award which was presented to the team at an awards ceremony in Formby Hall 12th October 2018. This important study aims to develop better dosing for medicines. We all vary in how we handle medicines which can result in differences in how well drugs work in

different people. By understanding these differences, we may be able to reduce this variability.

The success of this is due to team work including setting a recruitment strategy/ goals and clarifying responsibilities for each member of the team. We are committed to making sure that our patients and staff have the chance to participate in research and encourage our patients to discuss research opportunities with their doctors and nurses.

In March 2019, the Chief Executive received a commendation letter from the Sponsors of the FLOELA study (Fluid Optimisation in Emergency Laparotomy), praising the outstanding work of the Research Team. Out of 49 sites across the UK, SOHT have been recognised as a top recruiting site to this important study. This is an incredible achievement that demonstrates commitment and the success of multi-disciplinary team working.

The NIHR want to understand more about patient experience of clinical research taking placing in the NHS. During 2018/19 the Trust made a significant contribution to the survey by contacting our patients who have been involved in research.

A new approach to engage staff, raise awareness and improve recruitment to research was initiated in the Paediatric department. Staff were offered the opportunity to conduct both Good Clinical Practice and study specific training. This was a success in more than recruitment terms, the staff that undertook the training were really positive about the experience and feedback indicated that they now have a greater awareness of the research process and are really keen to engage with the promotion of research throughout the department and the wider trust.

In February 2019, we had a fantastic patient story that hit the local news. A five year old girl was enrolled onto the CAP-IT study, a study that helps us to understand how best to treat pneumonia in children and use antibiotics to their best effect. Her mum explained that she

had a positive experience and quoted “I would recommend anyone offered the opportunity to take part in a clinical trial to try it”. The Trust was asked to recruit 10 participants to this study but went onto recruit more, demonstrating the hard work of the Consultant (Principal Investigator) Dr Sharyn Gardner and the Research Nurses involved in the study.

A new approach to engage staff, raise awareness and improve recruitment to research was initiated in the Paediatric department. Staff members were offered the opportunity to conduct both Good Clinical Practice and study specific training. This was a success in more than recruitment terms, the staff that undertook the training were really positive about the experience and feedback indicated that they now have a greater awareness of the research process and are really keen to engage with the promotion of research throughout the department and the wider trust.

For the third year running the Trust has exceeded its target of 200 for recruitment to NIHR Portfolio studies. In particular 2018-19 has been an exceptional year as demonstrated in the graph below:

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 2018/19 was met.

SOHT have increased their research participation by promoting Research to staff and Patients via:

- Social media, and regularly posting good new stories on the SOHT Facebook and Twitter
- Library Services
- Training and Education

International Clinical Trials Day is celebrated around the world, on or near 20th May each year, to raise awareness of the importance of clinical trials for advances in research and healthcare. In May 2018, the research team celebrated with a stall promoting the campaign. This was a great opportunity to promote clinical research trials and let patients, staff and the public know more about the research trials on offer at our Trust.

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.

Service Developments

We have been working on improved depth of coding with support from the Clinical Engagement Manager to ensure the complexity of patients' illnesses is appropriately reflected. This has led to a sustained improvement in the accuracy of our information and will reflect in future mortality scores.

Better clinical engagement with IT – the current Wi-Fi upgrade, for example, will improve and stabilise access to mobile clinical systems.

Red2Green - getting patients home who no longer need hospital care is key to having beds available for people who urgently do. Whether that's preventing admissions or accelerating discharge of medically fit patients, we need to work closer than ever with our local NHS partners to achieve this

The Trust has spent over £1m on new medical equipment in 2018/19 and plans to spend an additional £6m over the next five years. This year's purchases include:

- Gastroscope £162,000
- Orthopaedic saws/drills £131,000
- Cardiology cart £57,000
- 40 volumetric pumps and battery packs £70,000
- IOL ophthalmology machine £37,000

- Orders in progress include replacement of all 30 anaesthetic machines with newer models; replacement of all hydraulic couches in Outpatients at both hospitals; and new drills for Maxillofacial.

The management and administration of recruitment has now moved back to the Trust from St Helens & Knowsley. From Monday 25 March 2019, all recruiting activity will take place within the Trust and this should create a more efficient process.

Getting It Right First Time (GIRFT) is now underway for orthopaedics and ophthalmology. The aim of GIRFT is to deliver improvements in clinical quality and process by reducing variation in practice and making sure patients get the best care. We want to do this at pace but be sure it's sustainable in the long-term. GIRFT is a key plank of creating a regional hub for routine planned care at Ormskirk hospital, one of the four themes of the Trust's Vision 2020 corporate strategy.

Congratulations to Rahul Mistry's team for being the first hospital in Lancashire to use a new steam treatment for men with benign prostate enlargement known as the Rezum procedure. It is a minimally invasive treatment and can be done under local anaesthetic without the need for an overnight hospital stay. Treatment is completed in less than 10 minutes, compared to up to two hours and a one or two-night stay in hospital previously. Their symptoms are expected to improve more quickly than with standard treatment.

Lastly we launched a new menopause clinic with Dr Paula Briggs. To help promote this service, two pop up menopause café events for the public have been held and both were very well attended.

Performance Improvements

We have some good news to report on performance management with some of the key highlights listed below:

- Diagnostics – there is targeted improvement work within x-ray focusing on specific modalities e.g. CT, MRI, non-observations ultrasound and ECG
- We have seen month-on-month improvements in our staff undertaking their mandatory training and have achieved the Trust's target
- Outpatients – a focus on increasing activity has seen improved clinic utilisation as we have been able to see more patients
- In Ophthalmology we have increased the numbers of patients on each list to six
- Our 'Did Not Attend' rate has reduced to 6.5%, so we have fewer patients missing appointments. The national average is 8%
- 14 Day Cancer target – our "What a Difference A Day Makes" initiative is seeing continued improvements in the tumour groups for our 14 day performance by focusing on a seven day pathway for patients. We aim to ensure that patients wait no long than seven days between each stage in their pathway
- Our Reducing Avoidable Mortality Project can demonstrate month-on-month improvements
- We have been rated as the top performing Emergency Department in the region

Staff Engagement

Ongoing executive team visibility has been a focus. We launched a '*Straight to Silas'* email inbox for staff to confidentially raise issues; an executive 'breakfast forum' which is open to all staff, and monthly 'back to the floor' shifts. This creates various mechanisms for staff to get to know the executive team and feel confident to speak up at all times

To recognise and reward staff, we launched *Thanks a Bunch* monthly staff awards in September. Individuals or teams can be nominated by their peers, across both sites. A thank you card and gift is delivered by a member of the executive team to each winner, each month.

New-look 'Time to Shine' staff awards were held in October, in Formby Hall for the first time. The event continues to be a popular way to recognise hard work from staff and teams who consistently go the extra mile. We will hold the awards again this year on 18 October.

A staff Facebook group, The Meeting Place, now has over 1,100 members after launching just over one year ago. The group is a lively ground for debate, with staff seeing it as a safe place to air their views. It is also very supportive with people across all levels sharing good news**.**

We appointed a Freedom to Speak Up Guardian as part of our work to create cultural change. We want to create a more open, honest and inclusive atmosphere.

Last September saw our first **Open Day** in seven years, which was well received by staff and visitors. One hundred staff members have started **apprenticeships**, far out-performing other local Trusts. We signed up for 'working with' status with the **Cavell Trust**, to provide better support for nurses, midwives and Health Care Assistants (HCAs) who might be struggling financially due to unforeseeable life events.

SOProud Week - in January saw staff invited to talk about their work with pride. During the week we hosted a visit from Roy Lilley, Health Policy Analyst. Roy toured both sites and was very well received by all.

An increased focus on wellbeing saw the launch of free, **weekly staff yoga sessions**. Staff members are being asked to suggest other ideas to support their wellbeing, in a way that works around their shift patterns. Other ideas in the pipeline are quick hand and head massages during break times for ward staff.

Staff Achievements and Awards

In September 2018 we introduced the monthly Thanks a Bunch award. This has proved extremely popular with over 80 nominations made and 11 winners already including:

- Spinal therapies team who moved out of their space to make way for Ward One during winter escalation
- Mandy Williams and Suzanne Clarke who arranged the Christmas craft fair, also from the spinal unit

- Richard Boydell and Jason Burge – information and IT respectively at Southport
- The entire team on ward 15b
- Ann McMaster and Laura Price from the children's department
- Sharon Wynne from Southport theatres
- Elaine Lloyd at Ormskirk
- Albie Houghton who recently retired after a long service on EAU

Further, Helen Hurst, Matron of Planned Care and Paul Jebb, Deputy Director of Nursing, Midwifery and Therapies (Quality) have been recognised by the Cavell Trust for going above and beyond. In March 2019 our hospitality and medical admin teams won Apprenticeship Star Awards at Southport College.

Tony Carson has been shortlisted in the Student Nursing Times Awards in the trainee nursing associate category – good luck Tony! And our Paediatric diabetes team has been shortlisted in the prestigious HSJ Value Awards 2019 for Diabetes Care Initiative of the Year - good luck team!

The discharge and transfer lounge opened in the summer, helping with patient flow and creating a better patient experience. Finally, we opened a new day surgery unit at Ormskirk, a quiet room also at Ormskirk named the 'Chillaxation Room' for young patients needing a calming environment, a new-look café at Southport and opening this month, a new sexual health clinic in Bootle.

2.1.16 Information Governance

During the period the Information Governance (IG) team made a concerted effort to improve the Trust's IG training provision as well as update and improve the policies and procedures underpinning Information Governance within the Trust.

Information Governance training is now a standing item on all Corporate Induction programmes. Classroom sessions are given monthly as part of the '*You Choose'* training events. A bespoke IG training session for facilities staff is now being delivered to accommodate their service needs. The eLearning Data Security Awareness session is also actively promoted as is the Information Governance Handbook. Information Governance Training is available at Southport and Ormskirk NHS Hospital Trust as a classroom, eLearning or training booklet in order to suit the different learning methods, staff availability and service requirements.

All the Information Governance training include 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.

Information security-related incidents are reported via the Trust's incident reporting system. Incidents are reviewed by the Information Governance Steering Group which is chaired by the Senior Information Risk Owner (SIRO). Where an ongoing information risk is identified, it 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 2018 to March 2019 of which six were reported to the Information Commissioner's Office (ICO).

The first incident related to the alleged theft or loss of four work diaries from a locked room which contained information relating to a number of patients. It was reported to the ICO on 15 June 2018 but no response was received. Since the incident the Information Governance team conducted two audits on the area and in both instances the preventive measures that were put in place were found to be adequate.

The second incident involved discharge records being given to the wrong patient. That incident was reported to the ICO on 29 June 2018. The records were collected and the patients were provided with an apology.

The third incident was reported to the ICO on 12 July 2018 and related to the disclosure of patients' medical records of another patient. The information was retrieved and an apology given.

The fourth incident was reported to the ICO on 26 July 2018 and involved a box of patient notes being lost in transit by Royal Mail. The box was sent by registered post to a solicitor, the box arrived at the solicitor's office but the contents were missing. The Royal Mail Investigation Team could find no trace of the notes.

The fifth incident involved the disclosure of two patients' medical notes to another patient as part of a complaint. It was reported to the ICO on 23 August 2018.

The sixth incident involved the disclosure of the administrator's username and password to the Doctors' Applicant Portal to successful applicants, the portal is used by Human Resources to administer the portal for registration by new doctors. Ten doctors received the administrator's details but after an investigation conducted by the Information Governance Manager, it was confirmed that none of the doctors involved had accessed the portal. The incident was also reported on 13 December 2018 to the ICO which declared it closed on 8 January 2019.

In August 2018 the Trust was the subject of a voluntary audit conducted by the ICO. As a result of the audit an action plan containing thirty-four actions was created. In December 2018 the ICO carried out a follow up audit and published their report on the ICO website. The report found that *'The Trust had made meaningful progress to or completed all the actions agreed in the original audit'.*

2.1.17 Annual Quality Report

Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 review of information available to the Trust has been undertaken, as well as a quality care service review to agree quality priorities for the coming year, this has involved service users, carers, staff and partner agencies

- 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 improvement Strategy and reflected the priorities of the Trust highlighted within Vision 2020. These measurable goals, against which progress can be monitored, are overseen by the Quality and Safety Committee.

The Director of Nursing, Midwifery and Therapies 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.

Mazars, our external auditors, undertake 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, 2018/19, 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's work commenced in October 2017. Each Pledge Group met bi-monthly. The groups are led by the matron for patient experience. 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.

The Trust is committed to continued quality improvement with the Reducing Avoidable Mortality Project and the Mortality Operational Group which are led by the Associate Medical Director for Patient Safety and the Trust's Programme Office.

Mortality data is reported each month to the Quality and Safety Committee and the Trust Board for assurance along with progress updates on the Reducing Avoidable Mortality Project.

The Trust rolled out the Structured Judgement Review (SJR) Method in 2018 to ensure comprehensive learning from deaths activity; quarterly reports for which are again submitted via the governance reporting structure for assurance.

In 2018, the Trust commissioned an External Mortality Review which, using the SJR method identified areas requiring improvement. As a result, workshops were held with key stakeholders from across the organisation to design a responsive action plan.

The current live action plan will be subsumed into the Reducing Avoidable Mortality Project, Phase 2 (April 2019 – March 2021) which will continue to drive quality improvement around the management deteriorating patient.

During 2018 / 2019 we aimed to reduce our number of caesarean sections which we have successfully achieved.

Indicator Name	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Month Trend	YTD 18/19	YTD Target
Maternity - Caesarean Rates - Overall	23.9%	23.56%	21.59%	27.17%	29.67%	23.91%	23.76%	17.48%	29.44%	23.08%	33.81%	27.43%	30.48%		%	24.%
Maternity - Caesarean % - Elective	8.81%	10.34%	12.5%	15.03%	14.84%	12.5%	10.4%	11.17%	17.78%	13.74%	18.1%	14.86%	17.65%		%	12.5%
Maternity - Percentage of Elective C-Sections <39 Weeks	28.57%	44.44%	59.09%	42.31%	25.93%	26.09%	22.22%	26.09%	25.%	36.%	18.42%	30.77%	15.15%		%	30.3%
Maternity - Caesarean % - Emergency	15.09%	13.22%	9.09%	12.14%	14.84%	11.41%	13.37%	6.31%	11.67%	9.34%	15.71%	12.57%	12.83%		%	######

For 2018/2019 the year to date caesarean section rate is 26.15% compared with 24.3% at the end of March 2018.

For the year to date instrumental birth rate is 9.82% compared with 13.18% at the end of March 2018.

We continue to monitor our caesarean section rates and assisted delivery rates which are in line with the national rates.

We contribute to benchmarking via the regional maternity dashboard

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 2019/20 have been developed in line with the Trust's Quality Improvement Strategy and include:

- *Care of the Deteriorating Patient*

- *Care of Older Adults*
- *Infection Prevention and Control*
- *Medicines Management*

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.

2.1.18 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 in Monitoring Finance

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 in Relation to Finance Management

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 in Relation to Finance Management

As stated above *The Finance, Performance and Investment Committee* has 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.

2.1.19 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 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 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 Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system that 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.

- The establishment of a Risk and Compliance Group whose purpose is to promote effective risk management, regulation and compliance and to maintain a dynamic Board Assurance Framework, risk registers and compliance and regulatory registers through which the Board can monitor the arrangements in place to achieve a satisfactory level of corporate integrated internal control, safety and quality.

- The Group promoted local level responsibility and accountability and challenged risk assessment and risk assurance arrangements in areas of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement

- A programme of Risk Management training for all staff

- A number of external reviews were commissioned to ensure that corporate governance and performance were more robust. These included:

    - A Rapid Review of Governance undertaken by EY resulting in the establishment of a Hospital Management Board, Hospital Improvement Board, Performance Review Boards where CBUs are held to account and an updated Integrated Corporate Governance Structure as shown above
    - Nurse Staffing/e-Roster plus Estates and Facilities review which focused on delivery of CIPs in E&F and roll out of rostering on wards

- The Internal Audit Plan which is risk based and 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 twice 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 plans and concerns relating to Well Led and any subsequent Care Quality Commission inspection. Members of the Clinical Business Units' (CBUs) Triumvirate are invited and in attendance at the Thursday meeting to give update reports on performance issues in the CBUs.

- The Board and its statutory and assurance committees have clear cycles of business and reporting structure to allow issues to be escalated via the *'floor 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 is summarised 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.

During the year a Well Led Review led by Advancing Quality Alliance (AQuA) and Mersey Internal Audit Agency (MIAA) was undertaken by the Board in preparation of a planned inspection by the Care Quality Commission later in the year. The CQC published its last full report in March 2018.

Work is continuing 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'.*

2.1.20 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 2018-19, 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:

Moderate Assurance can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk

2.1.21 Conclusion

Over the course of the year the Trust's system of internal control has highlighted shortcomings in a number of areas, all of which are being addressed. The Core Services Review undertaken in December 2018, highlighted areas of good practice and governance structures have been strengthened to ensure that the monitoring of and assurances received from the Quality Improvement Plan demonstrate that there is a clear route from Ward to Board as illustrated above.

Because the Trust is a challenged provider, a number of support personnel have been put into the Trust by the regulator to enhance quality and safety service delivery. They also support financial governance including cost improvement. This necessitated the services of a Turnaround Director. These additional support systems and personnel have resulted in enhanced practices and positive outcomes.

Notwithstanding the challenges we faced I believe we have demonstrated that the system of internal control itself has proved to be robust and has been further strengthened in the period as outlined in this Statement. I can confirm that within NHSI's definition of *significant internal control issues* the Trust, although it experienced a number of internal control issues during the period, none of them came under the definition of *significant.*

Accountable Officer:

Silas Nicholls

Chief Executive

Date: 22 May 2019

2.2. 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 2018/19 of the Audit Committee is set out below:

2.2.1 Work of the Audit Committee during 2018/19

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 Handbook. Its responsibilities are described in terms of reference; these were reviewed in April 2018 and are available on the SOHT website:

Membership and Meetings

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
Mr David Bricknell	Member from March 2018

Table 11

Brief biographical sketches of members including any declared interests are available on the Trust website and above in this report.

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

The Committee met four (5) times during the year including a special meeting in May to review the end of year documents. Attendance at the meetings is recorded below:

Audit Committee Attendance 2018/19												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
G Clarke (Chair)	✓	✓		✓			✓			✓		
J Birrell	✓	✓		✓			✓			**A**		
D Bricknell		✓		✓			✓			✓		
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
S Shanahan	✓	✓		✓			**A**			✓		
K Walsh	✓	✓		✓			✓			✓		
A Charles	✓	✓		✓			✓			✓		
G Murphy	✓	✓					✓			✓		
J Cosgrove		**A**		✓			**A**			✓		
M Wilson		✓										
S McGrath		✓										
J Royds		✓										
J Mahajan		✓										
J Gorry		✓										
R Fraser		**A**										
P Gibson		**A**										
G Singh		**A**										
S Nicholls		**A**										
T Patten		**A**								✓		
A Davenport										✓		
P McEvoy										✓		
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Mazars:												
C Waddell	**A**	✓					✓					
K Murray							✓			✓		
N Hallas							**A**					
M Carberry		✓					**A**					
J Hornsby	✓	✓		✓			**A**					
M Dalton							**A**					
D Watson										**A**		
MIAA:												
A Poll	✓	**A**		✓			✓			✓		
S Connor	✓	**A**		✓			**A**			**A**		
Anti-Fraud:												
P Bell	✓	**A**					✓			**A**		
A = Apologies ✓ = In attendance, - = No response												

Table 12

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 attended 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 2018 to present the Annual Governance Statement.

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

2.2.2 Board Governance Arrangements

There are three (3) statutory Board committees: Audit; Remuneration and Nominations and Charitable Funds. There are three Board assurance committees: Finance, Performance and Investment (FP&I); 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 Audit Committee

The Committee has an annual work plan (business cycle), developed from its terms of reference. In 2018/19, 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

The Committee 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 2018/19.

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.

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.

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 Reservation and 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 were reported directly to the FPI and via an Alert, Advise & Assure (AAAs) report to the Board. The Committee agreed that the new comprehensive report would strengthen the assurance provided on financial control. It was presented four times a year.

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

The Committee also followed up progress against issues it had identified in 2017/18 including medical job planning. It noted that management had focused on improving compliance with mandatory training (to limit risk and maintain safe working practice).

2.2.3 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 (FTSU) 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.

2.2.4 Internal Audit

MIAA was appointed as internal auditors in March 2017 and remained as internal auditors for 2018/19. A draft risk-based work plan for the coming year was approved in May 2018.

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.

The Committee referred some reports to other committees and the Board for a more in-depth discussion.

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 2019/20.

2.2.5 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.

2.2.6 External Audit, Review of Financial Statements and Annual Reports

In September 2018, the Committee reviewed and agreed the external audit plan with Mazars and received quarterly progress reports and briefings throughout the year.

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.

The final audited accounts received 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.

The Committee recommended the 2017/18 Annual Report and Accounts and the Quality Accounts to the Board for approval.

2.2.7 External Audit Tender

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.

The Committee will assess the auditors' work in July 2019 to ensure that the work is of a sufficiently high standard and fees are reasonable

2.2.8 Non-Audit Work

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

2.2.9 Evaluation and Assessment and Briefings

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.

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

2.2.10 Looking Forward to 2019/20

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 user friendly way to the Committee and Board.
- Contribute to the Trust's agreement of a Risk Appetite
- Strengthen corporate governance arrangements within 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 General Data Protection Regulation (GDPR)
- Review processes that relate to the raising concerns policy
- 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 at least once per year using an internal bespoke Tool for mid-year assessment and via an externally facilitated process at the end of the year.

2.2.11 Conclusion

Southport & Ormskirk Hospital NHS Trust's System of Governance

The Committee is of the opinion that the information in this report and the reports provided to the Board throughout 2018/19 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, Company Secretary, for their support. It also acknowledges the support given by external audit.

The Audit Committee shall review the Annual Report, the Annual Governance Statement and Financial Statements before submission to the Board, focusing particularly on:

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

Chair of Audit Committee, Ged Clarke

2.2.12 Business of the Quality and Safety 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 2018/19												
Core Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Mrs Julie Gorry **(Chair)**	**A**	✓	**A**	✓	✓	✓	**A**	✓		✓	✓	**Meeting cancelled**
Mr Jim Birrell	✓ **Chair**	✓	✓	✓	✓	✓	✓	✓		✓	✓	
Mrs Juliette Cosgrove		✓	**A**	✓	✓	✓	**A**	✓		✓	✓	
Mr Rob Gillies	**A**	**A**	**A**	**A**	**A**							
Dr Jugnu Mahajan	✓	✓	✓	**A**	✓	✓	✓	✓				
Mr Gurpreet Singh		**A**	✓	✓	✓	✓	✓	✓		✓	✓	
Mrs Therese Patten	✓	✓	**Attends QSC Quarterly**				✓	✓		✓	✓	
Members in Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	
Mr Audley Charles	**A**	**A**	✓	**A**	**A**	✓	**A**	**A**		✓	✓	
Mr Steve Christian			**A**	✓	**A**	**A**	✓	**A**		✓	✓	
Mrs Carol Fowler	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**				
Dr Chris Goddard	✓	✓	✓	✓	**A**	✓	✓	✓		**A**	**A**	
Mrs Gill Murphy	✓	✓	✓	✓	✓	**A**	✓	**A**		✓	✓	
Mrs Mandy Power	✓	✓	✓	✓	✓	✓	✓	✓		**A**	**A**	
Mrs Jan Ross	✓	**No longer a member of QSC & left Trust**										

Mrs Jane Royds (Non-voting)	✓	✓	✓	✓	✓	A	✓	✓		No longer a member of QSC		
Ms Jo Simpson	A	A	✓	A	A	A	A	✓		A	A	Meeting cancelled
Mr Kevin Thomas	✓	A	A	A	A	✓	✓	✓		A	✓	
Others in Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	
Mrs Caroline Griffiths	✓	✓	✓	✓	✓	✓	✓	A		✓	✓	
Mrs Michelle Brocklebank *(Committee Secretary)*	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	
Mrs Fiona Barnes	✓	✓	✓	✓	✓	✓	A	A		✓	✓	
Mr Paul Jebb	✓	✓	✓	✓	✓	✓	✓	✓		A	✓	
A = ***Apologies*** ✓ = ***In attendance*** **D** = ***Deputy***												

Table 13

2.2.13 Business of the Finance, Performance and Investment Committee

The Finance, Performance and Investment Committee has 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 2018/19												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
J Birrell (Chair)	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
D Bricknell		✓	✓	✓	A	✓	✓	✓		A	✓	✓
G Clarke	✓	A	A	✓	A	A	A	A		A	A	A
J Gorry	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	A
S Christian/J Farley		✓	✓	✓	✓	✓	✓	✓		✓	✓	A
J Mahajan	A	✓	✓	A	✓	✓	✓	✓				
S Nicholls (ex officio)	✓	A	✓	✓	✓	✓	✓	A		✓		
T Patten	✓	✓	✓	A	✓	✓	✓	✓		A	✓	✓
J Royds	✓	✓	✓	✓	✓	✓	✓	✓				
S Shanahan	✓	✓	✓	✓	A	✓	A	✓		✓	✓	✓
T Hankin										✓	✓	A
In Attendance												
A Charles	A	A	A	A	✓	✓	✓	A		✓	✓	✓
M Lightfoot	✓	✓	✓	✓	✓	✓	✓	A		✓	✓	S
K Walsh	✓	A	✓	✓	✓	✓	✓	✓		✓	✓	A
A Davenport				✓	✓	✓	✓	✓		✓	✓	✓
J Farley				✓								
J Roberts					✓	✓	✓	A		✓	✓	✓

J Cosgrove/ F Barnes						✓	✓	✓		✓	✓	
K McNaught					✓			✓		**A**	✓	**A**
A = Apologies ✓ = In attendance, S – sickness absence - = Did not attend												

Table 14

2.2.14 Business of the Workforce Committee

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 2018/19												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
(Chair) Pauline Gibson	**A**	✓	Meeting Cancelled	**A**	Meeting Cancelled	✓	**A**	✓	No Meeting Scheduled	✓	**A**	✓
Ged Clarke	✓											
David Bricknell		✓		✓		✓	✓	✓		**A**	✓	✓
Jim Birrell	✓											
Gurpreet Singh		**A**		✓		✓	**A**	✓		**A**	**A**	**A**
Tracy Gunn	✓	✓		✓		✓	✓	✓		✓	✓	**A**
Helen Baythorpe	✓	✓		**A**		**A**	**A**	**A**		✓	**A**	✓
Jacqui Flynn	**A**	**A**		**A**		**A**	**A**					
Joan Carter								**A**		**A**	**A**	**A**
Joanna Stark	✓	✓		✓		**A**	**A**	✓		**A**	**A**	✓
Audrey Cushion	✓	✓		✓		✓	✓	**A**		✓	✓	✓
John Flannery	✓	✓		✓		✓	✓	✓		✓	✓	✓
Henry Gibson	✓	✓		**A**		**A**	**A**	**A**		✓	**A**	**A**
Laura Hilton	✓	✓		✓		✓	**A**	**A**		**A**	✓	✓
Linda Lewis	✓	✓		✓		✓	✓	**A**		**A**	✓	✓
Juliette Cosgrove		✓		**A**		**A**	**A**	**A**		**A**	**A**	**A**
Gill Murphy	**A**	**A**		✓		**A**	**A**	**A**		**A**	**A**	**A**
Carol Fowler	**A**	✓		**A**		**A**						
Fiona Barnes							✓	✓		✓	✓	✓
Therese Patten	✓	**A**										
Steve Christian				**A**		**A**	**A**	**A**		**A**	**A**	**A**
Karen Chazen	✓	✓										
Robert Davies							✓	✓		✓	✓	✓
Jane Royds	✓	✓		✓		✓	**A**	✓		✓	**A**	✓
Steven Treadgold	**A**	**A**		**A**		**A**	**A**	**A**		**A**	**A**	**A**
Simon Williams	**A**	✓		✓		✓	**A**	✓		✓	✓	✓
A = Apologies ✓ = In attendance												

Table 15

2.2.15 Business of the Charitable Funds Committee

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 2018/19												
Members:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)							✓					
Neil Masom (Chair)							✓					✓
Julie Gorry							✓					✓
Steve Shanahan							✓					✓
In Attendance:												
Kevin Walsh							✓					✓
Mark Wilson							✓					✓
Suzanne McGrath							✓					

John Willis, Quilters							✓					✓
A = Apologies, ✓ = In attendance												

2.2.16 Business of the Remuneration and Nominations Committee

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

- seek any information it requires from any employee of the Trust in order to perform its duties as set out below
- obtain, within the limits set out in the Trust's *Scheme of Delegation*, outside professional advice on any matter within its terms of reference
- 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 and Nominations Committee Attendance 2018/19												
Members:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)		✓	✓			✓	✓					
Neil Masom (Chair)										✓		
Jim Birrell		✓	✓			✓	✓			✓		
David Bricknell		✓	✓			✓	✓			✓		
Ged Clarke		✓	✓			✓	✓			✓		
Pauline Gibson		✓	✓			✓	✓			✓		
Julie Gorry		✓	✓			✓	✓			✓		
Gurpreet Singh		✓	✓			✓	✓			**A**		
A = Apologies, ✓ = In attendance, - = No response												

Table 17

2.3 The Directors' Report

2.3.1 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 - left November 2018

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.

Neil Masom

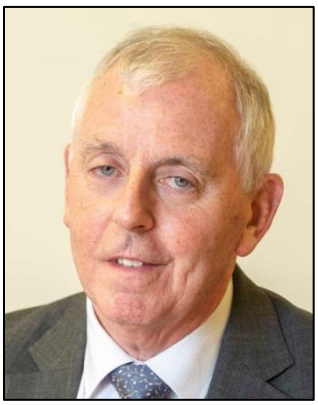
Chair of the Board of Directors; Chair of Remuneration and Nominations Committee, Chair of Charitable Funds

Appointed December 2018

An engineer by profession, Neil Masom OBE began his career with the former Hawker Siddeley Aviation aircraft company in 1977 before going on to gain more than 30 years' experience with BAE Systems, primarily in Manchester and Lancashire, holding three managing director posts at the company between 2000 and 2009.

He has held and continues to perform a number of non-executive posts, including as chairman of the Foreign and Commonwealth Office Services Organisation (2000-2006) and as a non-executive director at East Cheshire NHS Trust in Macclesfield (2009-2013).

He is currently senior independent director at WYG plc, a successful international engineering consultancy, and was for four years audit committee chair at HS2 Limited, the company responsible for designing and building the UK's new high-speed rail network.



Jim Birrell

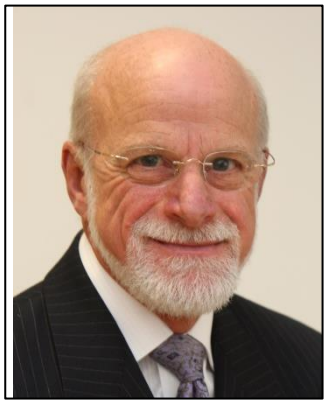
Non-Executive Director; Chair of Finance, Performance and Investment Committee

Appointed July 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.



David Bricknell

Non-Executive Director; Member of Finance, Performance and Investment Committee & Audit Committee

Appointed April 2018

A solicitor by profession, David Bricknell's career has embraced the public sector in a variety of roles, including as a non-executive director at the Liverpool Heart and Chest Hospital NHS Foundation Trust.

He held a number of legal and company secretarial posts including Group Legal Advisor and Company Secretary at Pilkington plc. He holds a directorship at The World of Glass, St Helens, and has a PhD in strategic decision-making.

Ged Clarke

Non-Executive Director; Chair of Audit Committee

Appointed May 2016 - left April 2019

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.

Pauline Gibson

Designate Non-Executive Director; Chair of Workforce Committee

Appointed July 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 & Safety Committee until January 2019. Member of the Committee.

Appointed August 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.

Gurpreet Singh

Non-Executive Director; Member of Quality & Safety Committee and Workforce Committee

Appointed April 2018

Gurpreet Singh is a former Trust surgeon and has more than 25 years' experience in general urology. He has been an executive member for The British Association of Urological Surgeons where he helped write the curriculum for functional and neuro-urology.

He has been the chair of the surgical speciality group for Urology for the Royal College of Surgeons, Edinburgh, leading on patient safety and training. He has an active research interest, predominately clinical, with more than 150 peer-reviewed publications.

Executive Directors

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.

Therese Patten
Chief Operating Officer/ Director of Strategy/Deputy Chief Executive

Appointed October 2016 as Chief Operating Officer and appointed Director of Strategy & Deputy CEO October 2018

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.

Steve Shanahan

Executive Director of Finance

Seconded to the Trust November 2015 and made substantive August 2016

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.

Terry Hankin

Executive Medical Director

Appointed January 2019

Dr Terry Hankin joined the Trust from St Helens and Knowsley Teaching Hospitals NHS Trust where he was deputy medical director for five years. He was also the Responsible Officer and Medical Director for the Lead Employer Organisation.

In these roles he gained extensive experience of supporting and managing clinicians in the workplace. He has a proven record in improving patient care, and as an active critical care physician and anaesthetist has a clear understanding of the challenges of the clinical workplace.

As Medical Director for the Lead Employer, he worked with the HR team and contributed to the development of an outstanding team managing more than 5,000 trainees.

Dr Hankin is dedicated to improving patient care and supporting the both the medical, nursing and the wider workforce in delivering such improvements. He has a particular affiliation with Southport hospital having completed some of his training there.

Steve Christian
Chief Operating Officer

Appointed October 2018

Steve Christian returns to the Trust from NHS Improvement where he was the Regional Director of Improvement. His appointment follows a secondment to the post during the summer of 2018.

Steve lives locally and is a former Trust operational manager. He brings a wealth of experience and recently led the Action on A&E programme across the North of England.

Juliette Cosgrove
Executive Director of Nursing, Midwifery and Therapies.

Appointed May 2018

Juliette Cosgrove has more than 30 years' nursing experience, most recently as Assistant Director of Quality and Safety at Calderdale and Huddersfield NHS Foundation Trust in West Yorkshire where she led on quality, governance and improvement.

In addition, she was a member of the North East Lincolnshire NHS Clinical Commissioning Group governing body from April 2013 and was also chair of the quality committee.

Prior to this, Juliette held a number of senior nursing posts including deputy chief nurse at Leeds Teaching Hospital NHS Trust and head of nursing quality at the former Yorkshire and Humber NHS Strategic Health Authority.

Dr Jugnu Mahajan

Interim Medical Director

Appointed January 2018 - Left January 2019

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

Director of Human Resources & Organisational Development

Appointed June 2017- Appointed Director of Human Resources & Organisational Development September 2018

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 an MA in Strategic Human Resources.

Table 18: Appointments and Attendance at Board of Directors - 1 April 2018 to 31 March 2019 (The Appointments and attendance of the Board Committees can be found in the AGS)

Board Attendance 2018/2019												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)										✓	✓	A
Richard Fraser (Chair)	✓	✓	✓	✓		✓	✓	A				
Jim Birrell	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
David Bricknell	✓	✓	✓	✓		A	A	✓	✓	✓	A	✓
Ged Clarke	✓	✓	✓	A		✓	✓	A	✓	✓	A	✓
Juliette Cosgrove			✓	✓		✓	✓	✓	✓	✓	✓	✓
Julie Gorry	✓	✓	✓	✓		A	✓	✓	✓	✓	✓	✓
Dr Terry Hankin										✓	✓	✓
Dr Jugnu Mahajan	✓	✓	✓	✓		✓	✓	✓	✓			
Silas Nicholls	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Therese Patten	✓	✓	✓	✓		A	✓	✓	✓	✓	✓	✓
Steve Shanahan	✓	✓	✓	✓		✓	✓	A	✓	✓	✓	✓
Gurpreet Singh	✓	✓	✓	✓		✓	✓	✓	✓	A	✓	✓
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓	✓	A	A		✓	✓	✓	✓	✓	✓	✓
Audley Charles	✓	✓	A	✓		✓	✓	✓	✓	✓	✓	✓
Steve Christian			A	A			✓	✓	✓	✓	✓	✓
Jane Royds	✓	✓	A	✓		✓	✓	✓	✓	✓	✓	✓
A = Apologies ✓ = In attendance, - = No response												

Table 18

2.3.2 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:

NHS
Southport and Ormskirk Hospital
NHS Trust

Register of Interests Declared by the Board of Directors 2018/2019

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 July 2017** **Updated 25 September 2017**
BRICKNELL, Dr David	Non-Executive Director	**Pilkington Family Trust** **St Joseph's Hospice** **The World of Glass** **Pilkington Glass Collection**	**Nil**	**Nil**	**Director, St Joseph's Hospice** **Director, Pilkington Family Trust**	**Director, St Joseph's Hospice**	**Nil**	**Nil**	**Nil**	**9 April 2018**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
CHRISTIAN, Mr Steven	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**28 June 2018**
CLARKE, Mr Ged	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Kinsella Clarke Chartered Accountants. A number of Trust's Medical Consultants are clients.**	**1 May 2016**
COSGROVE Ms Juliette	Director of Nursing, Midwifery and Therapies, Midwifery & Therapies	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 May 2018**
FRASER Mr Richard	Chairman & Non- Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 December 2016**
GIBSON, Mrs Pauline	Non-Executive Director Designate	**Nil**	**Director, Excel Coaching & Consultancy. Provision of coaching services to**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
			Directorate and senior NHS Management personnel							
GORRY, Mrs Julie	Non-Executive Director	**Catalyst Choices C.I.C.**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**2 August 2017** **Updated 14 March 2018 & 4 May 2018**
HANKIN Dr Terence	Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 January 2019**
JUGNU, Dr Mahajan	Interim Medical Director	**Nil**	**Director of M&M Professional Consultancy Services**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**22 January 2018**
MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB**	**CQC Holdings Ltd** (manufacturer of textile	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**3 December 2018**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
		NDLM Ltd **WYG Plc**	products)							
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 April 2018**
PATTEN, Ms Therese	Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Director of Human Resources	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**30 May 2017** **Updated 25 September 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother, Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust.**	**Nil**	**Nil**	**Nil**	**25th January 2018**
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**	**Nil**	**9 April 2018**

Table 19

2.3.3 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.

2.3.4 Details of Political Donations

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

2.3.5 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.

2.3.6 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 (Operational), Quality Report, CQC reports and associated Action Plans)

2.3.7 Summary of Stakeholder Relations

SOHT operates within the Cheshire and Mersey Sustainability Transformation Partnership (STP) footprint and have positive and developing relationships 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.

The Sefton Transformation Board continued to operate during the period. 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 2019/20.

2.3.8 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.

2.3.9 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.

2.4 The Remuneration and Staff Report

2.4.1 The Remuneration Report

2.4.2 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.

2.4.3 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.

2.4.4 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 Director of Human Resources are normally in attendance.

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

- Approval of appointment of the substantive Chief Executive
- Appointment and remuneration of two Non-Executive Directors
- Appointment and remuneration of three Executive Directors
- Appointment of Company Secretary on fixed-term basis
- Approved the appointment of the Director of Strategy
- Approved the appointment of the Deputy Chief Executive
- Approved the appointment of the Director of Human Resources and Organisational Development

2.4.5 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:

		2018-2019					
Name & Title	**Note**	**Salary (bands of £5,000)**	**Expense Payments (Taxable) to nearest £100**	**Performance Pay and Bonuses (bands of £5,000)**	**Long Term Performance Pay and Bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)**	**TOTAL (bands of £5.000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
S Nicholls - Chief Executive Officer	1	175-180				5-7.5	180-185
TA Patten - Deputy Chief Executive Officer		105-110				32.5-35	140-145
S Shanahan - Director of Finance		130-135	6			2.5-5	135-140
R Gillies - Medical Director	2	100-105	9				100-105
J Mahajan - Interim Medical Director	3	110-115				100-102.5	210-215
T Hankin - Medical Director	4	40-45				2.5-5	45-50
J Cosgrove - Nursing Director	5	95-100				100-102.5	195-200
R Fraser - Trust Chair	6	20-25					20-25
N Masom - Trust Chair	7	10-15					10-15
J Birrell - Non-Executive Director		5-10					5-10
J Gorry - Non-Executive Director		5-10					5-10
P Gibson - Non-Executive Director		5-10					5-10
GJ Clarke - Non-Executive Director		5-10					5-10
DJ Bricknell - Non-Executive Director	8	5-10					5-10
G Singh - Non-Executive Director	9	5-10					5-10

For 2018/19 the Chief Executive has confirmed that only voting Board members have the responsibility for directing and controlling major activities in the organisation.

Foot Note

(1) Started 03.04.18
(2) Left 31.10.18 but had been excluded since Aug 17.
(3) Left 31.12.18
(6) Left 30.11.18
(7) Started 01.12.18
(8) Started 09.04.18

		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				45-47.5	145-150
R.Fraser - Chair		25-30					25-30
S.Shanahan - Finance Director		130-135				12.5-15	140-145
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				2.5-5	105-110
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				2.5-5	30-35

All pension-related benefits and the TOTAL have been restated in 2018/19 to correct an error in the calculation of pension benefits.

Foot Note

(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) Exluded 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

Additional notes

Expense payments relate to the benefits in kind of salary sacrifice cars and are rounded to the nearest hundred pounds.

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 2018-19 was between £175,000 and £180,000 (2017-18, £175,000 to £180,000). This was 7.1 times the median remuneration of the workforce (2017-18, 7.5 times). The median value is £24,915 (2017-18, £23,597).

The median value has increased by nearly 6% and there are two reasons for this. Firstly, in particular with lower banded staff, their pay award has been significantly more than staff in the higher bands. Secondly in headcount terms there are more staff in 2018-19 than in 2017-18.

For the pay multiple calculation this has reduced in 2018-19 because the banded remuneration of the highest paid director has remained the same but the median has increased (reasons above).

In 2018-19, 13 (2017-18, 15) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £17,460 to £266,416 (2017-18 £15,404 to £296,895).

The remuneration of each director, median remuneration of the workforce and highest paid employee figures have all been audited.

There are no off-payroll engagements of Board members for 2018/19.

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)
	£'000s	£'000s	£'000s	£'000s
S Nicholls - Chief Executive Officer	0-2.5	(2.5)-(5)	35-40	70-75
TA Patten - Deputy Chief Executive Officer	0-2.5	0-2.5	25-30	50-55
S Shanahan - Director of Finance	0-2.5	2.5-5	15-20	55-60
J Mahajan - Interim Medical Director	5-7.5	15-17.5	40-45	130-135
T Hankin - Medical Director	0-2.5	0-2.5	65-70	195-200
J Cosgrove - Nursing Director	5-7.5	10-12.5	35-40	85-90

Name & title	Cash Equivalent Transfer Value at 1 April 2018	Real increase/(decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
	£'000s	£'000s	£'000s	£'000s
S Nicholls - Chief Executive Officer	482	78	575	0
TA Patten - Deputy Chief Executive Officer	363	81	456	0
S Shanahan - Director of Finance	N/A	N/A	N/A	N/A
J Mahajan - Interim Medical Director	836	182	1,103	0
T Hankin - Medical Director	1,403	23	1,545	0
J Cosgrove - Nursing Director	521	152	706	0

N/A - 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.

The pension figures in the tables have been audited.

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 SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

2.4.6 Remuneration Policy

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

- The level of remuneration should be reflective of the responsibility of the role to which the remuneration applies;
- 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;
- The Committee should avoid remuneration which is more than necessary for the purposes set out at (a) and (b) above;
- The Committee must be sensitive to pay and employment conditions elsewhere in the Trust and external to the Trust;
- 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);

- The Committee must be able to justify any salary higher than the Prime Minister's salary of £150,402.
- 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.
- No director shall be involved in deciding his or her own remuneration;
- Where any director is involved in advising or supporting the Committee care must be taken to recognise and avoid conflicts of interest;
- 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;
- 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;
- 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.

Service contracts

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

2.4.7 The Staff Report

Staff Numbers and Costs

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	93,322	-	**93,322**	94,952
Social security costs	8,448	-	**8,448**	8,484
Apprenticeship levy	482	-	**482**	465
Employer's contributions to NHS pensions	10,624	-	**10,624**	10,440
Pension cost - other	30	-	**30**	14
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	4
Temporary staff	-	18,783	**18,783**	13,772
Total gross staff costs	**112,906**	**18,783**	**131,689**	**128,131**
Recoveries in respect of seconded staff	-	-	**-**	(332)
Total staff costs	**112,906**	**18,783**	**131,689**	**127,799**
Of which				
Costs capitalised as part of assets	115	85	**200**	252

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

2.4.8 Staff Composition

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.

2018/19 Composition by gender

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	387	332	190	489	407	207	93	1	100	4	2,370
Male	57	120	53	26	75	66	37	29		172	8	643
Grand Total	217	507	385	216	564	473	244	122	1	272	12	3,013

2017/18 Composition by gender

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

** Senior managers

2.4.9 Sickness Absence Data

	2018/19	2017/18
Staff group	**% Full-time equivalent days sickness**	**% Full-time equivalent days sickness**
Medical and Dental	1.76	1.36
Administrative and Clerical	4.77	4.51
Estates and Ancillary	7.20	7.45
Additional Clinical Services	8.85	7.37
Nursing and Midwifery Registered	5.71	6.12
Students	24.26	19.43
Allied Health Professionals	3.16	3.17
Professional Scientific and Technical	7.14	5.54
Healthcare Scientists	1.59	3.17
Average	**5.76**	**5.51**

2.4.10 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.

2.4.11 Expenditure on Consultancy

Consultancy expenditure was £281,241 (prior year £1,500,000). This was spent on procurement, the Project Management Office and turnaround consultancy support.

2.4.12 Off-payroll Engagements

For all off-payroll engagements as of 31 March 2019, 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

New off-payroll arrangements where the reformed public sector rules apply. These are for off-payroll arrangements as of 31st March 2019, for more than £245 per day and that last longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	Number
Of which …	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

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.	17

2.4.13 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								
£10,001 - £25,000								
£25,001 - 50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Totals	-	-	-	-	-	-	-	-

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	**-**	**-**

Signed as Accountable Officer of the Trust

Chief Executive: Silas Nicholls

Signed:

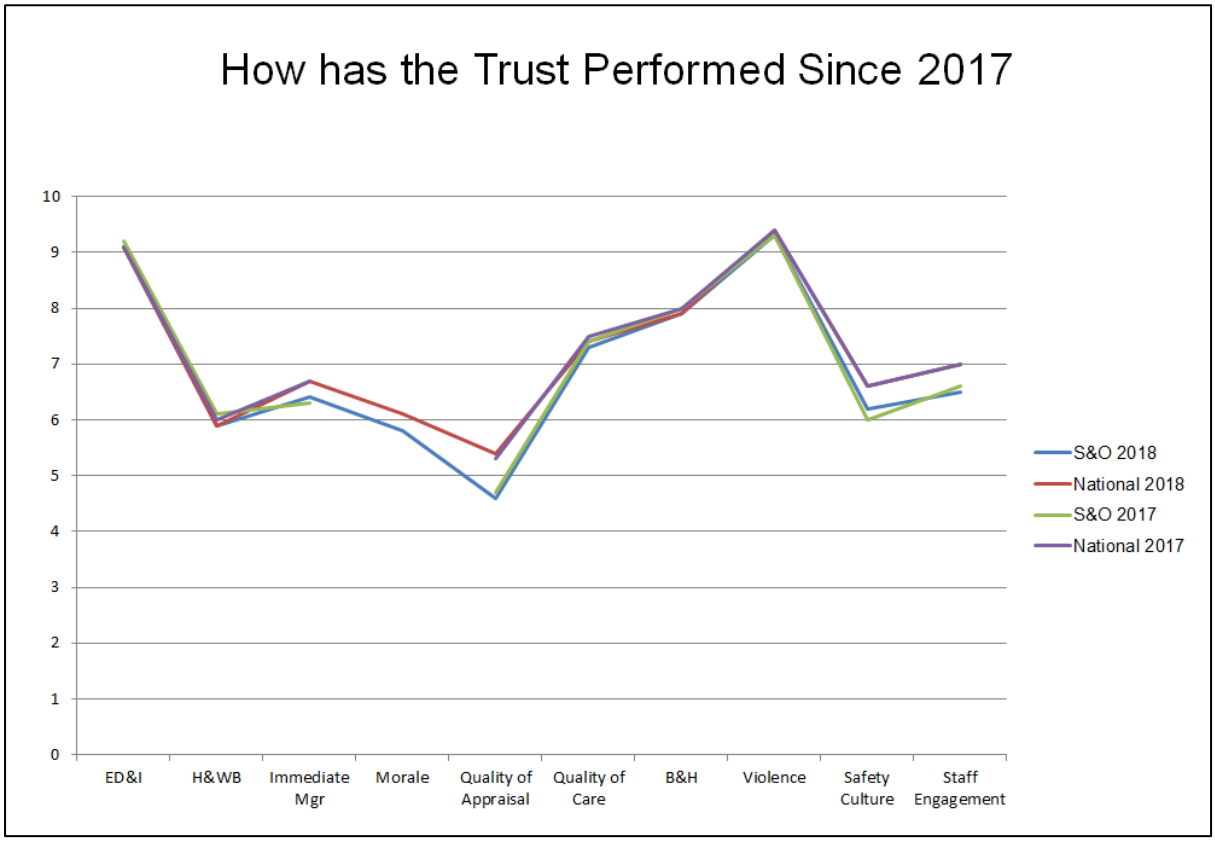
Date: 22 May 2019

2.4.14 Staff Survey Results

2.4.15 NHS Staff Survey 2018, Response Rate

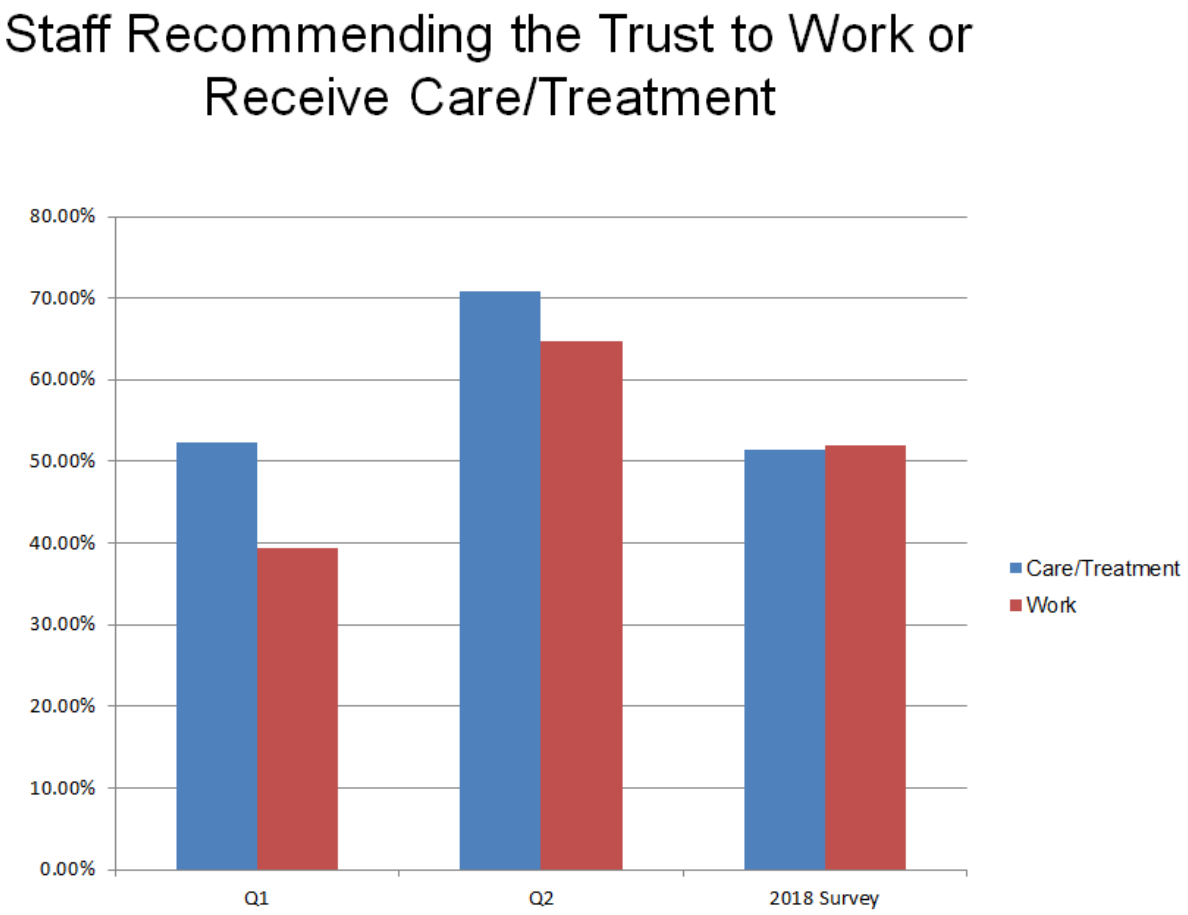
The NHS Staff Survey took place between October and December 2018 with a response rate of 40.4% equating to 1147 completed questionnaires. This was down on the response rate for 2017 which was 45.4%. This was benchmarked against 89 Acute Trusts nationally with a response rate of 44%

Table 29



2.4.16 Overall Picture

- Nationally five themes have remained static, one has gone up, three have gone down and one not scored previously.
- The Trust has six themes that have gone down, two increased, one remained static and one not scored previously.



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.....22/5/19.....

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

Opinion on the financial statements

We have audited the financial statements of Southport and Ormskirk Hospital NHS Trust ('the Trust') for the year ended 31 March 2019, which 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 interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to 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 2019 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 2018/19; 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.

Material Uncertainty relating to going concern

We draw attention to Note 1.1.2 in the financial statements, which indicates that the Trust has set a planned deficit for the year ended 31 March 2020 of £26.567m. As stated in Note 1.1.2 material uncertainties exist in relation to the availability of cash support from the Department of Health and Social Care, securing additional income from commissioners in the contracting process and delivery of the Cost Improvement Programme (CIP). 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.

Responsibilities of the Directors and the Accountable Officer for the financial statements
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 Accountable Officer is 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. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

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 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.

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

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 section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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Responsibilities of the Directors and the Accountable Officer for the financial statements
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- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required by section 21(3)(c) and 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 2019.

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.

Use of the audit report
This report is made solely to the Board of Directors of Southport & Ormskirk 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.

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.

Karen Murray
For and on behalf of Mazars LLP

One St Peter's Square
Manchester
M2 3DE
24 May 2019 .

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

.....22/5/19.....Date..... S Nicholls.....Chief Executive

.....22/5/19.....Date..... S Shanahan.....Finance Director

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	**155,816**	145,309
Other operating income	4	**12,296**	12,968
Operating expenses	6, 8	**(192,666)**	(185,545)
Operating surplus/(deficit) from continuing operations		**(24,554)**	(27,268)
Finance income	11	**48**	21
Finance expenses	12	**(4,440)**	(4,647)
PDC dividends payable		**-**	(1,085)
Net finance costs		**(4,392)**	(5,711)
Other gains / (losses)	13	**(2)**	42
Gains / (losses) arising from transfers by absorption		**-**	(693)
Surplus / (deficit) for the year from continuing operations		**(28,948)**	(33,630)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	**(3,924)**	3,135
Total comprehensive income / (expense) for the period		**(32,872)**	(30,495)
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		**(28,948)**	(33,630)
Remove net impairments not scoring to the Departmental expenditure limit		**17**	-
Remove (gains) / losses on transfers by absorption		**-**	693
Remove I&E impact of capital grants and donations		**(30)**	(66)
CQUIN risk reserve adjustment (2017/18 only)		**-**	(598)
Adjusted financial performance surplus / (deficit)		**(28,961)**	(33,601)

The adjustment in respect of donated assets removes the benefit of donated income at £170k being higher than depreciation at £140k.

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	**4,076**	5,407
Property, plant and equipment	15	**118,991**	121,383
Receivables	19	**966**	1,382
Total non-current assets		**124,033**	128,172
Current assets			
Inventories	18	**2,382**	2,454
Receivables	19	**11,678**	9,591
Cash and cash equivalents	20	**1,042**	1,079
Total current assets		**15,102**	13,124
Current liabilities			
Trade and other payables	21	**(22,771)**	(25,231)
Borrowings	23	**(22,051)**	(6,366)
Provisions	25	**(199)**	(131)
Other liabilities	22	**(1,025)**	(471)
Total current liabilities		**(46,046)**	(32,199)
Total assets less current liabilities		**93,089**	109,097
Non-current liabilities			
Borrowings	23	**(97,784)**	(81,822)
Provisions	25	**(207)**	(278)
Total non-current liabilities		**(97,991)**	(82,100)
Total assets employed		**(4,902)**	26,997
Financed by			
Public dividend capital		**98,214**	97,241
Revaluation reserve		**9,316**	13,240
Income and expenditure reserve		**(112,432)**	(83,484)
Total taxpayers' equity		**(4,902)**	26,997

The financial statements were approved by the Board on 22nd May 2019 and signed on its behalf by:

Name	Silas Nicholls
Position	Chief Executive
Date	**22 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**97,241**	**13,240**	**(83,484)**	**26,997**
Impact of implementing IFRS 15 on 1 April 2018	**-**	**-**	**-**	**-**
Impact of implementing IFRS 9 on 1 April 2018	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	**-**	**-**	**(28,948)**	**(28,948)**
Revaluations	**-**	**(3,924)**	**-**	**(3,924)**
Public dividend capital received	**973**	**-**	**-**	**973**
Taxpayers' equity at 31 March 2019	**98,214**	**9,316**	**(112,432)**	**(4,902)**

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
Prior period adjustment	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	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

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 expenditure. 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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**(24,554)**	(27,268)
Non-cash income and expense:			
Depreciation and amortisation	6.1	**6,282**	5,890
Net impairments	7	**17**	-
Income recognised in respect of capital donations	4	**(170)**	(206)
(Increase) / decrease in receivables and other assets		**(1,606)**	(1,664)
(Increase) / decrease in inventories		**72**	132
Increase / (decrease) in payables and other liabilities		**(1,033)**	3,385
Increase / (decrease) in provisions		**(4)**	(58)
Other movements in operating cash flows		**-**	(2,545)
Net cash generated from / (used in) operating activities		**(20,996)**	(22,334)
Cash flows from investing activities			
Interest received		**48**	21
Purchase of intangible assets		**(528)**	(594)
Purchase of property, plant, equipment and investment property		**(5,370)**	(3,772)
Sales of property, plant, equipment and investment property		**73**	65
Receipt of cash donations to purchase capital assets		**170**	206
Net cash generated from / (used in) investing activities		**(5,607)**	(4,074)
Cash flows from financing activities			
Public dividend capital received		**973**	1,039
Movement on loans from the Department of Health and Social Care		**31,600**	30,404
Capital element of finance lease rental payments		**(990)**	(984)
Capital element of PFI, LIFT and other service concession payments		**(737)**	(605)
Interest on loans		**(2,383)**	(1,284)
Interest paid on finance lease liabilities		**(439)**	(479)
Interest paid on PFI, LIFT and other service concession obligations		**(1,349)**	(1,100)
PDC dividend (paid) / refunded		**(109)**	(1,127)
Net cash generated from / (used in) financing activities		**26,566**	25,864
Increase / (decrease) in cash and cash equivalents		**(37)**	(544)
Cash and cash equivalents at 1 April - brought forward		**1,079**	1,623
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**1,079**	1,623
Cash and cash equivalents at 31 March	20.1	**1,042**	1,079

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 2018/19 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 the 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.

In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern. This is based on the fact that 2019/20 plans have been submitted and agreed with the Regulator, NHS Improvement (NHSI) together with a requirement from NHSI for the local system (ourselves, commissioners and other providers) to submit 5 year financial plans by Autumn 2019.

The 2019/20 plan is for a deficit of £26.567m (2017/18 £28.961m deficit). As the Trust has agreed to the NHSI control total this allows access to to the Provider Sustainability Fund (£3.464m) and the Financial Recovery Fund (£14.807m) which reduces the planned deficit to £8.296m.

There are the following uncertainties: the availability of cash support from the Department of Health & Social Care (DHSC); securing additional income from commissioners in the contracting process, and delivery of the Cost Improvement Programme (CIP).

Cash support continues from DHSC and they are deferring all principle repayments except on capital loans. Contract negotiations are progressing. In terms of the 2019/20 CIP target of £6.3m, £5.9m of schemes have been identified.

Considering the significant challenges described above which may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, and 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.

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 manual for accounts specifies that on-SOFP assets under IFRIC 12 must be shown under PFI disclosures.

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

Note 1.3 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:

Although the annual valuation of land and buildings is carried out by independent qualified surveyors their will be some estimation techniques involved including determining the percentage of obsolence, the calculation of the all in tender price index and the estimation of remaining lives. All these have an impact on the valuation of land and building assets, their remaining lives and the depreciation charge applied to assets.

The calculation of the value of partially completed spells at year-end is based on the previous 10 months data.

Provisions for early retirements are based on estimated life expectancy tables.

Public and employer liabilities are calculated using a percentage likelihood of a successful claim.

Accruals are made in the accounts, for example, in expenditure where an invoice has been received and therefore an estimated amount is put into expenditure based on past invoicing trends.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

A receivable is recognised when the services are delivered as this is the point in time that the consideration is unconditional because only the passage of time is required before the payment is due.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. It is calculated using actual coded patient data from April 2018 to January 2019. 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.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 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 1.4.3 Other income

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.

Note 1.5 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. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

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 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 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 lives.

Note 1.7.2 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. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed annually to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.

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 31st March 2019. The next full revaluation is due on 31st March 2020.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 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' cease 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'.

In applying the revaluation results, 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.

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 1.7.3 De-recognition

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 abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 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 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI 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 1.7.6 Useful lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	15	80
Dwellings	80	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	7
Furniture & fittings	10	15

Finance-leased assets (including land) are depreciated over the shorter of the useful 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 1.8 Intangible assets

Note 1.8.1 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 1.8.2 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	5	7

Note 1.9 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 1.10 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 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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 below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value trough income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.12 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 1.12.1 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 charge 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 1.12.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's 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 1.13 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 25.2 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 1.14 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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.15 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 1.16 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 1.17 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 1.18 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 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.20 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 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

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. Note that IFRS 16 leases does not apply to NHS providers until 2020/21.

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 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. In completing its segmental reporting review, these divisions are considered as segments.

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 6th March 2019. 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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Acute services		
Elective income	**17,903**	17,752
Non elective income	**66,768**	60,490
First outpatient income	**11,448**	8,336
Follow up outpatient income	**14,774**	17,502
A & E income	**11,736**	10,704
High cost drugs income from commissioners (excluding pass-through costs)	**4,727**	5,032
Other NHS clinical income **	**19,559**	18,961
Community services		
Community services income from CCGs and NHS England	**1,758**	1,757
Income from other sources (e.g. local authorities)	**3,307**	2,978
All services		
Private patient income	**83**	70
Agenda for Change pay award central funding	**2,027**	-
Other clinical income	**1,726**	1,727
Total income from activities	**155,816**	145,309

** This relates to non Payment by Results (PbR) incomefor specialist services - spinal injuries, adult critical care, neonatal critical care and for other services - rehabilitation and audiology.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	**18,959**	19,677
Clinical commissioning groups	**129,366**	119,796
Department of Health and Social Care	**2,027**	-
Other NHS providers	**756**	812
NHS other	**-**	84
Local authorities	**3,319**	3,095
Non-NHS: private patients	**83**	70
Non-NHS: overseas patients (chargeable to patient)	**65**	176
Injury cost recovery scheme	**825**	1,208
Non NHS: other	**416**	391
Total income from activities	**155,816**	145,309
Of which:		
Related to continuing operations	**155,816**	145,309

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

	2018/19	2017/18
	£000	£000
Income recognised this year	**65**	176
Cash payments received in-year	**8**	23
Amounts added to provision for impairment of receivables	**5**	1
Amounts written off in-year	**1**	97

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	**244**	224
Education and training (excluding notional apprenticeship levy income)	**6,181**	6,016
Non-patient care services to other bodies	**1,932**	2,531
Other contract income	**3,494**	3,925
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	**219**	11
Receipt of capital grants and donations	**170**	206
Charitable and other contributions to expenditure	**31**	30
Rental revenue from operating leases	**25**	25
Total other operating income	**12,296**	12,968
Of which:		
Related to continuing operations	**12,296**	12,968

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**428**

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**952**	898
Purchase of healthcare from non-NHS and non-DHSC bodies	**1,333**	1,458
Staff and executive directors costs	**131,264**	127,226
Remuneration of non-executive directors	**70**	66
Supplies and services - clinical (excluding drugs costs)	**18,096**	17,950
Supplies and services - general	**2,509**	2,268
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**8,957**	9,060
Consultancy costs	**281**	1,500
Establishment	**1,886**	1,949
Premises	**8,027**	5,395
Transport (including patient travel)	**333**	499
Depreciation on property, plant and equipment	**4,491**	4,075
Amortisation on intangible assets	**1,791**	1,815
Net impairments	**17**	-
Movement in credit loss allowance: contract receivables / contract assets	**148**	
Movement in credit loss allowance: all other receivables and investments	**-**	356
Increase/(decrease) in other provisions	**89**	41
Change in provisions discount rate(s)	**(4)**	3
Audit fees payable to the external auditor		
audit services- statutory audit **	**47**	47
other auditor remuneration (external auditor only)	**13**	11
Internal audit costs	**119**	121
Clinical negligence	**6,697**	4,925
Legal fees	**62**	35
Insurance	**213**	156
Research and development	**295**	289
Education and training	**568**	606
Rentals under operating leases	**150**	264
Redundancy	**-**	4
Charges to operating expenditure for on-SoFP IFRIC 12 schemes - PFI	**1,247**	1,568
Car parking & security	**427**	344
Hospitality	**19**	31
Losses, ex gratia & special payments	**-**	3
Other services, eg external payroll	**2,005**	1,938
Other	**564**	644
Total	**192,666**	185,545
Of which:		
Related to continuing operations	**192,666**	185,545

** 18/19 statutory audit fee was £47k. Other audit remuneration of £13k relates to the review of the quality accounts.

Note 6.2 Other auditor remuneration

	2018/19	2017/18
	£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	13	11
Total	**13**	11

Other non-audit services relates to the review of the quality accounts.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2018/19 or 2017/18.

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	**17**	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**17**	**-**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**17**	**-**

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	**93,322**	94,952
Social security costs	**8,448**	8,484
Apprenticeship levy	**482**	465
Employer's contributions to NHS pensions	**10,624**	10,440
Pension cost - other	**30**	14
Termination benefits	**-**	4
Temporary staff (including agency)	**18,783**	13,772
Total gross staff costs	**131,689**	128,131
Recoveries in respect of seconded staff	**-**	(332)
Total staff costs	**131,689**	127,799
Of which		
Costs capitalised as part of assets	**200**	252

Note 8.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £55k (£296k in 2017/18).

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

Note 9 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 for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 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.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	**25**	25
Total	**25**	25

	31 March 2019	31 March 2018
	£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.	**100**	125
Total	**225**	250

Note 10.2 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).

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	**150**	264
Total	**150**	264

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**110**	110
- later than one year and not later than five years;	**269**	377
Total	**379**	487

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	**48**	21
Total finance income	**48**	21

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	**2,664**	1,619
Finance leases	**337**	486
Main finance costs on PFI and LIFT schemes obligations	**575**	844
Contingent finance costs on PFI and LIFT scheme obligations	**863**	1,698
Total interest expense	**4,439**	4,647
Unwinding of discount on provisions	**1**	-
Total finance costs	**4,440**	4,647

Note 12.2 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 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	**-**	42
Losses on disposal of assets	**(2)**	-
Total gains / (losses) on disposal of assets	**(2)**	42

Note 14.1 Intangible assets - 2018/19

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**15,341**	**4**	**15,345**
Additions	**460**	**-**	**460**
Reclassifications	**4**	**(4)**	**-**
Valuation / gross cost at 31 March 2019	**15,805**	**-**	**15,805**
Amortisation at 1 April 2018 - brought forward	**9,938**	**-**	**9,938**
Provided during the year	**1,791**	**-**	**1,791**
Amortisation at 31 March 2019	**11,729**	**-**	**11,729**
Net book value at 31 March 2019	**4,076**	**-**	**4,076**
Net book value at 1 April 2018	**5,403**	**4**	**5,407**

Note 14.2 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	14,919	-	14,919
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2017 - restated	14,919	-	14,919
Transfers by absorption	(9)	-	(9)
Additions	411	33	444
Reclassifications	29	(29)	-
Disposals / derecognition	(9)	-	(9)
Valuation / gross cost at 31 March 2018	15,341	4	15,345
Amortisation at 1 April 2017 - as previously stated	8,135	-	8,135
Prior period adjustments	-	-	-
Amortisation at 1 April 2017 - restated	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 15.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**8,010**	**100,883**	**685**	**612**	**43,723**	**637**	**7,369**	**4,448**	**166,367**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	**-**	**1,406**	**-**	**1,076**	**2,798**	**-**	**737**	**98**	**6,115**
Impairments	**-**	**(17)**	**-**	**-**	**-**	**-**	**-**	**-**	**(17)**
Revaluations	**3**	**(6,693)**	**(14)**	**-**	**-**	**-**	**-**	**-**	**(6,704)**
Reclassifications	**-**	**1,486**	**-**	**(1,688)**	**42**	**-**	**153**	**7**	**-**
Disposals / derecognition	**-**	**-**	**-**	**-**	**(818)**	**-**	**-**	**-**	**(818)**
Valuation/gross cost at 31 March 2019	**8,013**	**97,065**	**671**	**-**	**45,745**	**637**	**8,259**	**4,553**	**164,943**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**545**	**4**	**-**	**34,248**	**491**	**5,482**	**4,214**	**44,984**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**2,227**	**4**	**-**	**1,647**	**42**	**526**	**45**	**4,491**
Revaluations	**-**	**(2,772)**	**(8)**	**-**	**-**	**-**	**-**	**-**	**(2,780)**
Disposals / derecognition	**-**	**-**	**-**	**-**	**(743)**	**-**	**-**	**-**	**(743)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**35,152**	**533**	**6,008**	**4,259**	**45,952**
Net book value at 31 March 2019	**8,013**	**97,065**	**671**	**-**	**10,593**	**104**	**2,251**	**294**	**118,991**
Net book value at 1 April 2018	**8,010**	**100,338**	**681**	**612**	**9,475**	**146**	**1,887**	**234**	**121,383**

Note 15.2 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 - as previously stated	6,899	117,402	1,191	536	41,310	637	6,906	4,421	179,302
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	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 - as previously stated	-	18,631	544	-	33,290	449	4,989	4,192	62,095
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 - restated	-	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 15.3 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	**8,013**	**80,910**	**671**	**-**	**7,148**	**104**	**2,240**	**204**	**99,290**
Finance leased	**-**	**10,649**	**-**	**-**	**646**	**-**	**-**	**-**	**11,295**
On-SoFP PFI contracts and other service concession arrangements	**-**	**4,007**	**-**	**-**	**2,295**	**-**	**-**	**-**	**6,302**
Owned - donated	**-**	**1,499**	**-**	**-**	**504**	**-**	**11**	**90**	**2,104**
NBV total at 31 March 2019	**8,013**	**97,065**	**671**	**-**	**10,593**	**104**	**2,251**	**294**	**118,991**

Note 15.4 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 16 Donations of property, plant and equipment

Southport & Ormskirk Hospital NHS Trust Charitable fund purchased plant and equipment for use by the Trust. These purchases were either made from restricted or unrestricted funds and complied with the donors wishes. Any restrictions were concerned with what the fund could be used eg. restricted for use in critical care, spinal unit etc.

The total value of donated asset additions in 18/19 was £170k split between plant & machinery £127k (medical equipment), £32k furniture and £11k on fittings.

Note 17 Revaluations of property, plant and equipment

The Trust's land and building assets were revalued effective at 31st March 2019. The valution was carried out by an independent valuation firm, Cushman & Wakefield using a modern equivalent asset valuation approach. The valuers used are all registered with RICS (Royal Institute of Chartered Surveyors).

The result was a decrease in the value of land and buildings by £3.941m. This was broken down between an impairment of £17k and a reduction in the revaluation reserve of £3.924m.

Note 18 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	**642**	587
Consumables	**1,668**	1,799
Energy	**72**	68
Total inventories	**2,382**	2,454
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £9,768k (2017/18: £10,606k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 19.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	**10,223**	
Trade receivables*		6,558
Accrued income*		550
Allowance for impaired contract receivables / assets*	**(137)**	
Allowance for other impaired receivables	**-**	(159)
Prepayments (non-PFI)	**1,120**	1,160
PDC dividend receivable	**65**	-
VAT receivable	**407**	500
Corporation and other taxes receivable	**-**	-
Other receivables	**-**	982
Total current trade and other receivables	**11,678**	9,591
Non-current		
Contract receivables*	**1,115**	
Allowance for impaired contract receivables / assets*	**(149)**	
Allowance for other impaired receivables	**-**	(194)
Other receivables	**-**	1,576
Total non-current trade and other receivables	**966**	1,382
Of which receivables from NHS and DHSC group bodies:		
Current	**8,042**	5,673

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 19.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**353**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	**353**	**(353)**
New allowances arising	**148**	**-**
Utilisation of allowances (write offs)	**(215)**	**-**
Allowances as at 31 Mar 2019	**286**	**-**

Note 19.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	317
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	317
Increase in provision	356
Amounts utilised	(320)
Allowances as at 31 Mar 2018	353

Note 20.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**1,079**	1,623
Net change in year	**(37)**	(544)
At 31 March	**1,042**	1,079
Broken down into:		
Cash at commercial banks and in hand	**79**	51
Cash with the Government Banking Service	**963**	1,028
Total cash and cash equivalents as in SoFP	**1,042**	1,079
Bank overdrafts (GBS and commercial banks)	**-**	-
Drawdown in committed facility	**-**	-
Total cash and cash equivalents as in SoCF	**1,042**	1,079

Note 20.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the 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 2019	31 March 2018
	£000	£000
Bank balances	**1**	2
Total third party assets	**1**	2

Note 21.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	**14,883**	12,307
Capital payables	**1,525**	2,021
Accruals	**3,115**	6,541
Social security costs	**53**	1,245
Other taxes payable	**1,123**	1,101
PDC dividend payable	**-**	44
Accrued interest on loans*		333
Other payables	**2,072**	1,639
Total current trade and other payables	**22,771**	25,231
Of which payables from NHS and DHSC group bodies:		
Current	**11,876**	9,636

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 23. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 22 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	**1,025**	471
Total other current liabilities	**1,025**	471

Note 23 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	**20,898**	4,620
Obligations under finance leases	**930**	990
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	**223**	756
Total current borrowings	**22,051**	6,366
Non-current		
Loans from the Department of Health and Scoial Care	**83,953**	68,015
Obligations under finance leases	**8,097**	9,027
Obligations under PFI, LIFT or other service concession contracts	**5,734**	4,780
Total non-current borrowings	**97,784**	81,822

Note 23.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**72,635**	**10,017**	**5,536**	**88,188**
Cash movements:				
Financing cash flows - payments and receipts of principal	**31,600**	**(990)**	**(737)**	**29,873**
Financing cash flows - payments of interest	**(2,383)**	**(439)**	**(575)**	**(3,397)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	**333**	**-**	**-**	**333**
Transfers by absorption	**-**	**-**	**-**	**-**
Additions	**-**	**-**	**1,173**	**1,173**
Application of effective interest rate	**2,664**	**337**	**575**	**3,576**
Change in effective interest rate	**-**	**-**	**-**	**-**
Changes in fair value	**-**	**-**	**-**	**-**
Other changes	**2**	**102**	**(15)**	**89**
Carrying value at 31 March 2019	**104,851**	**9,027**	**5,957**	**119,835**

Note 24 Finance leases

Note 24.1 Southport And Ormskirk Hospital NHS Trust as a lessee

Obligations under finance leases where Southport And Ormskirk Hospital NHS Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**9,027**	10,017
of which liabilities are due:		
- not later than one year;	**930**	990
- later than one year and not later than five years;	**4,069**	3,935
- later than five years.	**4,028**	5,092
Finance charges allocated to future periods	**-**	-
Net lease liabilities	**9,027**	10,017
of which payable:		
- not later than one year;	**930**	990
- later than one year and not later than five years;	**4,069**	3,935
- later than five years.	**4,028**	5,092

The main finance lease obligations relate to the 2 modular buildings on the Southport site.

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Other	Total
	£000	£000	£000
At 1 April 2018	**346**	**63**	**409**
Change in the discount rate	**(4)**	**-**	**(4)**
Arising during the year	**4**	**89**	**93**
Utilised during the year	**(70)**	**(19)**	**(89)**
Reclassified to liabilities held in disposal groups	**-**	**-**	**-**
Reversed unused	**-**	**(4)**	**(4)**
Unwinding of discount	**1**	**-**	**1**
At 31 March 2019	**277**	**129**	**406**
Expected timing of cash flows:			
- not later than one year;	**70**	**129**	**199**
- later than one year and not later than five years;	**207**	**-**	**207**
- later than five years.	**-**	**-**	**-**
Total	**277**	**129**	**406**

The other provision relates to public/employer liabilities.

Note 25.2 Clinical negligence liabilities

At 31 March 2019, £102,163k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Southport And Ormskirk Hospital NHS Trust (31 March 2018: £70,761k).

Note 26 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	**(49)**	(53)
Other	**(400)**	(500)
Gross value of contingent liabilities	**(449)**	(553)
Amounts recoverable against liabilities	**-**	-
Net value of contingent liabilities	**(449)**	(553)

Contingent Liabilities consists of £400k 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 4 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 by NHS Resolution.

Note 27 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	-	180
Intangible assets	-	-
Total	**-**	180

Note 28 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 28.1 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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**5,957**	5,536
Of which liabilities are due		
- not later than one year;	**223**	756
- later than one year and not later than five years;	**1,323**	2,301
- later than five years.	**4,411**	2,479
Finance charges allocated to future periods	**-**	-
Net PFI, LIFT or other service concession arrangement obligation	**5,957**	5,536
- not later than one year;	**223**	756
- later than one year and not later than five years;	**1,323**	2,301
- later than five years.	**4,411**	2,479

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**54,441**	55,896
Of which liabilities are due:		
- not later than one year;	**3,549**	3,378
- later than one year and not later than five years;	**15,217**	14,232
- later than five years.	**35,675**	38,286

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**3,437**	5,726
Consisting of:		
- Interest charge	575	844
- Repayment of finance lease liability	752	1,616
- Service element and other charges to operating expenditure	1,247	1,568
- Contingent rent	863	1,698
Total amount paid to service concession operator	**3,437**	5,726

Note 29 Financial instruments

Note 29.1 Financial risk management

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.

In addition the Trust borrows from the Department of Health & Social Care to support revenue spending as it is running at a deficit. Interest is at a fixed rate for the life of the loan and therefore on these loans there is 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note (Note 19).

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.

As the Trust is running with a deficit it has to submit monthly cash flow forecasts to NHS Improvement. Within these are requests for revenue loan funding. These are assessed by NHS Improvement and then forwarded to the Department of Health & Social Care who will provide the requested cash support by way of an interest-bearing loan.

Note 29.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	**11,052**	-	-	**11,052**
Other investments / financial assets	**-**	-	-	**-**
Cash and cash equivalents at bank and in hand	**1,042**	-	-	**1,042**
Total at 31 March 2019	**12,094**	**-**	**-**	**12,094**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	7,108	-	-	-	7,108
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,079	-	-	-	1,079
Total at 31 March 2018	8,187	**-**	**-**	**-**	8,187

Note 29.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	**104,851**	**-**	**104,851**
Obligations under finance leases	**9,027**	**-**	**9,027**
Obligations under PFI, LIFT and other service concession contracts	**5,957**	**-**	**5,957**
Other borrowings	**-**	**-**	**-**
Trade and other payables excluding non financial liabilities	**21,595**	**-**	**21,595**
Other financial liabilities	**-**	**-**	**-**
Provisions under contract	**-**	**-**	**-**
Total at 31 March 2019	**141,430**	**-**	**141,430**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	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
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	24,086	-	24,086
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	112,274	-	112,274

Note 29.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 29.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	**43,646**	30,452
In more than one year but not more than two years	**52,473**	17,215
In more than two years but not more than five years	**36,872**	57,035
In more than five years	**8,439**	7,572
Total	**141,430**	112,274

Note 30 Losses and special payments

	2018/19		2017/18	
	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	**366**	**216**	442	319
Stores losses and damage to property	**8**	**99**	6	78
Total losses	**374**	**315**	449	397
Special payments				
Ex-gratia payments	**30**	**27**	34	70
Total special payments	**30**	**27**	34	70
Total losses and special payments	**404**	**342**	483	467

Note 31.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £333k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in no change to the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,558k.

Note 31.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 32 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**	
	2019	**2018**	**2019**	**2018**	**2019**	**2018**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Southport & Formby CCG	**69,175**	63,459	**1,218**	385	**3,541**	3,718
West Lancashire CCG	**47,408**	44,280	**2,891**	1,208	**3,853**	2,565
NHS England	**18,579**	19,612	**116**	321	**964**	140
South Sefton CCG	**6,599**	6,579	**258**	273	**1,045**	1,085

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 £269,555 in 2018/19 (£377,596, 2017/18). The majority of transactions were pure recharges for equipment bought using the Trust's finance system. Only £31,448 (£30,386 2017/18)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 are 2 related party declaration (recorded on the Declaration of Interests) between Trust Board members and a current suppliers - Ernst & Young LLP and Ramsay Healthcare. The value of invoices in 2018/19 for Ernst & Young LLP is £468,845 (£235,260 in 2017/18)and for Ramsay Healthcare £3,644 (not a related party in 2017/18).

Note 33 Prior period adjustments

There are no material prior period adjustments that have required the restatement of prior year accounts.

Note 34 Events after the reporting date

There are no adjusting or non-adjusting events after the end of the reporting period.

Note 35 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	**33,825**	**57,152**	36,688	57,525
Total non-NHS trade invoices paid within target	**28,560**	**41,372**	23,391	31,449
Percentage of non-NHS trade invoices paid within target	**84.4%**	**72.4%**	63.8%	54.7%
NHS Payables				
Total NHS trade invoices paid in the year	**1,419**	**20,437**	1,583	19,367
Total NHS trade invoices paid within target	**858**	**11,867**	776	9,622
Percentage of NHS trade invoices paid within target	**60.5%**	**58.1%**	49.0%	49.7%

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 36 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	**30,883**	30,398
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**30,883**	30,398
External financing limit (EFL)	**31,002**	30,473
Under / (over) spend against EFL	**119**	75

Note 37 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	**6,575**	6,270
Less: Disposals	**(75)**	(23)
Less: Donated and granted capital additions	**(170)**	(206)
Charge against Capital Resource Limit	**6,330**	6,041
Capital Resource Limit	**6,330**	6,048
Under / (over) spend against CRL	**-**	7

Note 38 Breakeven duty financial performance

	2018/19 £000	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	**(28,961)**	(33,003)
Breakeven duty financial performance surplus / (deficit)	**(28,961)**	(33,003)

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Adjusted financial performance surplus/(deficit)		500	853	204	1,258	1,950	(896)	(17,202)	(20,709)	(33,601)	**(28,961)**
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)	**(28,961)**
Breakeven duty cumulative position	812	1,312	2,165	2,369	3,627	5,577	4,681	(12,521)	(33,230)	(66,233)	**(95,194)**
Operating income		146,757	153,368	178,182	181,098	189,224	188,905	182,236	186,695	158,277	**168,112**
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%)	**(56.63%)**

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 NHS long-term plan is to ensure that all providers are at a breakeven position or better by 2023/24.

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

2018/2019

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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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

Southport and Ormskirk Hospitals NHS Trust is pleased to present the Quality Account for the period 1st April 2018 to 31st March 2019. This document provides an overview of the progress made during the reporting period. The priorities for the coming year 1st April 2019 to 31st March 2020, and includes the regulated information prescribed under the National Health Service Quality Accounts Regulations. Throughout the report we will refer to Southport and Ormskirk Hospitals NHS Trust as The Trust.

The Trust has reviewed all the data available to them on the quality of care in all of the relevant health services.

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.

Once again we had much to be proud of in our achievement during the last 12 months. We have continued to make improvements in quality and safety whilst facing significant financial and operational challenges. We have continued to experience pressures relating to emergency admissions and capacity within our hospitals throughout the year, which has affected all NHS Trusts. We have worked with our partners in health and social care to improve the flow of patients and facilitate timely discharge. Focusing on mortality has resulted in decreased mortality rates during the year.

Everyone has worked hard to improve our services for patients this year. Investment in staffing Including Provision of 24 7 critical care outreach team, equipment, A&E, the Surgical Assessment Unit, the Day Surgery Unit and the new Discharge Lounge have all played their part – but it's been the dedication of staff that's made the real difference

The next couple of years are crucial to building on that success and making this organisation the model for smaller NHS hospitals in the 21st Century I know it can be.

That's the ambition and aspiration behind **Vision 2020**.

I hope you enjoy reading this summary of our achievements in 2018 / 19 and the work we have done to improve quality and safety in our hospital.

Silas Nicholls
Chief Executive

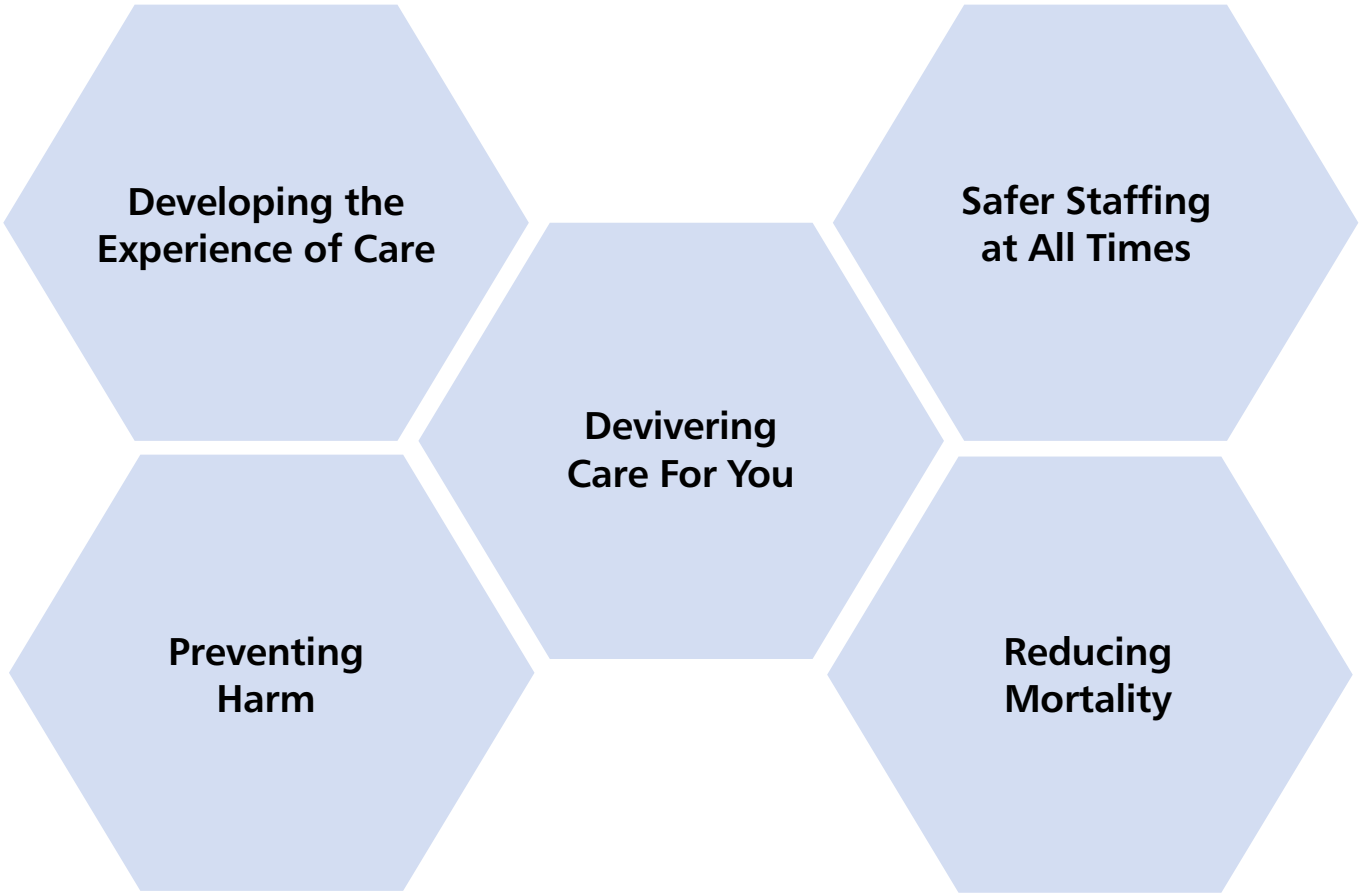
1.2 Our Quality Achievements during 2019/2020

- **Introduction of 2020 vision for the whole of the Trust**
- **Achieved advancing quality target for Sepsis performance**
- **Continued improvement in national cardiac arrest audit with decreased number of in hospital cardiac arrests**
- **Improved performance reported though national stroke audit**
- **Above average performance with national end of life audit**
- **Improvements in our National Bowel Cancer Audit Results**
  - **90-day mortality rate after surgery is only 2.1%**
  - **2 year mortality rate is only 13.1%**
  - **92% of patients are seen by a clinical nurse specialist (CNS)**
- **Improvement in Mortality Indicator Scores (SHMI & HSMR)**
- **Improvement in duty of candour implementation Trust wide**
- **Introduction of critical care outreach team providing 24/7 service**
- **SO Proud week focusing on quality held in January 2019**
- **Trust reported no MRSA since September 2017**
- **Lower than average mortality rates identified through MBRRACE audit**

1.4 Review of our Priorities for Improvement 2018-19

Progress against the five priorities for improvement we set for 2018 – 2019 are described in further detail throughout this full report

- Developing the Experience of Care
- Delivering Care for You
- Safer Staffing at All Times
- Reducing Mortality
- Preventing Harm



1.4.1 Priority One – Developing the Experience of Care

During 2018 / 2019 we continue to implement our Patient Experience Strategy 2017-2019 'Developing the Experience of Care.'

Pledge 1 – ' Involving carers and families in decision making'

Developments within this pledge have supported enabling carers to be present during a hospital admission. A number of 'Z' beds have been purchased through charitable funds to support overnight stays.

Due to the recognised success of carer/patient comfort packs in the Manchester area, the need for such items at Southport and Ormskirk NHS Trust was shared across local girl guiding groups. This received a good response and the Trust received a number of comfort packs which were shared across areas on the Southport site prior to Christmas.

In line with NHS England's 'Commitment To Carers' a number of NHSE regional workshops have been attended to network and learn from best practice to improve support from carers in the secondary healthcare setting. It is anticipated that the learning from this will support ongoing developments within this pledge in 2019.

Pledge 2 – ' Access to information is easy and relevant for patients, carers, families and professionals'

The launch of the new Trust Website is planned for the beginning of Spring 2019. This was recently demonstrated to the patient experience group and received positive feedback.

Recruitment of a new Trust Equality & Diversity lead (Robert Davies) is supportive of actions relevant to the accessible information standards. Mr Davies is now a member of the Trust patient experience group, as this ensures an E&D influence regarding any information that is reviewed by the group.

In response to staff feedback, and on completion of a uniform review which acknowledged staff comfort and identifiable roles as key issues. A phased implementation of nursing uniforms continues with the majority of Healthcare assistants and staff nurses now wearing smart scrubs tops with role clearly defined. Uniform posters within patient areas are currently being updated to reflect these changes.

It is also anticipated that the recent appointment of a lead for Older Peoples care and community implementation of the 'Red Bag' system will also positively impact on this going forward. The red bag scheme is helping to provide a better care experience for care home residents by improving communication between care homes and hospitals. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items.

Pledge 3 – 'Getting the basics right'

As an outcome of this pledge, the facilities assistant pilot was implemented on ward 7a our cardiology ward in October. The facilities assistant supported the ward for all meals/ drinks services Monday – Friday over a three week period. This was implemented in collaboration with ward staff, catering department and the matron for patient experience. The opportunity also enabled protected meal times to be relaunched on the ward alongside the pilot. The role positively impacted on both the patient experience and quality of care with the following results.

- Vital Pac data showed an 8% increase in timely observations, and a 13% decrease in breached observations.
- Vital Pac data showed an increase in the number of nutritional assessments/re-assessments completed.
- A 13.5% increase in the number of patients recognised through the red tray system as needing assistance with a meal.
- 20% increase in patients receiving assistance to order their meals.
- 50% increase in patients receiving the correct meal.
- 40% increase in patients reporting that the meal was hot enough.
- 60% increase in patients reporting they could access a drink when wanted.
- 30% increase in reporting that the ward was free from interruption during mealtimes.

Patients and staff were also asked for comments regarding the pilot. All those received were positive and supported the role to become a permanent addition to the Trust workforce.

"The benefits of having the catering staff are immense as you get fresh water every day at 7am and then regularly replenished throughout the day. The food and drinks are always on time as we are not waiting for the HCA's to be free. This has had a knock on effect as the HCA's are free to change beds, do blood pressures and to bring bed pans and commodes and to generally get on with the role that they are paid for. I would congratulate whoever came up with this idea." (Patient)

"Working even better than we had hoped" (Staff)

" Brilliant idea need them on all wards, saves so much HCA time and makes the patients feel special" (Staff)

"Felt for the nursing staff as they are so busy" (Catering Hostess)

"Great job satisfaction – ensuring that the patients received a hot meal." (Catering Hostess)

In response to this successful pilot, a business case is in development with the aim of implementing the role as a seven day service across the organisation in the near future.

A volunteer manager post has recently been appointed and in line with the local community interest in volunteering and Trust need, the first priority will be to increase the numbers of dining companions particularly on the Southport site.

Pledge 5 – Improve and Enhance Discharge Processes

With agreement from the Trust Patient Experience Group this Pledge and proposed plan has paused due to the extensive work ongoing Trust wide regarding patient flow and discharge. The positive impact of a new discharge lounge, Red to Green, #The Last 1000 days, and long stay Tuesday initiatives has been demonstrated. Discharge planning is also further supported by the recent recruitment of discharge facilitators to support the Southport site. Results around discharge from the 2018 National Inpatient survey (due Spring'19) will be monitored for ongoing evidence of improvement to the patient experience.

The North Mersey A&E Delivery Board communications group researched and compiled a campaign to support discharge this winter. A common discharge leaflet for the Royal, Aintree and Southport & Ormskirk was produced with supporting posters and social media collateral.

Pledge 6 – Responding to complaints in a timely manner

The management of complaints is currently under review and supported by the Deputy Director of Nursing. External support is currently being sourced to review complaints, aid learning and improve actions at ward level in the management of complaints. All are now Quality Assured by the Deputy Director of nursing and signed off by the Trust Chief Executive and Director of Nursing.

Pledge 7/Pledge 4 – Staff Awareness of Patient Experience/ Collecting and acting upon feedback in a more robust manner.

The decision has been taken due to reduced staff engagement and shared themes to merge these pledges for 2019.

Patient/Staff Stories

Ongoing patient/staff stories are taken on a regular basis to Trust board presented by both the matron for patient experience and Trust staff. Recent themes which have been discussed are:

– End of life care, pain control , and management of complaints

– Communication and display of waiting times in outpatient areas.

The opportunity for staff to attend board meetings to share a story has been well received and contributes to a positive listening culture in the organisation. The most recent story highlighted the support, opportunity and the professional determination of a long standing member of staff who has successfully now become one of the Trusts first associate nurses.

Pledge 8 – Capturing patients and family's memories to share and cherish for the future

The Garden of Reflection was formally opened on Sept-18 as part of the Trust Open day. This area has been developed with the intention of providing a pleasant quiet and calm outdoor space for patients, visitors and staff use. The copper tree centrepiece was purchased with donated monies provided by the Organ Donation Committee in memory of those who have donated their organs to help others.
In response to staff feedback a staff carol service was held on the 19th Dec supported by the Octave choir and led by the hospital chaplain – Martin Abrams. The service shared similarity with the ODGH baby remembrance service,

as staff were able to remember and acknowledge loved ones by recording a name on a tree bauble. The Garden of Reflection at Southport will be further developed over Spring/Summer this year.

The annual baby and child remembrance service led by Martin Abrams was again held on the Ormskirk site in early December. This was a special time for remembrance, sharing of support and empathy. To support improvements to the currently named 'Baby garden' on the ODGH site, a local landscaping business has contributed to the consultation process alongside parents and extended family members. As a result of this, a design has been approved by members of the bereavement group and a plan is in place to start work at the end of Feb-19. Charitable monies that have been donated specifically for this cause will support the cost of the redesign.

National Maternity Survey Results

In response to the initial results from the 2018 Maternity survey, PICKER (contracted company who complete the National surveys on behalf of the Trust) attended in late November and led an improvement workshop to support the development of a service action plan. Overall performance has decreased since the 2017 survey, with areas for improvement recognised around patient choice regarding where to have their baby, where to receive check ups and access to information to support these decisions.

Results were published on the CQC website in late January. Only results for the labour and birth section of the questionnaire are presented. This provides confidence that in all cases women were referring to the acute trust from which they were sampled. The survey also asked women about their experiences of antenatal and postnatal care to cover the entire pregnancy and birth for completeness. However, some women who gave birth at an acute trust may not have received their antenatal and postnatal care from that same trust. This could be due to one of several reasons, such as: having moved home; having to travel for more specialist care; or due to variation in the provision of services across the country.

During the summer of 2018, a questionnaire was sent to all women who gave birth in February 2018. Responses were received from 86 patients at Southport and Ormskirk Hospital NHS Trust.

During the summer of 2018, a questionnaire was sent to all women who gave birth in February 2018 (and January 2018 at smaller trusts).

Responses were received from 86 patients at Southport and Ormskirk Hospital NHS Trust.

	Trust Score	Compared with other Trusts
Labour and birth		
Advice at the start of labour Receiving appropriate advice and support	9.0/10	About the same
Moving during labour Being able to move around and choose the most comfortable position during labour	7.1/10	About the same
Skin to skin contact Having skin to skin contact with the baby shortly after birth	9.4/10	About the same
Partner involvement Partners being involved as much as they wanted	9.5/10	About the same
Staff		
Staff introduction Staff ***introducing*** themselves before examination or treatment	9.0/10	About the same
Being left alone ***Not*** being left alone by midwives or doctors at ***a time when it worried them***	7.7/10	About the same
Raising concerns Concerns being ***taken seriously*** once raised	7.7/10	About the same
Attention during labour If attention was needed during labour and birth, a member of staff helped them within a reasonable amount of time	8.7/10	About the same
Clear communication Being spoken to during labour and birth, in a way they could understand	9.2/10	About the same
Involvement in decisions Being involved enough in decisions about their care during labour and birth	7.8/10	About the same
Respect and dignity Being treated with respect and dignity during labour and birth	9.5/10	About the same
Confidence and trust Having confidence and trust in the staff caring for them during labour and birth	8.8/10	About the same
Care in hospital after the birth		
Length of hospital stay Feeling the stay in hospital after the birth was the right amount of time	6.6/10	About the same
Delay in discharge Discharge from hospital being delayed	5.2/10	About the same
Reasonable response time after birth If attention was needed after the birth, a member of staff helped within a reasonable amount of time	7.0/10	About the same
Information and explanations Receiving the information and explanations they needed after the birth	7.4/10	About the same
Kind and understanding care Being treated with kindness and understanding by staff after the birth	8.4/10	About the same
Partner length of stay Partner who was involved in care being able to stay with them as much as they wanted	7.8/10	About the same
Cleanliness of room or ward Thinking the hospital room or ward was clean	8.6/10	About the same

Healthwatch surveys

The Trust received the Healthwatch Sefton Feedback Report (Southport & Ormskirk Hospital NHS Trust: Southport & Formby District General Hospital June 2017 – June 2018) in Oct-18. The following issues were highlighted and have been responded to within an action plan returned to Healthwatch in Nov-18:

- Appointment letters sent out to patients are not being received or not being received in a timely manner.
- A lack of information about the location of services and information within letters not corresponding with trust signage
- Car parking issues
- Lack of corridor seating
- Allocation of appointments in line with availability of public transport.

1.4.2 Priority Two – Delivering Care For You

Everyone has worked hard to improve our services for patients this year. Investment in staffing, ward reconfiguration, establishing the safety hub, equipment, A&E, the Surgical Assessment Unit, the Day Surgery Unit and the new Discharge Lounge have all played their part - but it's been the dedication of staff that's made the real difference.

The next couple of years are crucial to building on that success and making this organisation the model for smaller NHS hospitals in the 21st Century I know it can be.

VISION 2020
CHANGE IS COMING

That's the ambition and aspiration behind **Vision 2020**

It is our road map to how we will become a successful and sustainable provider of healthcare for local people.

There are five themes at the heart of Vision 2020:

- Become a leading community general hospital, specialising in the care of older people
- Invest in our hospitals to make them fit for the 21st Century
- Become a successful integrated care organisation, delivering seamless hospital-to-home care that works for patients
- Create a regional hub for routine planned care, run from a dedicated hospital
- Become an employer of choice

The Vision 2020 strategy is underpinned by tasks we must make progress on if we're to become that model organisation. Key among them is achieving a CQC rating of "good", reducing avoidable deaths and getting a grip of our financial deficit.

The Trust submitted its initial thoughts about why hospital services need to change and how they might look in the summer of 2018.

Since then the Trust has been making the case to the NHS for investment in our Trust, briefed MPs, councilors and other stakeholders, and set out our case in an open letter to the local community.

We continue to work through various scenarios but options which emerge from them must be affordable, clinically-supported and be positive for patients. In time, there will be appropriate and timely consultation where it's required. Any option ultimately approved will take three to five years to take effect.

1.4.3 Priority Three – Safer Staffing at All Times

Nursing and Midwifery Monthly report to Workforce and Trust Board providing a summary of safe staffing data, fill rate, Care Hours per Patient Day (CHpPD) and red flags/ staffing incidents in line with national guidance. This information is also available on the Trust website.

Daily Staffing Huddles chaired by Head of Nursing/ Midwifery with Matrons, HealthRoster co-ordinator and NHSp to review the daily skill mix and number of staff and case mix of patients to proactively manage the risk across the Trust. At the w/end the Site Managers co-ordinates with the Medicine Bleep Holder to manage the staffing for the Site.

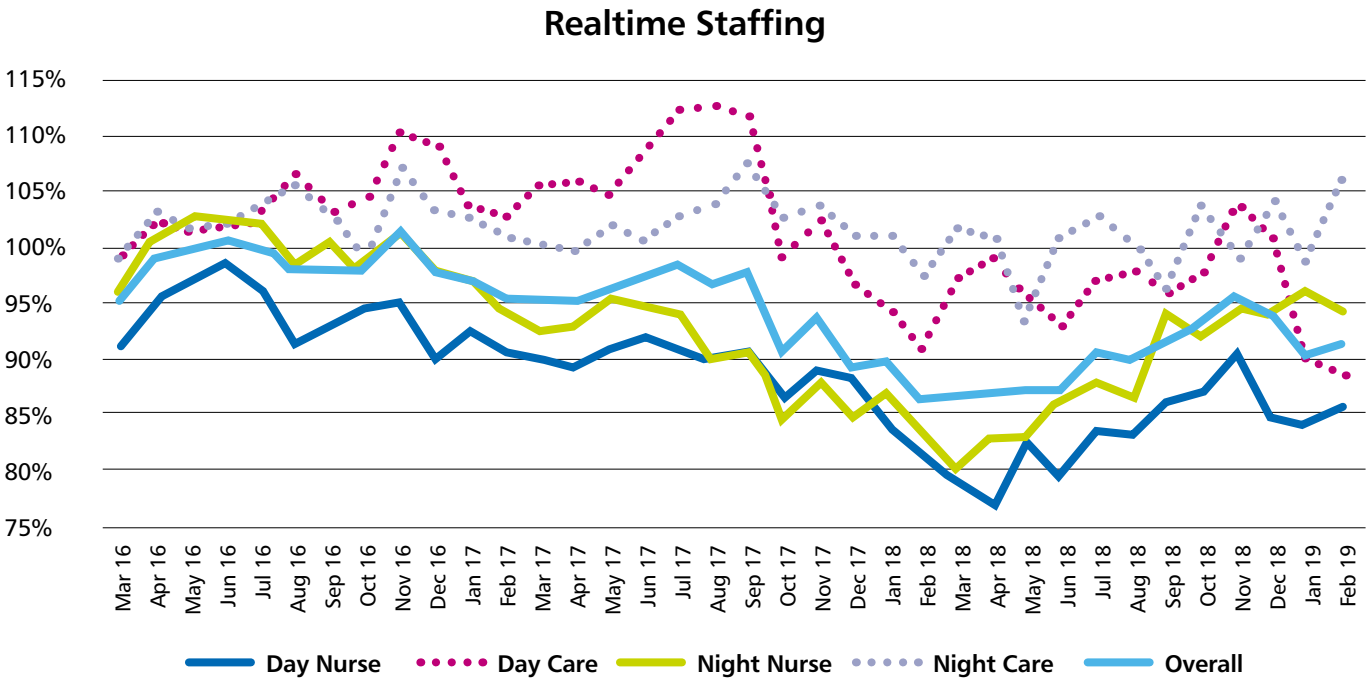
Safe Staffing remained above 90% across the year.

Recruitment & Retention remain a challenge for the Trust. Over the last year the organisation has been working with NHS Improvement to consider ways in which we can improve our retention. From this we held 'Brew & Review' forums to encourage staff to consider what they perceive the priorities to be for the Trust. Three key areas have been developed and the Trust is working on the implementation plan to promote the Trust and improve our recruitment and retention. Regular recruitment events held on site over the last 6 months. Established a Recruitment & Retention Group to focus on nurse workforce. Currently our vacancy rate for nursing is 9% which is the lowest since records of April 2017.

A nurse establishment review covering all our in patient wards has been undertaken in line with national principles. This was approved by the Trust Board in May 2019 - substantial investment for wards and some departments over the coming year.

First 2 Nursing Associates have completed their training and commence in the trust in their new roles. Within the Nurse Establishment Review there will be opportunity to develop new roles within the workforce focusing at trainee nursing associate and assistant practitioners.

We have also undertaken supported training of our leaders on the Healthroster system within Nursing & Midwifery and there are regular meetings to improve the efficiency and effectiveness of the system. E roster policy updated to support staff planning their time off.



Consolidated annual report on rota gaps and the plan for improvement to reduce these gaps for NHS Doctors and Dentists in Training

The rota gaps are discussed bimonthly at the local negotiating committee which is attended by the Trusts chief executive, medical director and a representative from the British Medical Association (BMA).

Junior Doctor Training Position Statement reported to local negotiating committee May 2019

Specialty	Total Number of deathsTrainee Slots	Gaps Identified
Anaesthetics	1	
Acute Internal Medicine	3	
Acute Internal Medicine	2	1xST3
Cardiology	2	
Community Sexual and Reproductive Health	1	1xST1
Core Anaesthetics Training	7	1xCT1
Core Medical Training	15	1xCT1
Core Surgical Training	4	1xCT1
Emergency Medicine	11	
Emergency Medicine	5	
Endocrinology and Diabetes Mellitus	2	
Gastroenterology	2	
General (Internal) Medicine	1	
General Medicine	3	
General Practice	9	
General Psychiatry	4	
General Surgery	11	1xST3
Geriatric Medicine	7	
Obstetrics and Gynaecology	13	
Ophthalmology	1	
Paediatrics	12	
Rehabilitation Medicine	1	
Respiratory Medicine	4	
Rheumatology	2	
Trauma and Orthopaedic Surgery	6	2xST3
Urology	3	1xST3
TOTAL	133	9

ST3 – specialty training doctor year 3 CT1 – core medical training doctor year 1

Plan for Improvement

- Continue to report bimonthly to the local negotiating committee to ensure the chief executive and medical director are aware of all rota gaps
- Operational management teams informed all expected rota gaps to allow contingency planning
- Review all staffing resourcing teams to provide safe affordable staffing to the Trust.

1.4.4 Priority Four – Reducing Mortality

The Trust is committed to improving mortality and in turn mortality rates through the 'Reducing Avoidable Mortality' (RAM) project which has the over riding aim of reducing avoidably mortality.

During April 2018 – March 2019, 879 of The Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Quarter 1- 229

Quarter 2 - 215

Quarter 3 - 208

Quarter 4 - 227

In relation to the 879 deaths, 567 case record reviews were undertaken which resulted in 52 structured judgement reviews being carried out and 0 investigations in relation to 879 deaths reported.

Structure judgement reviews are undertaken when the initial case record review identifies areas of concern which require a more detailed case note review. Following the structured judgement review if the death is deemed avoidable a full incident investigation will be trigged.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was

Quarter 1 – 213

Quarter 2 – 112

Quarter 3 – 112

Quarter 4 - 130

1 representing 0.1% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

-0 representing the 0% of the number of deaths which occurred in quarter 1

-0 representing the 0% of the number of deaths which occurred in quarter 2

-1 representing the 0.1% of the number of deaths which occurred in quarter 3

-0 representing the 0% of the number of deaths which occurred in quarter 4

These numbers have been estimated using the Royal College of Physicians Structured Judgement Review process which the Trust introduced in July 2018 to our planned care business unit and urgent care November 2018.

During April 2017 – March 2018 the Trust reported 958 patient deaths.

0 case record reviews and 0 investigations completed after 1st April 2019 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated as we did not introduce the Structured Judgement Review process within the Trust until July 2018 in planned care and November 2018 in urgent care.

Summary of what we have learnt from case record reviews and investigations conducted in relation to deaths identified

Delays in patients being put on the correct pathway for treatment
Issues with accessing a specialist diabetic nurse for inpatients
Improve End of Life documentation and conversations
Improve care for older people
Appropriate Escalation of the deteriorating patient

Actions and Assessment of Impact which were taken by the Trust during the reporting period

Action	Impact
Revised and updated the sepsis pathway	Data from regional benchmarking project indicates an improvement in patients been identified timely and receiving antibiotics within an hour of diagnosis
Produced a pathway for pneumonia management	This pathway is currently still being embedded into every day practice.
Produced a pathway for Acute Kidney Injury (AKI) management	This pathway is currently still being embedded into every day practice.
Updated and revised the fracture neck of femur pathway	This pathway is currently still being embedded into every day practice.
A full time diabetic nurse has been appointed	The member of staff is due to start working with the Trust in September 2019.
A substantive diabetologist has been appointed	Staff member in post and leading diabetic service.
Appointed a lead for older people	Dementia strategy has been launched and we are currently introducing a delirium screening tool.
Introduced a 24/7 critical outreach team	The team has been in post since the beginning of April 2019 and receiving an increasing number of referrals.

1.4.5 Priority Five – Preventing Harm

In October 2018 a small team of staff comprising of Matt Parry, Casting Services Manager, Janet Golightly, Specialist Tissue Viability Nurse and Carol Jump, Theatre Trauma Lead Nurse carried out a review of clinical incidents specifically related to the 'plaster casting' on patients with bone fractures over the last 5 years, as part of the national Collaborative for Tissue Viability.

This review showed that the majority of incidents related to 3 main things:

a) Insufficient patient education

b) The need for more education for the staff on wards caring for patients with a cast

c) The competencies and skills of those staff responsible for applying casts

The team has since worked on a number of initiatives, including a competency framework for the education of staff responsible for applying casts and a comprehensive patient information pack.

The team recently attended an event in London organised by NHS Improvement where they were the winners of the 'Idea Most Likely To Be Adopted By Other Trusts'. Since then, the team has been approached by a number of other Trusts who have similar experiences and have shared their ideas around their 'good practice initiative'.

The Trust is also proud to report that over the past 12 months there have been no reports of 'avoidable' incidents relating to plaster casting which is an excellent achievement in relation to patient safety and experience

Safety Thermometer

The NHS Safety Thermometer is used nationally but is designed to be a local improvement tool for measuring, monitoring, and analysing patient harms and developing systems that then provide 'harm free' care. The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a 'snapshot' of harm once a month from pressure ulcers, falls with harm, urinary infection in patients with catheters (CAUTI) and treatment for blood clots (VTE). These harms are measured in two ways, harms which are old and sustained prior to admission and new harms which occurred whilst the patient was in hospital. The data is used alongside other outcome measures to help us understand themes, analysis findings and plan improvements in care delivery.

The score below shows the percentage of patients who received harm free care whilst an inpatient.

97.61% of patients did not experience any of the four harms

In March 2019, SOHT achieved 97.61% harm free care, with 2.39% of patients on the day recorded in the category of 'new' harm (sustained whilst they were in our care). Broken down into the four categories this equated to 3 falls with harm, 3 VTE, 1 CAUTI and 2 incident of pressure ulcer development of grade 2 or above.

Progress is monitored through the Trusts Quality & Safety Committee

For more information, including a breakdown by category, please visit: **www.safetythermometer.nhs.uk**

1.5 Safeguarding

The safeguarding team has continued to ensure safeguarding is embedded throughout the trust.

- The team has requested for each clinical and non-clinical area to identify a safeguarding champion in order to support the safeguarding agenda in their area.
- The adult team has secured regular attendance at both the Matrons and Ward Leaders meetings.
- Safeguarding Children information boards have been introduced in AED at SDGH and Paediatrics at ODGH.
- Communications from both Lancashire and Sefton adult and children boards, including 7 minute briefings and training opportunities are shared with staff through trust news and on the trust intranet on the Safeguarding pages.
- Links to NHS England Safeguarding Portal and both the Adults and Children's Safeguarding Boards are contained within the trust safeguarding intranet pages.
- An ascom has been purchased for the team allowing the team to be contactable at all times during working hours.
- The team continue to embed routine lines of enquiry and professional curiosity in AED, paediatric and maternity departments although this remains an on-going piece of work with the completion of audits of the clinical documentation, and staff who access the C-PIS system.

In January 2019 the team changed the reporting process for safeguarding training in order to provide an accurate position of the trust's compliance. The change of process resulted in a decrease in compliance for level 3 safeguarding children's training, this was further compounded by the unavailability of staff during 2018 to be released for the level 3 safeguarding children's training (2 hours per year is required to remain compliant). In response a recovery action plan was submitted to the CCG, and included the team providing a significant number of bespoke training sessions to the AED between December 2018 and March 2019. Prior to the change in process the team remained green for the CCG commissioning standards other than being < 1% below the compliance target of 90% for Prevent and MCA and DoLs training.

In addition the team has introduced a significant number of quality improvements during 2018/2019 including:

- Following the introduction of a domestic abuse risk assessment pack the team has seen an increase in the number of domestic abuse cases referred from 78 in 2017/18 to 107 in 2018/19
- The development of a 16-17 year old report detailing the 16-17 year olds located in our adult in-patient areas
- Changes to the S42 process to ensure the 'provider enquiry response' is completed by the CBU and quality assured by the safeguarding team
- Reviewing and developing a trust-wide assessment tool for enhanced level of supervision. This is to be trialled in 15a and SSU before implementation across the trust. This will be supported by the development of an enhanced level of supervision standard operating procedure/policy
- Supporting the CCG by undertaking the 'initial LEDER review'

- Since the Named Nurse has taken has taken over the role of the Prevent Lead stronger links with the Merseyside and Cheshire Dovetail Team have been developed. This has led to the trust being invited to support local Channel Panels.

- Changes to the 'deprivation of liberty' and 'outcome of referrals' databases to ensure there is an improved accuracy of information available

- Development of both concealed pregnancy and home antenatal assessments for Sefton

- Implementation of a quality assurance and audit process for children's safeguarding referrals

- Attendance at Pan Mersey Safeguarding Adult Board sub-groups has improved the profile of the trust and lines of communication between the trust and other local providers, Local Authorities and CCGs

- The trust safeguarding team are the sole health representative on the Sefton Domestic Abuse Operational Group providing a clear link with local agencies and informing trust policy and procedures.

This year the trust was part of a CQC inspection for Children's Services in Sefton which resulted in an extensive action plan developed in conjunction with the CCG and the trusts within Sefton. The team have already completed a number of the improvement actions and remain on target for the completion of all other actions. These include:

The safeguarding team has a number of quality improvements planned for 2019-2020 including:

- The introduction of new MCA and DoLs documentation to reduce the burden on frontline staff in completing the document and to improve the ongoing assessment of need for those patients with a DoLs in place.

- The introduction of a new adult referral form to improve the quality of the referrals. This has been agreed by both Lancashire and Sefton Local Authorities

- Changes to AED and PAED CAS cards to increase and improve routine lines of enquiry especially for 16-17 year olds

- Introduction of a DoLs proforma in Medway in order to facilitate the development of a daily report detailing in-patients with a DoLs in place

- The implementation of FGM-IS; an alert system for known cases of Female genital mutilation (FGM), and to include FGM as routine line of enquiry in sexual health

- Work with the local authority to improve the referral processes for both adults and children

- Review of front facing safeguarding information available for patients and visitors

- Review of the Domestic Abuse Affecting Trust Employees policy and processes

- Introduction of a rolling programme of level 3 children's training for AED

- Review of the safeguarding supervision policy, and the inclusion of staff working in sexual health to undertake safeguarding supervision

- Review of the mental health assessment used in AED

- Improved alerts and flagging including within sexual health

- Introduction of a 'Did Not Attend' policy for Maternity
- Review of training in line with the intercollegiate document; review of policies; on-going audit plan
- Continued involvement in Sefton and Lancashire Serious adult and children's reviews
- Involvement in a regional task and finish group to review standardising safeguarding supervision documentation
- Updating of the adult safeguarding referral flow chart to simplify the information contained within the flow chart
- Complete the transition of Learning Disability Lead from the Quality Matron to the Adult Safeguarding Team.

1.6 Supportive, Palliative and End of Life Care

A consultant led, **Supportive and Specialist Palliative Care Service (S&SPCS)**, subcontracted to Queenscourt Hospice by Lancashire Care Foundation Trust (LCFT) (Southport & Formby) and Virgin Care (VC) (West Lancashire) works out of Queenscourt, into Southport & Ormskirk Hospitals NHS Trust, on honorary contracts.

This service consists of two Palliative Medicine Consultants, Dr Karen Groves and Dr Clare Finnegan, supported by Queenscourt specialty doctors; a team of Specialist Palliative Care Nurses and a team of Transform (Supportive Care) Facilitators.

A seven day, 9-5, Queenscourt based, Central Access Hub provides a responsive, human, contact point for patients, families, the public and health professionals alike, and administrative support for the **S&SPCS**.

1. Specialist Palliative Care Services

The multiprofessional **Specialist Palliative Care Team**, for whom Cathy Brownley has been Team Lead, 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 their families and the staff who care for them, arranging for follow up by the Community Specialist Palliative Care Services on discharge where appropriate.

During 2018/19, there were 824 hospital referrals to the service, of which 772 were new referrals and the rest readmissions and rereferrals. 274 (33%) had non-malignant disease. 659 (80%) were seen within 24 hours of referral by specialist palliative care nurses (most are prescribers) and doctors. 52 referrals received telephone advice only. 446 (62%) were discharged from hospital back to their usual place of residence, 265 (37%) died in hospital and 9 (1%) were still inpatients at the year end. For those who died in hospital, who had a recorded preferred place of care, 70% achieved it.

The SPCS MDT meets weekly to discuss all patients referred to their care and those who have died. This is an opportunity to review and augment the plan of care created by the team member who made the original assessment, and for those who have died, reflect briefly on the care provided leading up to death to ensure that learning from this is not lost.

2. Supportive Care Services – Transform Team

The Supportive Care element, the **Transform Team**, for whom Louise Charnock is Hospital Clinical Lead, 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. The team 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.

During 2018/19 the Transform Team has seen, or discussed with ward staff, approximately 1320 patients and their families who are either recognised to be approaching the last months/years of life or who are recognised as likely to be dying.

Newly, during this year, Transform Facilitators have followed care home residents, who have been inpatients in hospital, back to the care home to ensure that the care home staff understand the management plan (current or anticipatory) which has returned with them and to try to clear up any questions the staff may have.

3. End of Life Care

End of life care, is of course, everybody's business and the core work of every frontline staff member in the clinical areas. Frontline staff take pride in being able to provide good care and skilled support at a very difficult time for patients and their families. Two staff nurses have been supported to undertake the Queenscourt / Edge Hill University module 'Transforming Integrated Palliative and End of Life Care'.

The organisation of Palliative and End of Life Care within the Trust is co-ordinated by the End of Life Care Strategy Steering Group which met monthly from 2008 following the publication of the national End of Life Care Strategy, and during 2017-19 period the frequency was reduced to quarterly. The Executive End of Life Care Lead is Juliette Cosgrove, Director of Nursing, Non Executive End of Life Care Lead is Julie Gorry and Clinical Lead Dr Karen Groves. The S&O End of Life Care Strategy 2017-19, is due for revision in 2019/20.

West Lancs, Southport and Formby has a population of approximately 235,000 and a higher than average elderly population. Locally 1.2% of the population die each year, which is higher than the national average of 1% and higher than the previous years locally, which has been 1.1%. There are over 100 care homes locally with approximately 3,500 beds and approximately 12% of all those who die in S&O Hospital are admitted from a care home. Over the last 10 years the proportion of local residents who die in hospital has reduced from 51% to 42% and the proportion who are able to be cared for and to die in their usual place of residence (which is where most people state they would prefer to be, and which may be a care home) has risen from 43% to 51% of all local deaths.

For 544 (59%) of all those who died in hospital, dying was recognised and an individual plan for the care of those thought likely to be dying was developed with them and their family to ensure that their care needs were met, as far as possible, in accordance with their wishes and preferences. In common with previous years, approximately 5% of all those who were thought likely to be dying, and for whom an individual plan for the care of those thought likely to be dying was developed, have improved and a new care plan has been developed to meet their new needs.

The total number of people in West Lancs, Southport & Formby for whom there was a recorded preferred place of care (PPC) was 1724. This equates to approximately 66% of the expected number of WL,S&F deaths – usually about 2,600 per annum. Of those who had a recorded PPC and died (1489), 1332 (89%) achieved it. 1064 (62%) had a PPC of home.

In 2018/19 there was a 67% increase in the number of people recognised as approaching the last months of life, whose Gold Standards Framework (GSF) registration was prompted by the hospital rather than their GP (752). Hospital prompted GSF registrations account for approximately 46% of all those known to be GSF registered.

There has been a 9% decrease in the number of deaths occurring in hospital over the last year from 935 2017/18 to 873 in 20918/19. Following 408 conversations about, and an offer of, a Rapid End of Life Transfer (REoLT) 27% more people (127) (than in 2017/18) achieved a Rapid End of Life Transfer when they were recognised to be dying, but wanted to be in their own homes. The median length of life following REoLT was 3 days.

4. Carer & Family Support

Families of those 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. Each individual plan for the care of those thought likely to be dying has an area for the assessment of family needs and the creation of a plan to meet those needs and support the family. The Transform Team and PCNSs are aware of family of those who are likely to be dying and provide support and a listening ear, alongside the chaplaincy team. Local schools and girl guide groups, as well as making syringe driver bags, have been hand making comfort packs to give to relatives who stay over in hospital unprepared – Transform ensure that families receive these wherever possible.

Queenscourt volunteers have now been trained to help provide some of this support for families or provide company for dying patients who may have no family. Bereavement calls are made to next of kin / carer 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.

The move of the Mortuary and Bereavement Service to another provider has had an impact on the bereavement services within the Trust and work is ongoing to try to restore the extra elements of sensitive support of those who are bereaved.

5. Audit

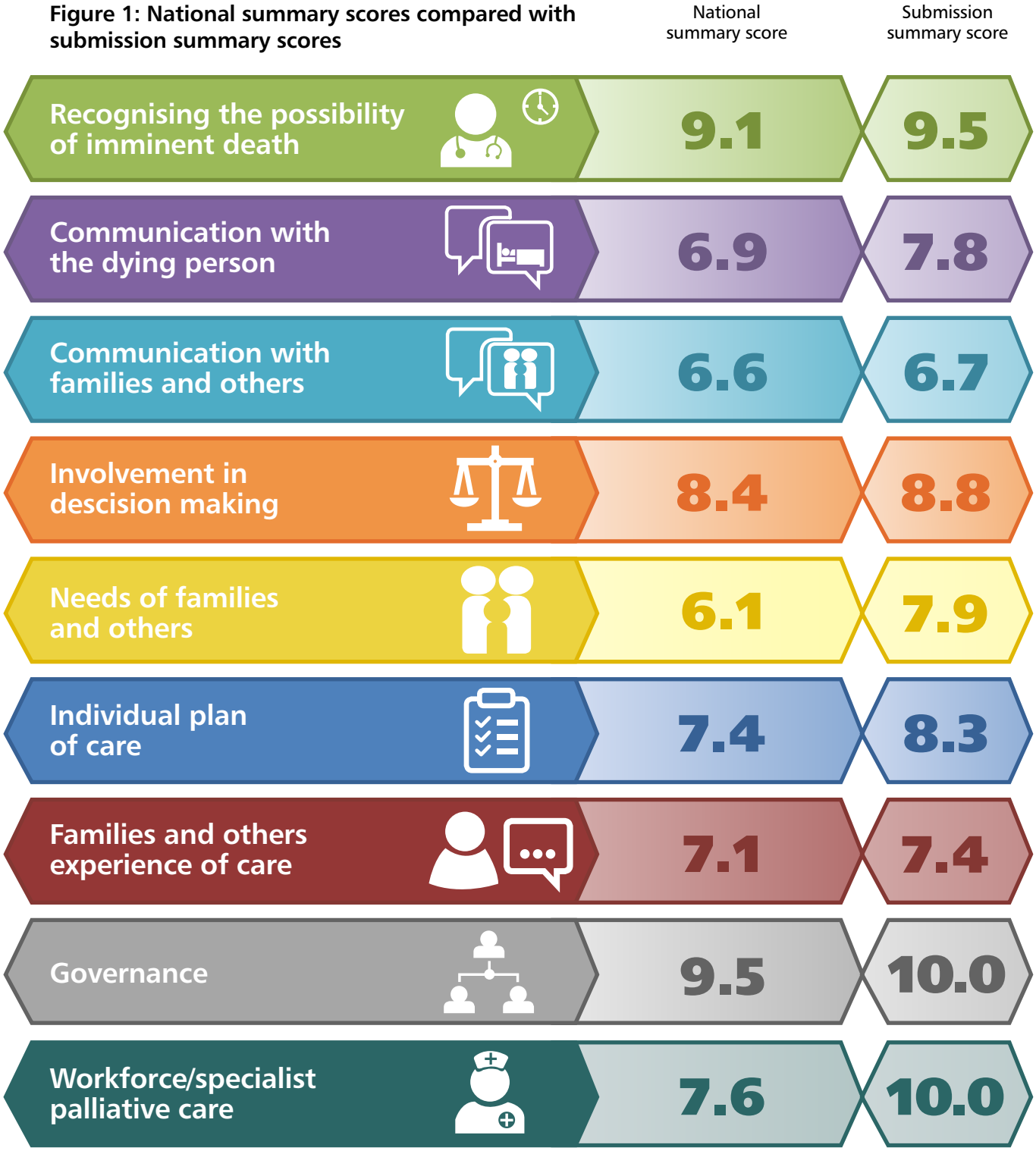
Two important audits have taken place this year, which demonstrate and assure of the palliative and end of life care within the Trust.

NACEL AUDIT

S&O NHS Trust has taken part in each of six biennial national audits of care of the dying in hospital, the last of which took place in 2018 and was reported in 2019. The audit included a retrospective case note review of all non sudden hospital deaths which occurred in April 2018 and a quality survey sent to bereaved relatives.

Nine themes were reviewed (see infographic below: left - national scores; right – S&O scores) and summary scores given for each theme. It is pleasing that S&O NHS Trust's scores in every domain were above the national average which is reassuring of the care given. Although overall scores compared well with other trusts, there is room for improvement across the board.

Figure 1: National summary scores compared with submission summary scores



The average age of dying is higher than the national average in line with the average age of the local population. Interestingly the proportion of deaths occurring at weekends (24%) is lower than the national average (27%), and the time that death occurs is broadly in line with the national average with a slight increase in deaths during the night.

Where dying is recognised by the team caring for the patient there is documentation of the conversations with families about what is happening and the planning of care to support both patient and family practical, psychological, emotional, social and spiritual needs at the difficult time. There was good documentation of prescribing for, and control of, symptoms associated with dying.

It is clear from the audit that although about half of those who are dying are able to be accommodated in a side room, almost all patients and families report a sense of privacy regardless of location. Relatives report feeling supported around the time of death and remarked on the promptness of paperwork and administrative details associated with death certification.

S&O NHS Trust has a full face to face Specialist Palliative Care Service seven days a week (with palliative medical advice available 24 hours a day) unlike some hospitals which have less than seven day services. Priority training in care of the dying patient has been undertaken for 80% registered nurses and 75% healthcare assistants (compared to a national average of 69% RGN and 62% HCA). However training for doctors (40%) and Allied Health Professionals (50%) don't quite reach national averages of 57% and 65% which will be addressed in the coming year.

There is further work to be done in ensuring that the likelihood of dying is recognised early and discussed with patient and family to ensure that all are able to be involved in developing the plan for care, and also ensuring that family concerns about hydration are elicited even when not volunteered, and then discussed fully.

GOSPORT AUDITS

National reports of inappropriate use of opioids at the Gosport War Memorial Hospital, where 450 patients are said to have had their lives shortened over a period of 10 years, prompted a series of audits into the use of opioids and the delivery of continuous subcutaneous infusions using syringe drivers within the Trust.

Two of the proposed audits have been completed to date: a retrospective audit of continuous subcutaneous infusions (CSCI) via syringe driver over the month of April 2018 and a snapshot audit of the prescription sheets of all patients (302) in hospital on one day in November 2018 (23% were recognised to be approaching the end of life and 3% recognised as likely to be dying with an appropriate plan for care in place)

The evidence concluded that in S&O hospitals:

1. Opioid usage with appropriate clinical indication was confirmed for patients who were dying (93%), although documentation of clinical indication on a prescription sheet was less likely earlier in the illness.

2. There were no instances of anticipatory prescribing of 'just in case' symptom management medicines using a wide range of doses and there was no anticipatory prescribing of CSCI medication in line with local guidance. Prescribing of 'just in case' medicines was of lowest doses in line with local and network guidance.

3. There was no evidence that opioids were being inappropriately used for patients who were not recognised as approaching the end of life, particularly patients on elderly care wards did not have high use of opioids. All patients with a CSCI in situ had already been recognised prior to use, as approaching the end of life and were appropriately GSF registered either before or on admission.

4. Where a continuous subcutaneous infusion (CSCI) of opioids was required, small doses of one or two drugs, with appropriate clinical indications were used for a short period of time, starting doses met local and network guidelines in 100% with dose adjustments/titration required only in small minority (14%) with rationale clearly documented in 100% e.g. poor symptom control needing breakthrough doses in previous 24 hrs.

5. Dose conversions from the oral to subcutaneous route followed local guidance and were correctly calculated.

6. Less than 1/3 patients who die require medicines to be delivered via a continuous subcutaneous infusion (CSCI) using a syringe driver and the average length of use of CSCI at time of audit was 8 days (range 2-10 days).

7. All CSCI and anticipatory prescribing identified met local and network guidelines.

8. The NACEL & GOSPORT audits 2018/19 confirms that a large proportion of deaths are due to pneumonia, are on orthopaedic wards and in admissions areas in keeping with the illness trajectories of many of our elderly patients with multiple comorbidities.

The evidence assures S&O Hospitals NHS Trust that prescribing/administration of opioids and use of continuous subcutaneous infusions (delivered with use of a syringe driver), within the Trust, follows local, regional and national guidance.

6. Into the future

Future Care Planning is an important contribution to the Safety Hub developments within the Trust and SPCS are involved in the transformation currently taking place. Close working relationships between Critical Care Outreach and Supportive and Specialist Palliative Care Services will hopefully improve managing uncertainty of those acutely ill with an already significant disease burden.

Future Care Planning consists of two parts – Advance Care Planning (personal plans made by patients about their wishes and preferences for the future) and Anticipatory Clinical Management Planning (clinical plans made in advance by health professionals for predicted events).

In the year to which this report relates, across WL, S&F, 444 have had an Advance Care Planning conversation relating to their personal wishes and preferences for their future care. 185 (42%) chose to document an advance statement of their wishes and preferences, 118 (27%) chose to make an Advance Decision to Refuse Treatment, 267 (60%) chose to appoint a Lasting Power of Attorney for health & welfare.

Anticipatory Clinical Management Plans are made by clinical staff either as a preparation for an anticipated clinical event or to try to plan care for those who may lack the capacity to make decisions for themselves. The Elderly Medicine Teams have started to make Anticipatory Clinical Management Plans with patients and their families to try and ensure that appropriate treatments and admissions were undertaken and avoided, as wished by the patient, especially out of hours, by teams who do not necessarily know them. The number of ACMPs made with patients and families in 2018/19 has trebled on the previous year.

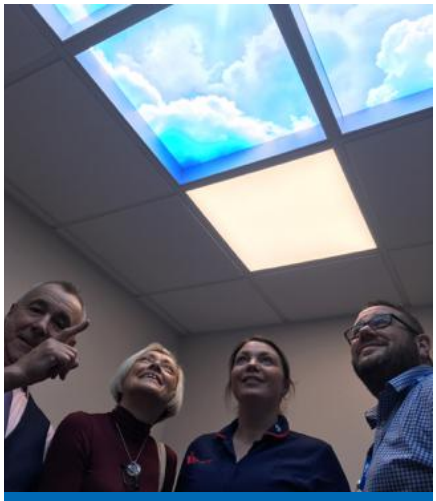
These Advance Care Plans and Anticipatory Clinical Management Plans then provide guidance in the event of 'Best Interests' decision making, if the person does not have the capacity to contribute to decision making for themselves as they approach the end of life.

The North West Coast Learning Collaborative has designed and developed an Advance Care Planning training day for frontline health and social care staff, which is being funded by Health Education England and delivered from the Terence Burgess Education Centre at Queenscourt. So far 56 Trust staff have undertaken the day's training to help them in supporting patients to discuss and make Advance Care Plans should they so wish.

1.7 So Proud Week

We celebrated So Proud Week beginning Monday 26th January 2019. We invited the Fab Academy and shared our achievements with them

S&O PROUD



Our A&E calm room

Working to improve patient flow

Development of a booklet to help combat loneliness co-produced by patient, staff and local communtiy group

Launch of CAVELL Nurses charity in Trust

1.8 Implementing priority clinical standards for seven-day hospital services

Our progress with implementing seven day services has been assessed as guided by the Seven Day Services Board Assurance Framework. In March 2019, we submitted our first board self assessment following the changes to 7 day services nationally.

Measures and Achievements	March 2017	Sept 2017	Spring 2018
Standard 2 Clinical assessment by a suitable consultant within 14 hours of arrival at hospital	63%	71%	74%
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	92%
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	100%
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	77%

1.9 Cancer Services

National Cancer Waiting Times Standard is that 85% of patients with a confirmed cancer diagnosis should start treatment within a 62 day target. Unfortunately the Trust failed to meet this standard in 10 of the previous 12 months. The team recognises that fundamental changes are required to ensure we provide safe and efficient care for our patients and therefore the Trust have now introduced a Cancer Improvement Work stream that overarches other improvement works within the Trust and holds to account those areas that are under-performing.

Nationally, we are now shadow reporting against a 28 day Faster Diagnosis Standard, and this is demonstrating an improvement in the number of patients being told their diagnosis within the 28 day standard. Measured reporting for this will commence April 2020.

The Cancer Clinical Nurse Specialists (CNS) are now directly line managed by the Lead Cancer nurse and to date we have a vacancy in Acute Oncology role and a short term (maternity leave) vacancy in Dermatology. The CNS for Urology has been successfully recruited as a developmental role.

Results from National Cancer Patient Experience Survey have demonstrated small rises in patient satisfaction, compared with last year, with the service received at Southport & Ormskirk NHS Hospital Trust, and the CNS team as a whole have pledged to work on areas for improvement which we hope to see in the 2020 survey results.

Risk Stratified Follow-Up is going from strength to strength in both Colorectal and Prostate cancer pathways. Cancer alliance funding for both these roles will finish in April 2020, and the subsequent business cases are currently underway

Close working with Cancer Alliance to establish a Vague Symptoms pathway resulted in a short term Vague Symptoms CNS who was able to support the service 2 days a week form the Trust.

Continued working with both Southport and West Lancashire Macmillan Information and Support Centres ensures all our cancer patients have access to ongoing community based support.

1.10 Women and Children's Services

Women's and Children's Services are working on the development of a new clinical model through a clinically led approach which describes a future state based on a focus of improving outcomes for women and babies. The model describes an intention to deliver a local maternity service with midwifery and consultant led pathways alongside a community based birthing unit.

The model advocates better coordination across providers to ensure that a single point of coordinated access across the region works more effectively and that births suitable for Southport and Ormskirk NHS Trust are led by patient choice rather than being unnecessarily diverted to other providers.

The emphasis will be on increasing choice for women in maternity services by the provision of the community located birthing unit and a hospital-based midwifery led unit in the hospital setting whilst maintaining existing levels of service access to Consultant led care.

The new model of care for Obstetrics and Neonatal has been developed based on clear evidence of the need for the service to evolve to keep pace with changing need, expectations and environmental pressures. The model assumes a shift to a more coordinated service with the added element of testing an initial community birthing unit (location yet to be confirmed).

The model is premised on closer collaboration with other service providers to sustain a fit for purpose workforce and to support efficiency in care pathways as well as more partnership working with community and primary care services.

The new care model assumes that existing resources, together with some pump priming monies for the initiation of the hub can be directed to a different way of working. Proof of concept for the model will be tested with the first birthing and sustainable recruitment to replace the reliance on locums. Should the model be evidenced further hubs could be developed, subject to investment plans and the availability of suitable estate.

This model of care is supported by the clinicians and staff within the Obstetric and Neonatal service. It requires further engagement with wider stakeholders as part of next steps.

The HUB
Our services were successful in a bid to establish a Women's & Children's community hub/ The location being in AInsdale.

The Ainsdale Women's and Children's Pilot Hub Project aims to provide a community hub that will be accessible to all women, children and families across the Sefton and West Lancashire population. The hub will be a family centric centre that provides wrap around care for the child (whose needs range from general wellbeing to complex care) capitalising on existing best practice offered by existing services.

The hub will incorporate a full life view of women's needs inclusive of extending the range of delivery options (in line with Better Births) to include a stand-alone birth centre and women's health services (including

maternity care; pre and post-natal) as well as providing early intervention out-patient clinics for targeted and vulnerable children. The hub is a model of integrated healthcare and partnership working within and across primary and secondary care agencies.

The pilot objectives are:

1. Providing maternity care (pre and post-natal) in a community-based setting to increase the range of service choices for women.

2. Providing out-patient clinics for cohorts of children identified by the MDT with an unstable long-term condition (likely to be a frequent attender at A&E or the GP practice) to intervene early and improve self-care and community-based condition management (thus potentially reducing avoidable attendances at A&E or the GP).

3. Testing the viability for future delivery (see benefits criteria) and potential replicability at other sites.

1.11 Duty of Candour

The Being Open principles and ethical duty of openness applies to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, significant harm or death has occurred.

During the year the Trust has reviewed the Duty of Candour processes in order to strengthen the statutory process. The Trust reviews all incidents on a daily basis to identify Duty of candour requirements. Datix is used to monitor both the verbal and written duty of Candour requirements and each Business unit has ownership of the Duty of Candour requirements which is monitored through the Governance processes daily. The Duty of Candour letter is sent to the relevant person within 10 days and a copy should be placed in the patient's clinical records and also detailed on the Datix system.

In year the Being open and Duty of Candour policy has been reviewed. Duties of Candour packs have been developed and are available on all wards, departments and on the Trust intranet. Mersey Internal Audit Agency (MIAA) has undertaken an independent audit of the Duty of Candour processes as part of our routine governance management.

1.12 Freedom to Speak Up

Ways in which staff can speak up (i.e. the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust)

Staff can speak up by speaking to their line manager, lead clinician or tutor. If this does not resolve the situation then they can contact any of the following people via telephone, email, face to face or in writing:

Martin Abrams, Freedom to Speak Up Guardian

Freedom to Speak Up Champions

Juliette Cosgrove, Director of Nursing

Silas Nicholls, Chief Executive – Straight to Silas

Pauline Gibson, Non-Executive Board Lead with responsibility for raising concerns

Staff can also seek independent advice and raise a concern with an outside body.

How feedback is given to those who speak up

Feedback is given regularly so the person is kept up to date with developments and timescales. Investigation reports will be shared wherever possible. This is done via email, telephone or face to face. Concerns that are raised through the guardian are reported back on regularly to the person raising the concern.

How they ensure staff who do speak up do not suffer detriment

A persons concern can be anonymous or can remain confidential.

The Trust has a Freedom to Speak Up; Raising Concerns Policy and will not tolerate the harassment or victimisation of anyone as a result of raising a concern or the bullying of a person into not raising a concern. This would be dealt with under the Disciplinary Policy.

The Trust also has an Equality and Diversity Lead.

Feedback is always asked from people speaking up and any detriment would be picked up as part of this process and escalated.

1.13 Statement of Responsibilities from Board of Directors

Southport & 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 2019

Chief Executive June 2019

PART 2

2.1 Priorities for Improvement 2019-2020

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

We will measure progress towards our 4 priorities using the measurable criteria below. An update report will be produced each month for our quality and safety committee to monitoring progress with each of our quality improvement priorities. Our priorities link to our VISON 20 / 20 discussed in section 1.4.2 of this report.

	Measurable 1	Measurable 2	Measurable 3	Measurable 4
Care of the Deteriorating Patient	Embed ward checklists	Develop 24/7 Critical Outreach services	Focus on observations and VitalPac	Embed Sepsis and AKI pathways
Care of Older People	Relaunch #EndPJParalysis	Recruit Admiral Nurse	Develop falls prevention strategy	Develop continence strategy
Infection Prevention and Control	Review hand hygiene policy	Review PPE policy	Roll out ANTT training	Develop ward level standard operating procedures
Medicines Management	Ward based pharmacy technician pilot	Develop case to increase pharmacy input at weekends	Review prescription sheets	Implement checklists

In common with most organisations we are developing our internal approach to Quality Improvement led by an executive director (Chief Operating Officer) who has substantial experience in service improvement.

The development of our approach will be aligned and applicable to the delivery of our quality and operational priorities which have been developed in Vision 2020.

In developing our approach we will focus on the use of evidence-based tools and techniques, learning from best practice and research particularly in organisations which have achieved improvement to Good and Outstanding. The development of our QI approach will be based on the following principles;

- Fit for this Trust and its quality improvement priorities
- Simple and easy to use across all staff groups
- Applicable to any improvement initiative irrespective of size
- Scalable and can be adopted across all aspects or the Trust and its services
- Co-designed with our staff and tested/evaluated in the workplace

The Trust has re-established its membership with the Advancing Quality Alliance (AQuA) which enables services to engage in broader improvement initiatives which are pathway specific and benchmark progress against clinical outcomes across the North West.

The Trust is also engaged with a number of national collaboratives which enable us to share and implement best practices across a wide number of Trusts. The collaborative cover;

- Frailty
- Pressure Ulcers
- Home First
- Ambulatory Emergency Care
- Mouthcare Matters Programme with Health Education England

2.2 Review of Services

Statements of Assurance from the Board (in regulations)

During April 2018 and March 2019 the Trust provided 3 relevant health services:

- acute hospital
- paediatric
- sexual health community based

The NHS services are 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 to them on the quality of care in all of the relevant health services.

The income generated by the relevant health services reviewed in the period April 2018-March 2019 represents 91% of the total income generated from the provision of relevant health services by the Trust for April 2018 - March 2019.

2.3 Participation in Clinical Audit - April 2018-March 2019

During the period April 2018 – March 2019 48 National Clinical Audits and 2 National Confidential Enquires covered relevant health services that the Trust provides

During that period the Trust participated in 100% of the National Clinical Audits and 100% of the National Confidential Enquiries of the national clinical audits and national confidential enquires 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 48 national clinical audit were reviewed by the provider in April 2018 – March 2019 and The Trust intends to take the following actions to improve the quality of healthcare provided.

- Introduce a 24/7 critical outreach team
- Focus on documentation
- Develop a falls strategy
- Introduce a delirium screening tool

The reports of 217 local clinical audits were reviewed by the provider in April 2018 – March 2019 and The Trust intends to take the following actions to improve the quality of healthcare provided. (Please refer to section 2.1)

Neonatal and Perinatal Mortality Audit

The National Neonatal and Perinatal Mortality Audit (MBRRACE) indicates the Trust is up to 10% lower than the average, when compared with similar service providers.

Southport & Ormskirk Hospital NHS Trust
2,000 - 3,999 births >=24 weeks gestional age per annum

HQIP Healthcare Quality Improvement Partnership

Maternal, Newborn and Infant Clinical Outcome Review Programme

	Metric	CQC Key Question	2017 Report [1]	2018 Report [2]	Comparator group average (UK)	National Aspirational Standard	Comparison to other trusts with similar service provision	
2,378 births	Stabilised and risk-adjusted extended stillbirth mortality rate (per 1,000 births)	Effective	3.30 (2.55 to 4.39)	**3.67 (2.96 to 4.46)**	3.73	None	Up to 10% lower than the average	●
2,378 births	Stabilised and risk-adjusted extended neonatal mortality rate (per 1,000 births)	Effective	1.28 (0.78 to 1.94)	**1.01 (0.63 to 1.71)**	1.06	None	Up to 10% lower than the average	●
2,378 births	Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)	Effective	4.57 (3.79 to 5.72)	**4.69 (3.98 to 5.74)***	4.79	None	Up to 10% lower than the average	●

MBRRACE-UK

Produced by HQIP in partnership with the Care Quality Commission

KEY ONLY
- More than 10% lower than the average
- Up to 10% lower than the average
- Up to 10% higher than the average
- More than 10% higher than the average

RVY
Slide produced on 25/02/2019

[1] Jan 15 - Dec 15
[2] Jan 16 - Dec 16

*Upper and lower 95% confidence intervals

National Bowel Cancer Audit

- Our 90-day mortality rate after surgery is only 2.1%
- Our 2 year mortality rate is only 13.1%
- 92% of patients are seen by a clinical nurse specialist (CNS)

Improvement and changes made following National Clinical Audit Projects

Audit Project	Improvement/Change
Compliance with Good Clinical Practice re consent, record keeping and storage of documents in research	Introduced a quality checklist which covers area's requiring improvement. This will be conducted on a monthly basis.
Audit of Head Injury Observations in A&E	Audit obtained full assurance with 91% of patients having a head injury pathway in place after arriving in A&E
Audit of major haemorrhage protocol	New Major haemorrhage protocol rolled out to all relevant areas
Maternity Anaesthetic patient questionnaire	Have increased the amount of written information available, and encouraged information to be given to the patient at time of intervention.
Audit of Nutrition Policy	The Trust has identified a lead for older peoples care and has estabished a nutrition group to take forward all the nutrition improvements required
Evaluations of opinions and awareness of drug incident reporting (ITU)	There has been a significant culture change amongst critical care nurses, demonstrated by a turnaround in opinions from staff feeling reluctant and fearful to report errors, to feeling encouraged to report. This is demonstrated by the overall increase in medication error reports, and in the willingness of nurses to report.
Patient experience acute oncology	Introduction of a new referral pathway
Use of IV Paracetamol	Ensure 'Medication Safety Bulletin' for IV paracetamol is on display on all wards across the trust . Education to be provided to all healthcare professionals involved in the prescribing, administering of IV paracetamol. Education and feedback to be provided on ward for nurses and during pharmacy prescribing teaching sessions for doctors.
Traumatic Ankle Pain – Adequacy of clinical information with reference to the Ottawa Ankle Rules	1st Audit cycle found that only 43% of the ankle radiographs performed for traumatic ankle pain were justified according to the Ottawa ankle rules. To raise awareness the audit findings were presented at the accident and emergency morning teaching session and radiology clinical governance meeting. Posters detailing the Ottawa ankle rules were put up in the emergency department to remind clinicians of their significance. Re-audit was undertaken after 2 months and indicated an improvement with 83% of the ankle radiographs performed for trauma ankle pain were justified according to the Ottawa ankle rules.

2.4 Participation in Clinical Research

Evidence suggests that NHS Trusts that support high quality patient-centred research can show better healthcare outcomes for patients.

Southport and Ormskirk Hospitals NHS Trust (SOHT) is committed to providing the best possible care to patients, and acknowledges that research has been widely recognised as being an important factor in providing high quality care for healthcare organisations.

Research has built the NHS we have today. Getting involved in healthcare research could help shape the NHS for the future, discovering life-saving treatments, uncovering the secrets behind diseases, and developing the answers to the problems causing ill health today.

Every year, more than half a million people take part in health research. Patients and members of the public also help design research studies and advise what our priorities for future research should be.

The Trust is a partner organisation in the Clinical Research Network, North West Coast (CRN NWC) 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 CRN NWC provides funding for the research staff to work on studies adopted by the NIHR portfolio at the Trust. This enables the RDI department to participle in more clinical trials and offer more choice to our patients. The funding is based on the previous year's performance.

Our reputation for research is constantly improving; the Trust has again exceeded its recruitment target for the third consecutive year, with the numbers for 2018/19 being the highest recorded over the three year period.

During 2018-19 the Trust actively recruited to 23 studies.

The number of patients receiving relevant health services provided or subcontracted by The Trust in April 2018 – March 2019 that were recruited during that period to participate in research approved by a research ethics committee 424.

- 421 Recruited to NIHR adopted studies.

- 3 Recruited to non-NIHR adopted studies, that is local and student.

We were pleased that NIHR recruitment figures have exceeded those forecasted during 2018-19, and that the Trust successfully recruited 421 participants against the proposed target of 200.

The Trust has impressive research activity across a wide range of clinical specialities. Since 1st April 2018 we have produced RDI Permission (Confirmation of Capacity & Capability) for 9 NIHR studies in the following areas:

Speciality	Number of Studies
Anaesthetics /Surgery	1
Paediatrics	4
Sexual Health	1
Trauma and Orthopaedics	2
Woman and Child Health	1

Performance in initiation and delivery of research (PID data)

Performance benchmarks have been introduced by the National Institute of Health Research (NIHR) for the time taken to initiate and deliver clinical trials within the NHS. The Trust's performance against these benchmarks is published in quarterly reports and is available at:

www.nihr.ac.uk/research-and-impact/nhs-research-performance/performance-in-initiating-and-delivering-research/performance-information-on-the-initiation-and-delivery-of-clinical-research.htm

Commercially sponsored studies

During the time period 1st April 2018 to 31st March 2019 we have participated in 4 commercially sponsored studies, 3 in Sexual & Reproductive Health in 1 in Paediatrics.

Key achievements

- The Research Team were inspirational in the delivery and set up of the FUTURE initiative study and recruited 225 participants. This resulted in the team winning the 2018 Time to Shine Award which was presented to the team at an awards ceremony in Formby Hall 12th October 2018. This important study aims to develop better dosing for medicines. We all vary in how we handle medicines which can result in differences in how well drugs work in different people. By understanding these differences, we may be able to reduce this variability.

  The success of this is due to team work including setting a recruitment strategy/ goals and clarifying responsibilities for each member of the team. We are committed to making sure that our patients and staff have the chance to participate in research and encourage our patients to discuss research opportunities with their doctors and nurses.

- SOHT has also been recognised as the top recruiting site, for the FLOELA study out of 49 sites across the UK. This is an incredible achievement that demonstrates commitment and the success of multi-disciplinary team working. (FLO-ELA is the FLuid Optimisation in Emergency LAparotomy trial. It is a large pragmatic clinical trial which aims to find out whether cardiac-output guided haemodynamic therapy given to patients during and shortly after emergency bowel surgery could save lives, when compared with usual care. The trial is being run in 100 UK hospitals and will study nearly 8000 patients).

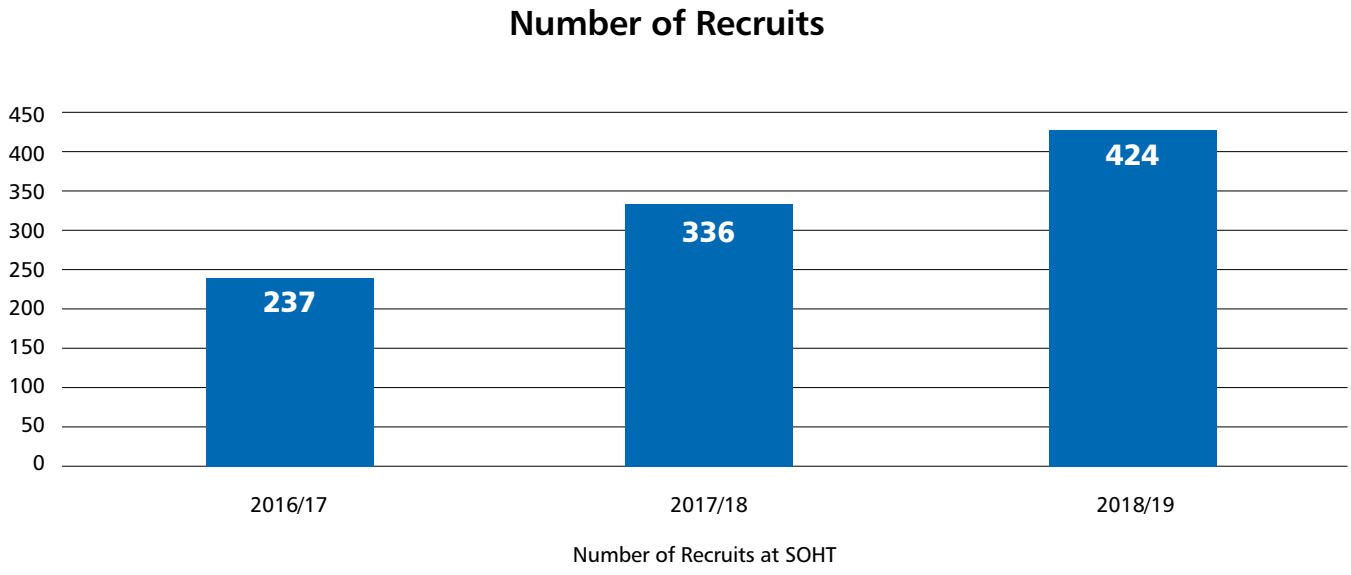
- The NIHR want to understand more about patient experience of clinical research taking placing in the NHS. During 2018/19 the Trust made a significant contribution to the survey by contacting our patients who have been involved in research.

- In February 2019, we had a fantastic patient story that hit the local news. A five year old girl was enrolled onto the CAP-IT study, a study that helps us to understand how best to treat pneumonia in children and use antibiotics to their best effect. Her mum explained that she had a positive experience and quoted "I would recommend anyone offered the opportunity to take part in a clinical trial to try it".

  The Trust was asked to recruit 10 participants to this study but went onto recruit more, demonstrating the hard work of the Consultant (Principal Investigator) Dr Sharyn Gardner and the Research Nurses involved in the study.

- A new approach to engage staff, raise awareness and improve recruitment to research was initiated in the Paediatric department. Staff were offered the opportunity to conduct both Good Clinical Practice and study specific training. This was a success in more than recruitment terms, the staff that undertook the training were really positive about the experience and feedback indicated that they now have a greater awareness of the research process and are really keen to engage with the promotion of research throughout the department and the wider trust.

- For the third year running the Trust has exceeded its target of 200 for recruitment to NIHR Portfolio studies, in particular 2018-19 has been an exceptional year as demonstrated in the graph below:



- 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 2018/19 was met in June 2019.

- Throughout 2018-19 there has been a concerted effort to raise the profile of research within the Trust and the community it serves, increasingly also using social media. We continue to promote research via the 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 2019- 20

Our aims for 2019-20 are to:

- Include research in the Trust Strategy and Vision
- To promote and increase engagement in Trust research, by raising awareness of research activities amongst all staff and patients
- To increase research in areas new to research and those areas that are currently research naïve
- Work in partnership with the Clinical Research Network to ensure the NIHR high level objectives are met
- Generate research funding by increasing the number of commercially sponsored studies on our portfolio
- Ensure high quality delivery of studies, to time and on target

2.5 Goals agreed with commissioner's use of CQUIN payment framework

A proportion of The Trusts income in April 2018 – March 2019 was conditional on achieving quality improvement and innovation goals agreed between The Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details on the agreed goals for April 2018 – March 2019 an for the following 12-month period are available electronically at – Link to further CQUIN information.

Improvement of health and wellbeing of NHS staff	**Partially achieved**
Healthy food for NHS staff, visitors and patients	**Fully achieved**
Improving the uptake of flu vaccinations for front line staff within Providers	**Fully achieved**
Timely identification of sepsis in emergency departments and acute inpatient settings	**Fully achieved**
Timely treatment for sepsis in emergency departments and acute inpatient settings, IV within 1 hr	**Partially achieved**
Antibiotic review	**Partially achieved**
Reduction in antibiotic consumption per 1,000 admissions	**Partially achieved**
Improving services for people with mental health needs who present to A&E	**Fully achieved**
Offering advice and Guidance (A&G)	**Partially achieved**
Preventing ill health by risky behaviours Tobacco screening	**Partially achieved**
Preventing ill health by risky behaviours Tobacco brief advice	**Partially achieved**

Preventing ill health by risky behaviours Tobacco referral and medication offer	Partially achieved
Preventing ill health by risky behaviours Alcohol Screening	Partially achieved
Preventing ill health by risky behaviours Alcohol brief or referral	Partially achieved
NWRSCIC Spinal Delayed Discharged	Fully achieved
Neonatal Critical Care Community Outreach	Partially achieved
Dental Referral Management	Fully achieved
Dental Managed Clinical Networks	Fully achieved

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).

Southport and Ormskirk Hospitals NHS Trust is required to register with the Care Quality Commission and it's current registration status is requires improvement.

The Trust has no conditions on registration.

The Care Quality Commision has not taken enforcement action against Southport and Ormskirk Hospitals NHS Trust during April 2018 – March 2019.

The last Trust inspection was on the 27th and 28th November 2017, when the Trust underwent a two-day inspection by the Care Quality Commission Chief Inspector of Hospitals using the new inspection model.

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	**Requires 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**

On the 7th March 2018 we had an unannounced visit from the CQC who did not re-rate our services, but provided improvement suggestions for our urgent and emergency care services.

2.7 Data quality: relevance of data quality and action to improve data quality

The Trust will be taking the following actions to improve data quality:

- implement a programme of work aimed at improving data quality
- align focus on 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.

2.8 NHS number and general medical practice code validity

The Trust submitted records during April 2018 – March 2019 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data.

Which included the patient's valid NHS number was:

- 97% for admitted patient care
- 99% for outpatient care
- 98% 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

2.9 NHS Data Security and Protection Toolkit

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they have been practising good data security and that personal information is handled correctly.

We submitted all 100 mandatory items, which met the required standard for 2018/ 2019.

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	**2018/19**	**2017/2018**	**2016/2017**
Primary diagnosis	**97%**	**96%**	**95%**
Secondary diagnosis	**93.1%**	**90.76%**	**94.7%**
Primary procedure	**97.1%**	**95.89%**	**95.78%**
Secondary procedure	**92.81%**	**90.32%**	**96.55%**

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period.

PART 3

REVIEW OF QUALITY PERFORMANCE

3.1 Performance During 2018 / 2019 on National Metrics

Indicator Name	Description	Trend	Actual
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').	**96%**	**98.4%**
62 day GP referral to treatment	Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer.	**85%**	**79.8%**
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting.	**85%**	**84.1%**
Accident & Emergency – 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission.	**95%**	**85.9%**
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.	**95%**	**49.6%**
Duty of Candour – Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	**100%**	**100%**
Duty of Candour – Evidence of Letter	The proportion of patients who have received a letter of apology when something that has gone wrong with their treatment or care.	**100%**	**100%**

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 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.*

The Trust has taken the actions discussed in section 1.4.4 of this report to improve this indicator and so the quality of its services by focusing on mortality improvementthroughout the Trust.

	Oct 17 - Sep 18	Oct 16 - Sep 17
Trust	**113.16**	**117.73**
Banding	**1**	**1**
Highest performing trust	**69**	**112.78**
Lowest performing trust	**126.81**	**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.

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 17 - Sep 18	Oct 16 - Sep 17
Trust	**17%**	**20%**
England	**18%**	**31%**
Highest performing trust	**34%**	**59.5%**
Lowest performing trust	**8%**	**11.5%**

Prescribed information (Data from NHS Digital)

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.*

The Trust has taken the actions discussed in section 1.4.4 of this report to improve this indicator and so the quality of its services by focusing on mortality improvement throughout the Trust.

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. The PROMs results are published at least a year behind to allow for finalisation of the dataset.

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 2017 – March 2018 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
Hip Replacement	**91.5%**	**90%**	**3.4%**	**5.3%**	**5.1%**	**4.8%**
Knee Replacement	**76.3%**	**82.6%**	**7.5%**	**8.9%**	**16.3%**	**8.4%**

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 which is above the national average and knee replacement which is below 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 Score % Reporting Improvement	England % Reporting Improvement	Trust Score % 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 2017 – March 2018 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
Hip Replacement	**48.5%**	**68.3%**	**12.1%**	**9.7%**	**39.4%**	**22%**
Knee Replacement	**53.8%**	**59.7%**	**14.1%**	**11.7%**	**32.1%**	**28.6%**

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 2018 / 2019 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.

The percentage of patients aged 0 to 15 and 16 and over readmitted to hospital within 28 days of discharge.

	0-15	16+
April 2018	**6.25%**	**10.41%**
May 2018	**5.96%**	**10.07%**
June 2018	**7.43%**	**11.09%**
July 2018	**8.84%**	**9.91%**
August 2018	**7.41%**	**11.06%**
September 2018	**5.43%**	**10.59%**
October 2018	**6.67%**	**11.33%**
November 2018	**6.47%**	**11.25%**
December 2018	**7.65%**	**11.58%**
January 2019	**8.77%**	**11.30%**
February 2019	**7.14%**	**11.95%**
March 2019	**7.06%**	**12.04%**
Total	**7.07%**	**11.07%**

The Trust considers that this data is as described for the following reasons: the information is collected internally from our patient admission and discharge electronic records.

Prescribed information: The Trust intends to take the following actions to improve this indicator score, and so the quality of its services by:

- Reviewing all specialties where readmission rates are being flagged as higher than the expected rate.
- Identify where readmissions are due to complications of the previous admission.

3.6 Responsiveness to the Personal Needs of the Patient

National Inpatients Survey 2018

Responses were received from 533 patients at Southport and Ormskirk Hospital NHS Trust, which is a 44.71% response rate.

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	8.3 / 10	About the Same
Waiting lists and planned admissions	8.4 / 10	About the Same
Waiting to get to a bed on a ward	6.4 / 10	Worse
The hospital and ward	7.7 / 10	About the Same
Doctors	8.5 / 10	About the Same
Nurses	7.6 / 10	About the Same
Care and treatment	7.8 / 10	About the Same
Operations and procedures	7.9 / 10	About the Same
Leaving hospital	6.6 / 10	About the Same
Overall views of care and services	2.9 / 10	Worse
Overall experience	7.8 / 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 and embedded during 2018 / 2019
- Matron – Patient Experience to set up a collaborative group including staff, patient representatives and third sector organisations to look at improvements regarding discharge. Support to be requested from NHSE to re-launch and implement the Always Event Methodology®.

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.

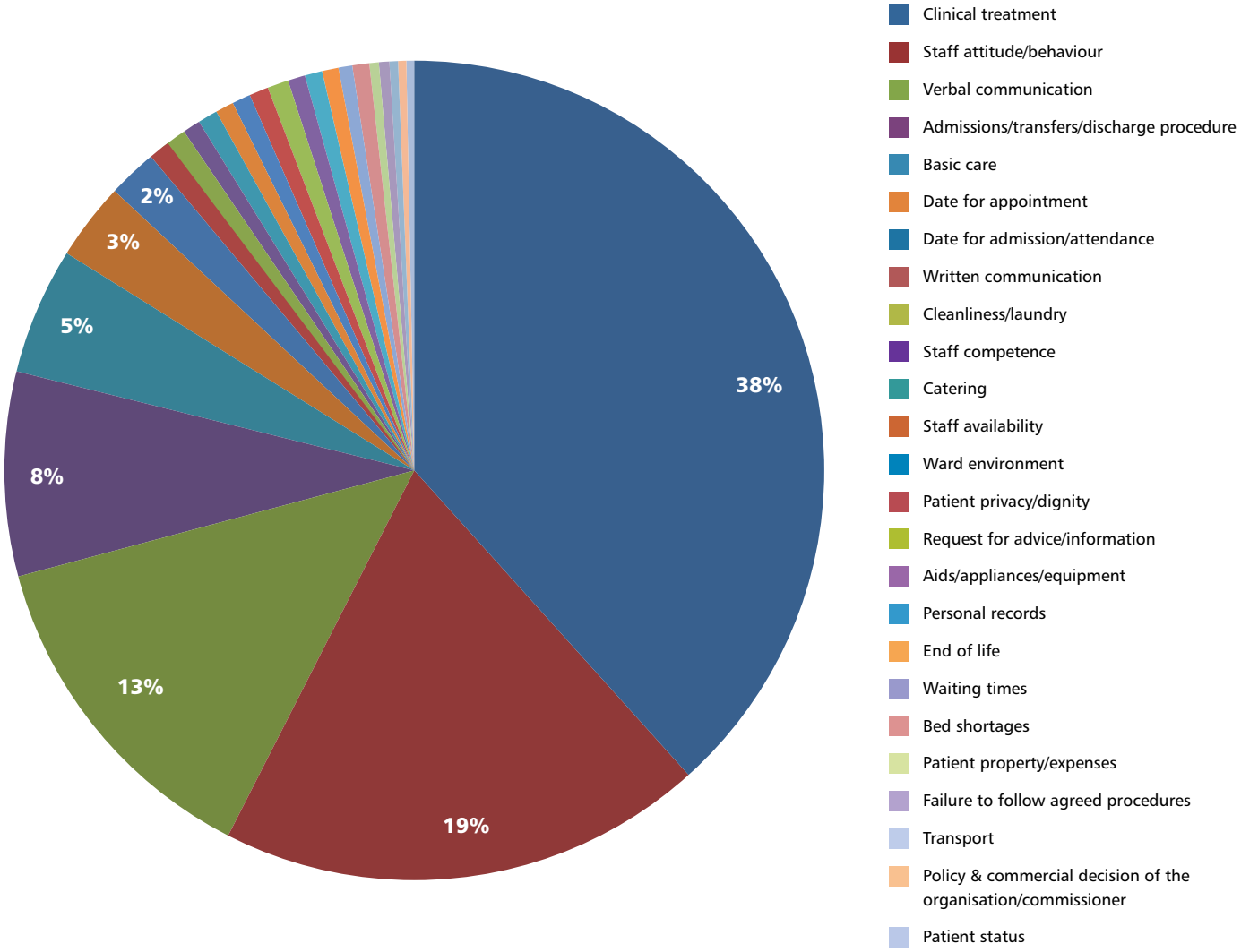
The service is responsible for coordination the process and managing the responses once the investigations and updates are received from the relevant Clinical Business units. They are contactable by telephone, email, via the Trust web site, in writing or in person. The service acknowledges all formal complaints within the required 3 days achieving 96% compliance on the standard for 2018- 2019, which is an improvement from the previous year (94%).

Patient Experience and Complaints Team information, (formal complaints, information requests and concerns by financial year- April 2018 to March 2019:

	2016/17	2017/18	2018/19
Formal Complaints	**656**	**321**	**272**
Concerns/Information Requests	**241**	**429**	**335**
Totals	**897**	**750**	**607**
Percentage change against previous year	**25% decrease**	**16% decrease**	**19% 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 2018 to March 2019 the Trust received 272 formal complaints. There has been a 19% decrease in all complaints, concerns and information requests; the decrease is a direct result of the community services being recommissioned outside of the Trust.

Complaints by ubject – 2018/19



Reopened Complaints

	Formal complaints received	Formal complaints reopened	% resolved at first response
2018/19 Q1	71	5	93%
2018/19 Q2	62	4	94%
2018/19 Q3	74	5	93%
2018/19 Q4	65	2	97%
Totals	**272**	**16**	**94%**

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 patients who have AKI and Sepsis
- 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
- Introduction of 24/7 critical out-reach team

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 2019

	2016/17	2017/18	2018/19
Investigated – not upheld	3	3	1
Investigated – fully upheld	0	0	0
Investigated – partially upheld	3	3	2
Complaint withdrawn by PHSO	1	1	1
No decision made yet – carried forward	5	4	4
Totals	**12**	**11**	**8**

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 1147 staff take part in this survey, which gave us a response rate of 40.4%. 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

Trust	Best	Average	Worst
51.9%	81%	62.6%	39.2%

	Trust 2015	Trust 2016	Trust 2017	Trust 2018
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	54%	52%	53%	51.5%
Percent of staff believing the organisation provides equal opportunities for career progression/promotion	87%	79%	79%	80.6%

Staff Experience

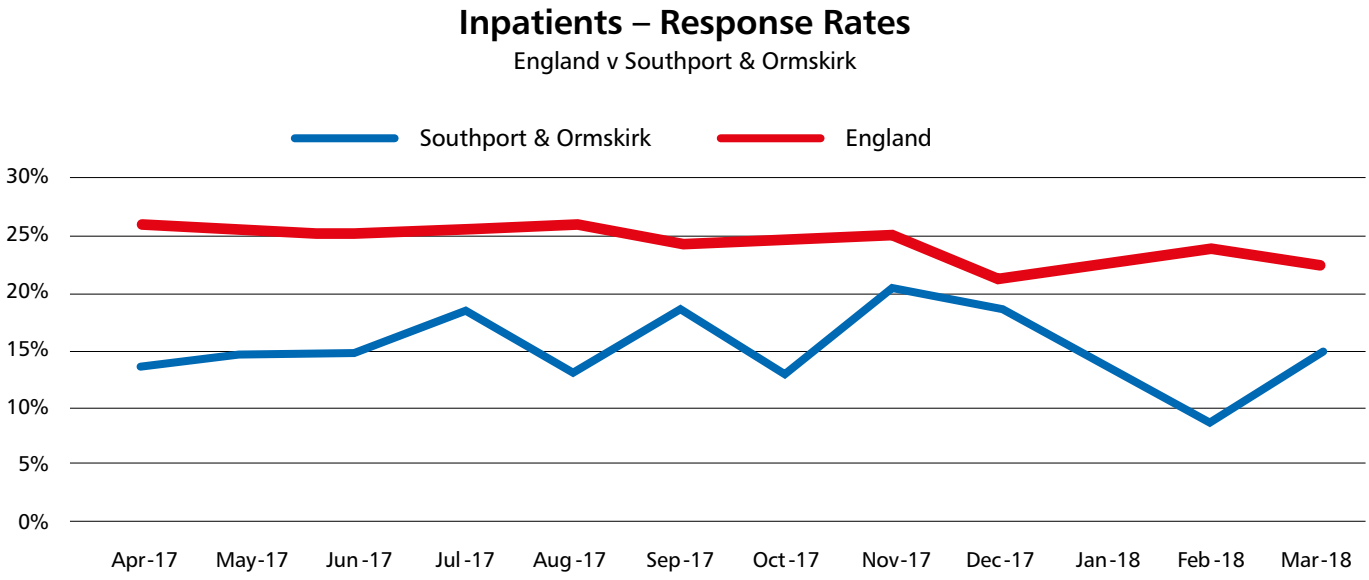
It is widely recognised that the quality of staff experience will impact on that of the patient, family and carers. This is continually acknowledged by the Trust as demonstrated below:

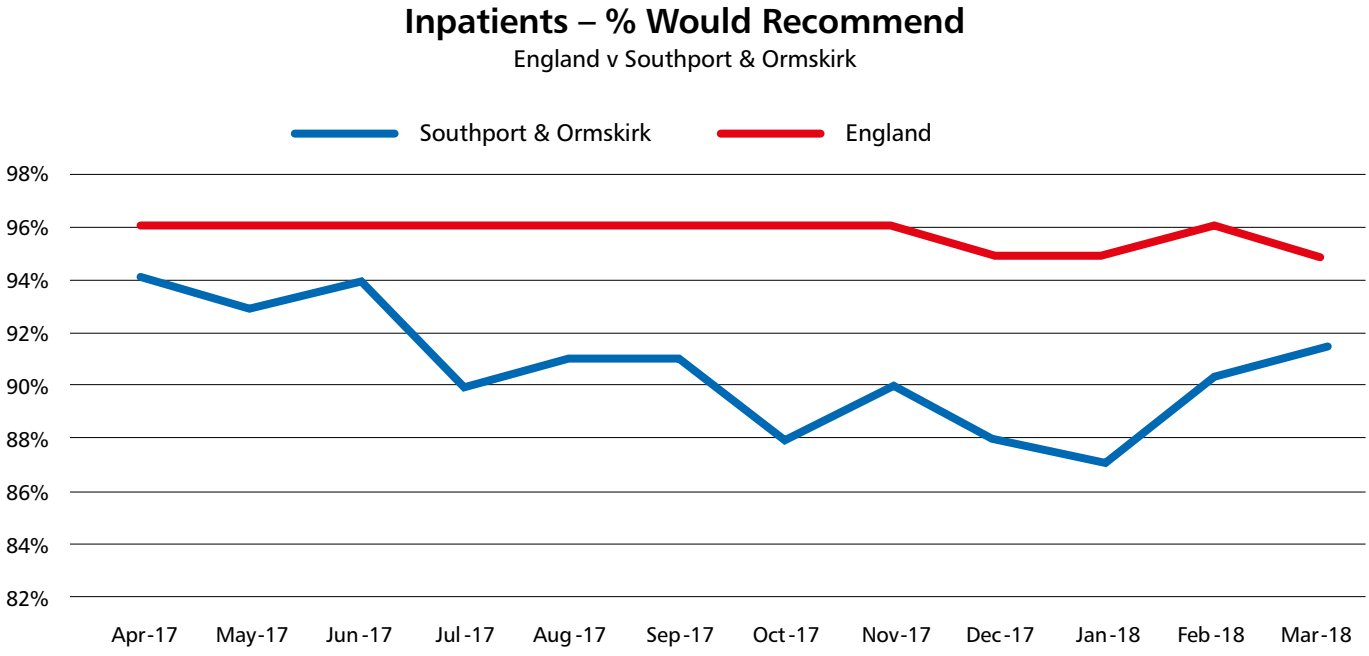
- Appointment of a freedom to speak up guardian.
- 'The Meeting Place' closed Facebook group which now has 1000 members.
- 'Straight to Silas' a way for staff to directly raise concerns with the Chief Executive.
- 'Back to the Floor' every month a member of the executive team joins staff for the day.
- Thanks a Bunch! A nominated member of staff received recognition for their work.
- 'Time to Shine' Staff awards.
- Cavell Trust 'Boost In a Box'

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	2018/2019			
	Q1	Q2	Q3	Q4
Trust	96.74%	97.48%	97.47%	97.82%
England	95.63%	95.49%	95.65%	95.74%
Highest performing trust	100%	100%	100%	100%
Lowest performing trust	75.84%	68.67%	54.86%	74.03%

Data from NHS Improvement

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

Health Care Associated Infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions. Clostridium difficile (C. difficile) and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia are nationally monitored as we are trying to reduce the incidence of these infections. C. difficile is a type of bacterial infection that can affect the digestive system, causing diarrhoea, fever and painful abdominal cramps - and sometimes more serious complications. The bacteria do not normally affect healthy people, but because some antibiotics remove the 'good bacteria' in the gut that protect against C.difficile, people on these antibiotics are at greater risk.

The MRSA bacteria are often carried on the skin and inside the nose and throat. It is a particular problem in hospitals because if it gets into a break in the skin it can cause serious infections and blood poisoning.

It is also more difficult to treat than other bacterial infections as it is resistant to a number of widely-used antibiotics.

We have a zero tolerance policy to MRSA bacteraemia infections and are working towards reducing C Difficile infections; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough.

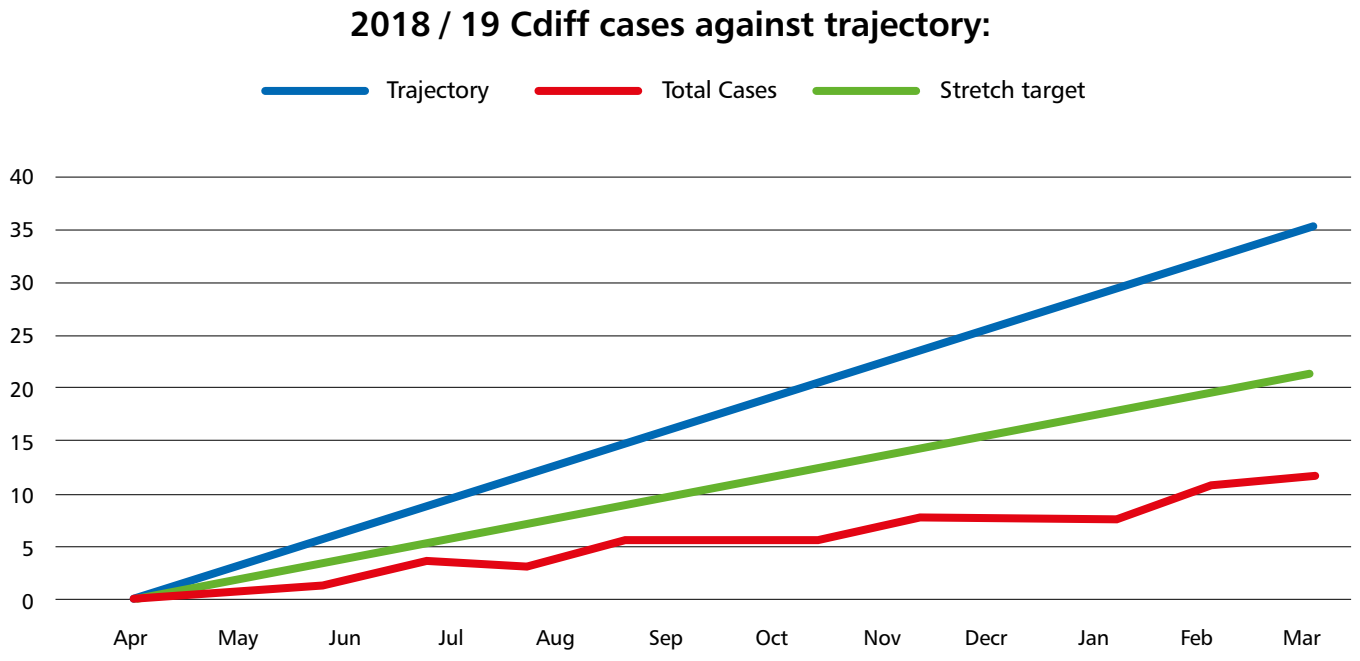
The table below shows the number of infections we have had this month plus the improvement target which has been set for us by the National Health Service Improvement (NHSi) Agency and results for the year to date. The Trust also sets its own 'internal stretch' targets as a way of improving ourselves even further.

	C. difficile	MRSA
March 2019	**1**	**0**
Annual improvement target	35	0
Actual year to date	12	0

Each incident of infection is reviewed and a thematic analysis undertaken. This is monitored through the Trusts Quality & Safety Committee

Hospital-acquired MRSA by year

10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
2	5	0	0	2	2	1	1	0



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	2015/16	2016/17	2017/18	2018/19
Trust	**26.3**	**15.9**	**15.2**	**12.7**
England	14.9	13.2	13.7	Information not available at time of publishing
Highest trust (Best Performing)	0	0	0	Information not available at time of publishing
Lowest trust (Worst Performing	67.2	82.6	91	Information not available at time of publishing

Data from NHS Improvement

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 2018/19 two incidents were 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 two Never events, 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
Never Event 1	Failure to remove guidewire from an Intravenous access line causing complications for the patient.	Lack of dedicated long term IV access service and protected time for insertions.	• Development of an dedicated long term IV access service. • Guidelines to be compiled in line with Association of Anaesthetists of Great Britain and Ireland (AGBI) Guidelines. • Review of available lines. • Dedicated theatre time for IV access lines.. • IV access line passport to be implemented for nurses to follow.
Never Event 2	Retained delivery tampon.	The panel considered the root cause of the incident as failure to acknowledge the insertion of the tampon at the time of perineal repair.	• Removal of the tampon from the delivery packs and package separately. • Traceability sheet implemented when tampons used and details removal. • A review of the Maternity Standard Operating Procedure 30: the role of the scrub person to ensure a dedicated scrub person in theatre for all Maternity cases. • Review of maternity documentation to include use of tampon. • Audit changes in practice • Development of Maternity LocSIPPs. • Share lessons learned regionally via the Cheshire and Merseyside Clinical Expert Group. • Strengthen locum arrangements in Maternity services.

3.12 Reported Patient Safety Incidents

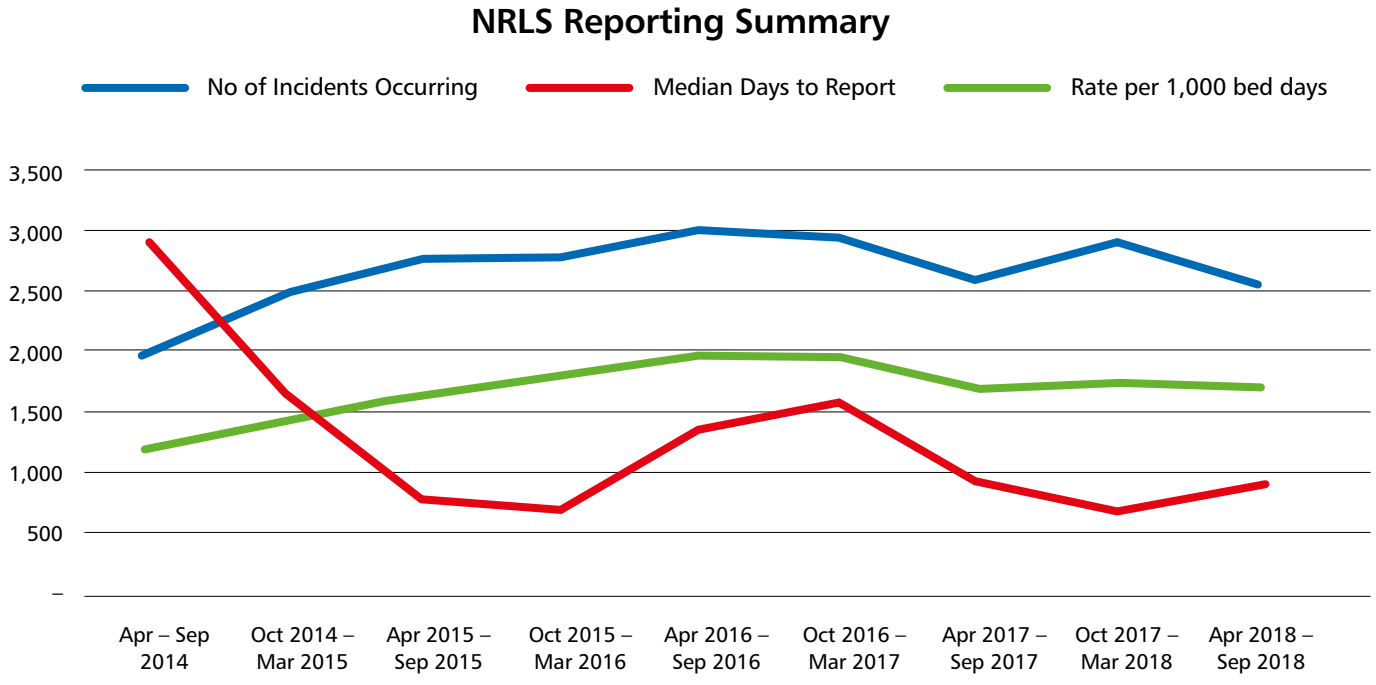
The Trust exports all patient safety incidents on an ongoing basis to the National Resource and Learning System (NRLS). Data submitted to the NRLS is published bi-annually. Increases in the number of incidents reported reflects an improved reporting culture and should not be interpreted as a decrease in the safety of the NHS. Equally, a decrease cannot be interpreted as an increase in the safety of the NHS.

The latest published data for Southport & Ormskirk shows a decrease in the number of incidents reported in the six months from April – September 2018, with 2,555 incidents reported (2,908 in the previous 6 month period). Interrogation into this decrease has highlighted issues with 5 files (totalling 283 incidents) which have been exported from Datix but have not been received by the NRLS. This has been escalated to the NRLS and is awaiting a response. Taking into account the missing files, this is still a decrease on the previous period.

This decrease in reporting has resulted in a reduction in our reporting per '000 bed days and a lower ranking against other Acute trusts (83/131, previously 71/134). There has also been a slight increase in our median days to report to the NRLS, from 16 to 21 days, as a direct result of delays with incident management within the Clinical Business Unit's. The performance is illustrated in the table and graph below.

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 2018 – Sept 2018	2,555	21	39.6	83/131

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.



Incident Reporting by Harm

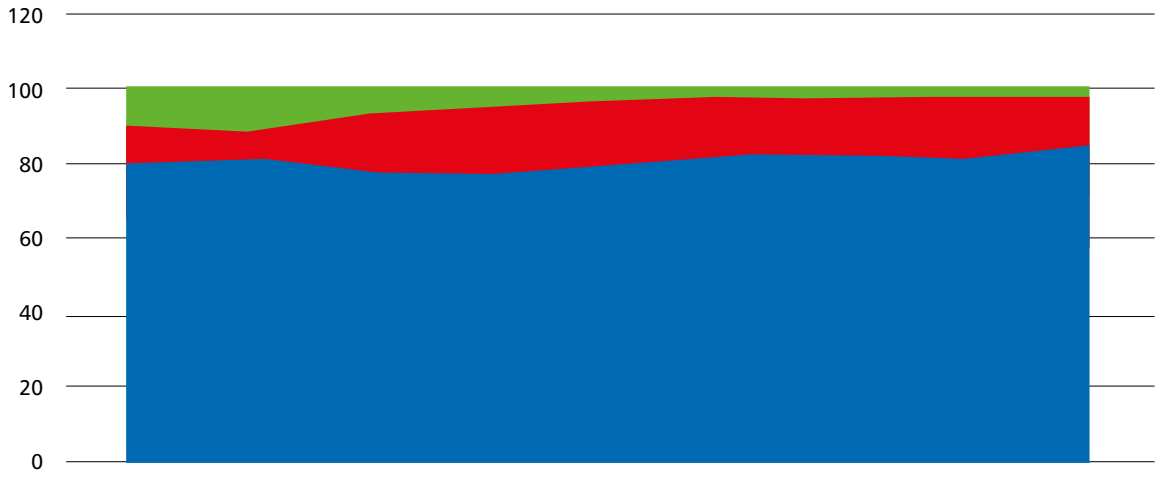
Analysis of the patient safety incidents by level of harm is favourable and shows improvement. 98.3% of all reported incidents caused no or low harm to the patient and no incidents resulting in death were reported. The table below compares data for Southport & Ormskirk with all Acute Trusts.

	% No Harm	% Low Harm	% Moderate Harm	% Severe Harm	% Death
All Acute Trusts	78.5	19.4	1.8	0.2	0.1
Southport and Ormskirk Hospital NHS Trust	85.1	13.2	1.5	0.2	0

Incident Reporting by Category

All incident categories and sub-categories contained within each Trust's local incident management system are mapped to the national Common Classification System (CCS) coding, which enables benchmarking across all reporting organisations. The way local codes are mapped can differentiate between organisations and can account for some of the differences between Trusts.

NRLS Reporting by Level of Harm



	Apr – Sep 2014	Oct 2014 – Mar 2015	Apr 2015 – Sep 2015	Oct 2015 – Mar 2016	Apr 2016 – Sep 2016	Oct 2016 – Mar 2017	Apr 2017 – Sep 2017	Oct 2017 – Mar 2018	Apr 2018 – Sep 2018
% Death	0.1	0.2	0.2	0.04	0.1	0.0	0.1	0.0	0.0
% Severe Harm	0.5	0.3	0.5	0.3	0.3	0.1	0.2	0.1	0.2
% Moderate Harm	9.5	10.2	5.9	3.9	1.7	1.5	1.5	1.3	1.5
% Low Harm	9.8	7.9	14.2	18.1	18.7	15.7	15.0	16.4	13.2
% No Harm	80.2	81.3	79.1	77.7	79.1	82.6	83.1	82.2	85.1

The table below shows the proportion of incidents reported by CCS code; comparing all Acute Trusts with Southport & Ormskirk.

	All Acute Trusts	Southport and Ormskirk Hospital NHS Trust
Patient accident	15.2	15.5
Implementation of care and ongoing monitoring / review	14.6	4.9
Access, admission, transfer, discharge (including missing patient)	12.6	22.4
Treatment, procedure	12.2	13.9
Medication	10.9	6.9
All other categories	8	7.9
Clinical assessment (including diagnosis, scans, tests, assessments)	6.8	4.2
Documentation (including records, identification)	6.5	10.6
Infrastructure (including staffing, facilities, environment)	5.7	4.1
Consent, communication, confidentiality	4.5	7.9
Medical device / equipment	3	1.8

The table above highlights the following:

- Southport & Ormskirk is in line with peer organisations for reporting of patient accidents.
- Southport & Ormskirk are reporting a higher proportion of Communication and Documentation incidents than peer organisations. This is as a direct result of an increase in Information Governance incidents impacted by lack of electronic records and non-compliance with Information Governance training.
- The Trust is reporting a lower proportion of Medication, Clinical assessment, Infrastructure and Medical device incidents, which could indicate under reporting.
- Southport & Ormskirk are reporting a higher proportion of Access, admission, transfer, discharge (including missing patient) incidents than peer organisations. This is primarily due to the reporting of Bed management incidents.
- The Trust is reporting a lower proportion of Implementation of care and ongoing monitoring / review incidents. This primarily relates to Pressure Ulcers, some Infection Control and some Clinical Care incidents.

Conclusion

- Whilst a reduction in incident reporting is evident in the latest published 6 month period, the proportion of incidents reported as causing no harm to the patient has increased and is almost 7% higher than the national average for Acute Trusts.

- In response to the missing files, the Integrated Governance Team has implemented robust methods to check every file has been received. Checks on the latest six month period have not shown any issues.

- The Trust is working closely with the Patient Safety team at NHS Improvement and will become involved in the DPSIMS project. Part of the remit of this project is to work with both Trusts and local risk management system providers to standardise coding around incidents. This will enable more meaningful benchmarking and comparisons in incident reporting between Trusts.

- The Trust recognises there could be under-reporting of some incident types and continues to educate staff around incident reporting. Improvements in dissemination of lessons learnt will further support this.

3.13 Pressure Ulcers

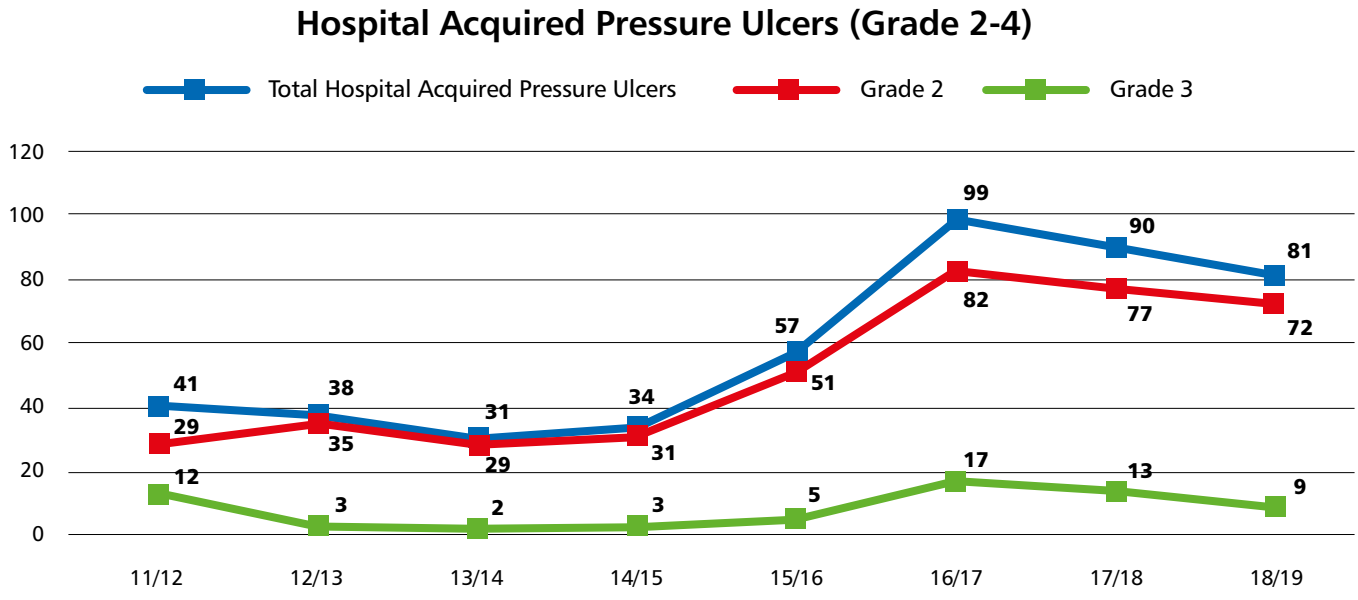
Pressure ulcers are localised injuries to the skin and/or underlying tissue as a result of pressure. They are sometimes known as bedsores. They can be classified into four categories, with one being the least severe and four being the most severe. The pressure ulcers reported include all validated avoidable / unavoidable pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.

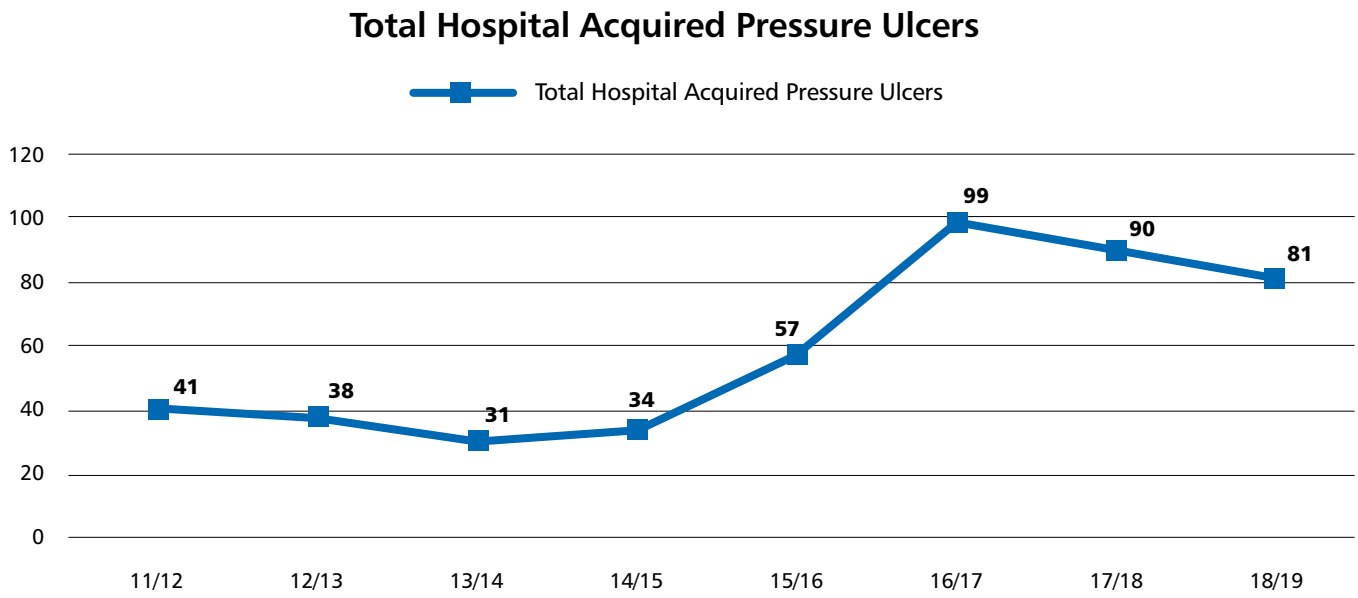
The pressure ulcer numbers include all pressure ulcers that occurred from 72 hours after admission to this Trust

So we can know if we are improving, even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report pressure ulcers in different ways, and their patients may be more or less vulnerable to developing pressure ulcers than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 1,000 occupied bed days	0.67

We have reduced the overall number of hospital acquired pressure ulcers from 90 in 2017/2018 to 81 in 2018/19.





There 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.

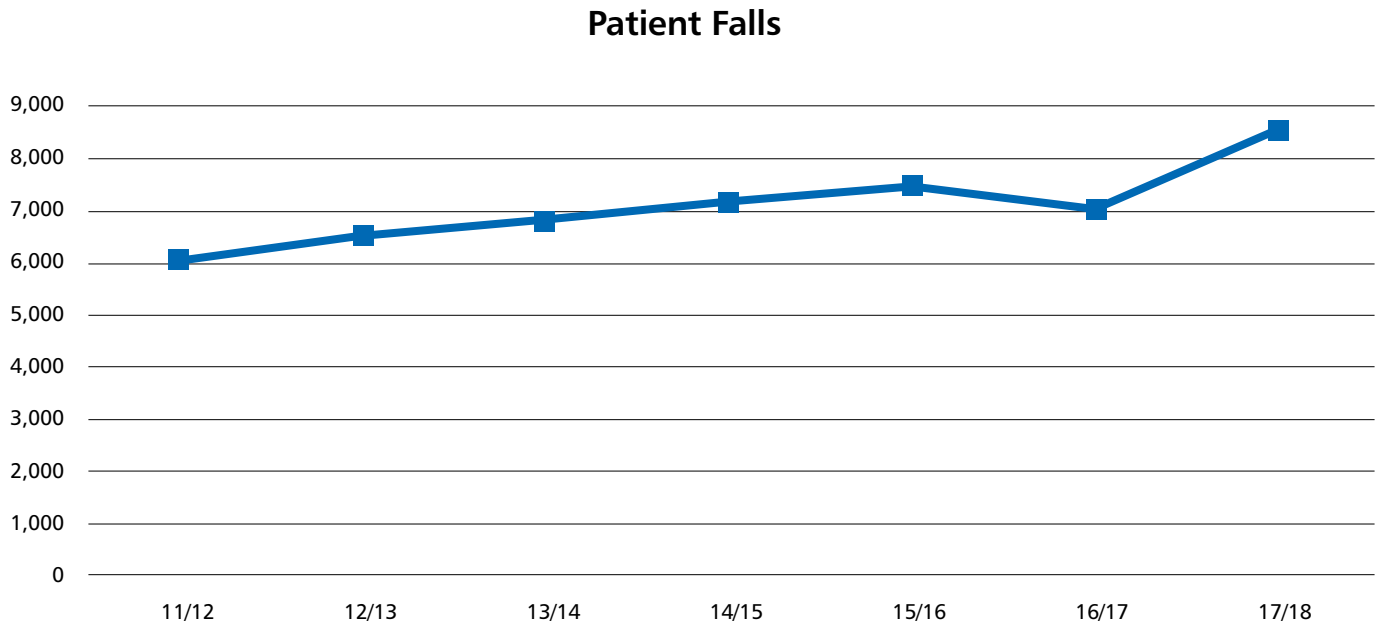
This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause. This includes avoidable and unavoidable falls sustained at any time during the hospital admission.

March 2019	1	Falls that caused at least moderate' harm

In order to know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us to other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 1,000 occupied bed days	5.42

The total number of patient falls has increased during 2018 / 2019



During 2018 / 19 the Trust identified a lead for falls which a clear action plan for improvement. Including reviewing our falls risk assessment tool and reviewing our falls alarms currently in use.

APPENDIX 1

The national clinical audits that the Trust participated in during April 2018 – March 2019 are as follows:

Not Eligible – 16

Participated/participating – 48

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Eligible/Participating
Acute Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	Not eligible
Adult Community Acquired Pneumonia	British Thoracic Society	Date Collection underway
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: Radical Prostatectomry	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
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
Elective Surgery (National PROMs Programme)	NHS Digital	All eligible cases submitted
Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians	All eligible cases submitted
Feverish Child	Royal College of Emergency Medicine	All eligible cases submitted
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
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	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

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Eligible/Participating
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
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes and Research	Currently behind with inputting cases due to staff vacancy
National Asthma and COPD Audit Programme	Royal college of Physicians	All eligible cases submitted
National Audit of Anxiety and Depression	Royal college of Psychiatrists	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 Cardiac Rehabilitation	University of York	All eligible cases submitted
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking	All eligible cases submitted
National Audit of Dementia	Royal College of Psychiatrists	All eligible cases submitted
National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	Not eligible
National Audit of Percutaneous Coronary Intervention (PCI)	National Institute for Cardiovascular Outcomes Research	Not eligible
National Audit of Pulmonary Hypertension	NHS Digital	Not eligible
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	All eligible cases submitted
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	Not eligible
National Bowel Cancer Audit (NBOCA)	NHS Digital	All eligible cases submitted
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	All eligible cases submitted
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology	All eligible cases submitted
National Clinical Audit of Psychosis	Royal College of Psychiatrists	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 Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research	Not eligible
National Diabetes Audit – Adult	NHS Digital	All eligible cases submitted

National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Eligible/Participating
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	All eligible cases submitted
National Mortality Case Record Review Programme	Royal College of Physicians	Introduced the Structured Judgement Review process
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	All eligible cases submitted
National Oesophago-gastric Cancer (NAOGC)	NHS Digital	All eligible cases submitted
National Ophthalmology Audit	The Royal College of Ophthalmologists	All eligible cases submitted
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	All eligible cases submitted
National Prostate Cancer Audit	Royal College of Surgeons of England	All eligible case submitted
National Vascular Registry	Royal College of Surgeons of England	Not eligible
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Not eligible
Non-Invasive Ventilation –Adults	British Thoracic Society	Date Collection underway
Paediatric Intensive Care (PICANet)	University of Leeds	Not eligible
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	Not eligible
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Public Health 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
Seven Day Hospital Services	NHS England	All eligible cases submitted
Surgical Site Infection Surveillance Service	Public Health England	All eligible case submitted
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	All eligible cases submitted
Vital Signs in Adults	Royal College of Emergency Medicine	All eligible cases submitted
VTE risk in lower limb immobilisation	Royal College of Emergency Medicine	All eligible cases submitted

The national confidential enquiries that Southport & Ormskirk Hospital NHS Trust participated in during April 2018 – March 2019 are as follows:

	Number of clinical questionnaires returned	Number of case notes returned
Perioperative Diabetes	1	1
Pulmonary Embolism	2	5

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 2018-19 Commentary.

Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the draft Quality Account 2018-19. We attended the Quality Account session on the 3rd May 2019 at which the Trust presented and this was very useful.

In reviewing the readability of the report, it was very helpful to have access to the presentation slides from the above event, as this made the report more user-friendly. From a public perspective, the use of abbreviations is a concern despite there being a comprehensive glossary. It would be helpful if the glossary was at the front of the account to support the reader. There are also a number of abbreviations which are used throughout the account which are not included within the glossary for example, AKI is used on page 29 and on page 22 SSU is used This can make reading the report confusing.

Southport and Ormskirk Hospital NHS Trust and their staff have been very supportive of the role and presence of Healthwatch Sefton this year and we continue to remain proactive in the following areas: member of the patient experience group, equality and diversity agenda, holding patient experience stands at both trust sites and supporting the review of patient leaflet reviews.

It is great to read information within the account about the Trusts work to improve patient experience, 'developing the experience of care', being one of the quality aims for 2018-19. The report shows evidence of the trusts engagement with the voluntary, community and faith sector, for example, the comfort packs from Girl Guide groups, work undertaken to capture patient and families memories and the development of a booklet to support with the issue of loneliness. There is also evidence of the recognition of carers, which is a focus for pledge one and how the trust is ensuring their needs are met whilst in the hospital setting. All of the work above has been undertaken to support the progression of the pledges made to improve patient and family experience and should be noted.

We have supported the Trusts 'Patient Led Assessment of the Care Environment (PLACE) visits over the past 12 months but have struggled to receive copies of the reports. We did receive a copy of the reports following a formal request to the Deputy Director of Nursing and have since written to the trust to formally share our position in being involved in future visits.

Healthwatch Sefton
Sefton CVS, 3rd Floor, Suite 3B, North Wing, Burlington House,
Crosby Road North, Waterloo, L22 0LG
Tel: 0800 206 1304/ 0151 920 0726 ext 240 Mobile: 07434810438
info@healthwatchsefton.co.uk, www.healthwatchsefton.co.uk
Healthwatch Sefton *Company Ltd by Guarantee Reg. No: 8453782*

healthwatch Sefton

The report also recognises the work of the Trust's 'Patient Experience Group. As an organisation, we have over the last 12 months shared our concerns about the role and remit of the group. The group which meets bi-monthly and has representation from Healthwatch Sefton and other patient representatives, has not been asked to monitor for example, the results of patient experience surveys/questionnaires nor results from the Friends and Family test and this is an area of concern. We as an organisation do not have assurances at present and also have no assurances as to where the reports and feedback we share are reviewed within the trusts governance structure. We are aware that the Trust is currently reviewing the group and how patient experience is monitored moving forward and we would be keen to be part of the two groups which the Trust is looking to establish.

In reviewing information relating to staff working at the trust, we are concerned that only 51.5% of staff would recommend the trust as a place to receive treatment. There is however, evidence that staff welfare is being supported.

We are concerned that in assessing the Trusts progress with seven day service provision, there are a number of targets which have not been achieved and in some areas, targets have fallen. We were however pleased to read that there is a plan in place to improve this area.

Length of stay/ delays in discharge are particularly apparent within the report, particularly for those patients receiving postnatal care (pledge 5). We would like to be updated on this area over the next 12 months.

We were pleased to review a number of the Trusts key highlights for the previous year and we would like to note the improvements in the national bowel cancer screening results, particularly for the 90 day mortality rate after surgery, with the trust being second in the region for this target. The introduction of a critical care outreach team which is providing a 24 hour, 7 day a week service is welcomed, as is the Trusts achievement in not reporting a case of MRSA (meticillin-resistant Staphylococcus aureus) bacteria since September 2017. The improvements in implementing 'duty of candour' across the trust, is also welcomed to address the issues of transparency.

We have reviewed the quality aims for the coming year and will note them with regards to our own work over the next 12 months. In looking forward, we would like to be involved in the trusts 'Vision 2020' and look forward to working with the Trust over the next 12 months. .

4.2 Sefton Overview and Scrutiny Committee

Sefton Council

Mr. Silas Nicholls
Chief Executive
Southport and Ormskirk Hospital NHS Trust
Southport and Formby District General Hospital
Town Lane
Kew Southport
PR8 6PN

Sefton Council,
Town Hall,
Trinity Road,
Bootle
L20 7AE
21 May 2019
Ref: DAC/QAs
Tel: 0151 934 2254
Email: debbie.campbell@sefton.gov.uk

Dear Mr. Nicholls,

Southport and Ormskirk Hospital NHS Trust – Quality Account 2018/19

As Chair of Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health), I write to submit a commentary on your Quality Account for 2018/19.

Members of the Committee met informally on 10 May 2019 to consider your draft Quality Account, together with representatives from Healthwatch Sefton and from the local Sefton CCGs. We welcomed the opportunity to comment on your Quality Account and I have outlined the main comments raised in the paragraphs below.

Dr. Terry Hankin, Medical Director and Juliette Cosgrove, Director of Nursing, attended from your Trust to provide a presentation on the Quality Account and to respond to our questions.

We had chosen to comment on the Trust's draft Quality Account as we were conscious that you have now been in post for some months and we were keen to hear about any developments.

We received a presentation from the Trust representative outlining the following:-

- Key Highlights of Previous Year 2018/19;
- Review of Quality Aims 2018/19;
- Developing the Experience of Care;
- Pledge 8 – Capturing patients and family's memories to share and cherish for the future;
- National Maternity Patient Survey (CQC);
- Reducing Mortality;
- Learning from Deaths;
- Preventing Harm;
- Looking Forward to 2019/20
- Looking Forward to Quality Aims 2019/20;
- Care of the Deteriorating Patient;

- Care of Older People;
- Infection Prevention and Control;
- Medicines Management;
- 7 Day Services; and
- Details of ways in which staff can speak up without fear of suffering detriment.

We were reminded that the Trust is separated over two different sites in both Southport and Ormskirk which are very different communities and that emergency services needs to be brought together into one place, although it remains to be seen where this could be.

We heard about the 2020 Vision; the Garden of Reflection; and safer staffing. Regarding reduced mortality, we were told that the Trust is one of 15 hospitals where mortality is higher than expected. Respiratory disease is one of the main killers, particularly with an older population, and more work needs to be done on recognising this. There is also a national strategy to learn from deaths and performance needs to be better in relation to acute kidney injury.

We asked about unexpected deaths associated with poor care and heard that end of life conditions are not always recognised as such within the community and that end of life care needs to be appropriate. We also asked about pneumonia in hospital and heard that patients are treated for the condition and that heart failure, the commonest cause of death in such cases, is not always recognised.

We heard about the Trust's 4 Quality Aims for 2019/20; care of older patients; pharmacy capacity; and ways in which staff can speak up without fear.

We discussed the Friends and Family Test for the Trust, as we felt that the response rate could be improved and heard that the Trust recognises this and is looking at IT initiatives to improve rates. It was acknowledged that a more responsive patients' engagement process is required. Trust representatives also acknowledged that a better staff survey is important. We also discussed the importance of protecting A&E services, particularly in terms of sustainability for the Trust. It was acknowledged that the 2 sites for the Trust presents an issue for A&E, especially as there is unlikely to be any additional funding for improvements to the existing estate in the next 5 years.

We heard about elective care, which takes the pressure of A&E and beds, particularly in Southport. It was acknowledged that the actual patients experience is not always as good as it could be. Trust representatives recognised that over-crowding on wards can occur.

We also discussed mortality and heard that discharging patients from hospital as quickly as possible has reduced mortality. We asked whether demographics is a factor that influences the Trust's mortality rates and it was considered that there are multiple factors, such as increasing demand for acute care, with no one clear answer.

It was acknowledged that services required by the local population need to be delivered locally, as that is what local communities want. There is a need to consider which basic district general hospital services are required and how they will be delivered.

Discussion took place on stroke services as the Trust has a 24-hour stroke service, in order to meet the needs of the local population. The data for TIAs is not currently being collected for scrutiny by the Committee.

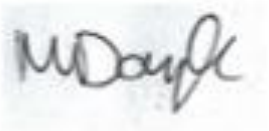
We discussed staff morale and the need to improve staff's working lives. It was acknowledged that a number of interim Chief Executives have passed through the Trust during the last few years and it has been a challenge to reassure staff that the Trust was sustainable. Regulators had an expectation of rapid improvement, which could be

frustrating if it was not easily achievable. There was a need to obtain measurable patient experience in order to support the Trust's success stories. We discussed the need for an integrated healthcare system and it was acknowledged that this will take time. There is a need to obtain and maintain stability at the Trust. There will be a CQC inspection over the summer and the Trust will be under pressure to prove it has improved.

We very much appreciated the opportunity to scrutinise your draft Quality Account for 2018/19 and were grateful for the attendance at our meeting of the Trust representative. I hope you find these comments, together with the suggestions raised at the meeting, useful.

Please accept this letter as Sefton OSC's formal response to your Quality Account.

Yours sincerely,



Councillor Mhairi Doyle, M.B.E.
Chair of Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health)

4.3 West Lancashire CCG and Southport & Formby CCG

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

NHS
West Lancashire
Clinical Commissioning Group

NHS Southport & Formby and NHS West Lancashire CCGs, welcome the opportunity to comment on Southport & Ormskirk Hospitals NHS Trust Quality Account for 2018/19. We have continued to work closely with the Trust in what has been another challenging year and in particular with the new executive leadership, to gain assurances that the services delivered were safe, effective and personalised to service users. The CCG share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care. The account reflects progress against most indicators.

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 promote safety and quality of care.

The Commissioners welcome the progress made on the 2018/19 quality priorities and acknowledges the commitment to reducing mortality and preventing harm and of particular note is the implementation of the new clinical pathways for pneumonia, sepsis and acute kidney injury and the outcomes of the national cancer bowel audit.

The CCGs also acknowledge the commitment of the Trust during 2018/19 in working towards the aim of developing the experience of care. The Trust continues to perform relatively below other comparable Trusts in relation to the numbers of patients and staff responding and feeding back via the Friends and Family Test (FFT). The CCGs looks forward to working with the Trust in 2019/20 in improving response rates through sharing best practice from within the Health Economy.

The Trust currently has an open Contract Performance Notice – Breach of National Serious Incident Framework. The Trust has an improvement plan in place; the CCGs note that the culture of reporting, investigating incidents and the quality of root cause analysis (RCA's) has improved. There has been work undertaken to increase openness and transparency across directorates. The Trust acknowledges that there is still work to be done to see sustainable improvements. The Trust expects to be able to deliver against the 60 day timeframe by November 2019.

The CCGs acknowledge the Quality Aims of the Trust which underpins the Vision 20/20 strategy to provide successful and sustainable care for local people:

NHS Southport & Formby CCG Chair: Dr Rob Caudwell
NHS South Sefton CCG Acting Chair: Dr Craig Gillespie
Chief Officer: Fiona Taylor

HSJ VALUE AWARDS 2018
HIGHLY COMMENDED

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

NHS
West Lancashire
Clinical Commissioning Group

1. Care of the Deteriorating Patient
2. Care of Older People
3. Infection Prevention and Control
4. Medicines Management

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account against the latest nationally published data where possible.

Commissioners are aspiring through strategic objectives 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 excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are reflective of how the Trust will further improve services to address the current issues across the health economy.

We acknowledge the actions the Trust is taking to improve the quality as detailed in this Quality Account. It is felt that the priorities for 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

Signed
Fiona Taylor, Chief Officer

Date: 17/05/2019

West Lancashire CCG

Signed
Mike Maguire, Chief Officer

Date: 17/05/2019

HSJ VALUE AWARDS 2018
HIGHLY COMMENDED

NHS Southport & Formby CCG Chair: Dr Rob Caudwell
NHS South Sefton CCG Acting Chair: Dr Craig Gillespie
Chief Officer: Fiona Taylor

4.4 Independent Auditors Limited Assurance Report to the Directors of Southport and Ormskirk Hospitals NHS Trust on the Quality Account

We are required to perform an independent assurance engagement in respect of Southport and Ormskirk Hospital NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 2019 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 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 the DHSC on 29 January 2015 ("the Guidance") and applicable to 2018/19; 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 conclude whether it is consistent with the requirements of the Regulations and to 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 2018 to April 2019;

- papers relating to quality reported to the Board over the period April 2018 to May 2019;

- joint feedback from NHS South Sefton, Southport and Formby, and West Lancashire Clinical Commissioning Groups dated 17 May 2019;

- feedback from Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health) dated 21 May 2019;

- feedback from Healthwatch Sefton dated 5 June 2019;

- 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 2019;

- the annual governance statement dated 24 May 2019; 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, is made solely to the Board of Directors of Southport and Ormskirk Hospitals NHS Trust. We permit the disclosure of this report 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 Hospitals NHS Trust for our work or this report save 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;
- making enquiries of management;
- 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 & Ormskirk Hospital NHS Trust.

Basis for qualified conclusion

We identified five errors from a sample population of twenty five items in our detailed testing of the percentage of patients risk-assessed for venous thromboembolism (VTE) indicator.

We were unable to reconcile reported quarterly performance to the underlying data for quarters one and two of 2018/19.

The indicator included in the Quality Report for the year ended 31 March 2019 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 matters 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 2019:

- 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.

Signed:

Karen Murray
Director for and on behalf of Mazars LLP

Date:

On St. Peter's Square
Manchester
M2 3DE

GLOSSARY

A&E (AED)	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
DoLs	Deprivation of Liberty
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
LeDeR	The Learning Disabilities Mortality Review
MDT	Multi-Disciplinary Team

GLOSSARY	
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
Red Bag	When a care home resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items.
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
VitalPAC	is a mobile software information system for monitoring the vital signs of hospital patients
VTE	Venous Thrombo-Embolism
WRVS	Women's Royal Voluntary Service